RISE CENTER FOR PSYCHOLOGY

NEW CLIENT FORM

CLIENT:

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

FOR CLIENTS UNDER AGE 18:

MOTHER'S NAME: _____ AGE: _____ FATHER'S NAME: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____

CELL: (M) _____ (D) _____

EMAIL: (M) _____ (D) _____

MARITAL STATUS OF PARENTS: (Circle One) Married Separated **Divorced*** Widowed

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***If Divorced:** Custody: _____

Visitation: _____

Child's Main Residence: _____

SIBLINGS:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

DOES THE CLIENT HAVE A HISTORY OF, OR IS THERE ANY FAMILY HISTORY OF THE FOLLOWING? (PLEASE NOTE RELATIONSHIP TO THE CLIENT IF THERE IS A FAMILY HISTORY):

DEPRESSION: □YES □NO _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: □YES □NO _____

ANXIETY: □YES □NO _____

ADHD: □YES □NO _____

AUTISM: □YES □NO _____

DEVELOPMENTAL DELAYS: □YES □NO _____

SELF-INJURY: □YES □NO _____

ATTEMPTED/COMPLETED SUICIDE: □YES □NO _____

ALCOHOLISM/SUBSTANCE ABUSE: □YES □NO _____

LEARNING DISABILITIES: □YES □NO _____

PSYCHIATRIC HOSPITALIZATION: □YES □NO _____

HEAD INJURY: □YES □NO _____

HEART PROBLEMS: □YES □NO _____

DIABETES: □YES □NO _____

SEIZURE: □YES □NO _____

ALLERGIES: □YES □NO _____

OTHER SIGNIFICANT MEDICAL/PSYCHIATRIC FAMILY HISTORY:

_____

_____

_____

_____

_____

_____

_____

MEDICAL:

1) OTHER THERAPIST OR OTHER MENTAL HEALTH PROVIDER:
May we contact this person for the purposes of treatment coordination? □ YES □NO

NAME: _____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

2) PRIMARY CARE PHYSICIAN/PEDIATRICIAN:
May we contact this person for the purposes of treatment coordination? □ YES □NO

NAME:_____ OFFICE PHONE:_____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP:_____

3) CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)

MEDICATION NAME	DOSAGE	SCHEDULE (e.g AM, PM)	REASON

CURRENT SCHOOL IF APPLICABLE:

SCHOOL: _____ GRADE: _____

IS THERE A 504 PLAN IN PLACE? YES □ NO □ IS THERE AN IEP IN PLACE? YES □ NO □

HAS PSYCHOLOGICAL OR PSYCHOEDUCATIONAL TESTING EVER BEEN ADMINISTERED? YES □ NO □

IF IN HIGH SCHOOL, DO YOU CURRENTLY HAVE A COLLEGE COUNSELOR? YES □ NO □

HOW DID YOU HEAR OF OUR PRACTICE?

REFERRAL SOURCE:_____