POSITIVE YOUTH CONCEPTS
Child and Adolescent Therapy

24 Front Street, Suite 302
Exeter, NH 03833
603-418-7480

Scott D. Singleton: LCMHC, LMHC, M.Ed.

NEW CLIENT FORM

Date: _______/_______/______

Client's Name: ____

Address: __________________________________ City _____________________ State _____ Zip ________

D.O.B.: _________/________/_________ Age: _______________ Sex: ____________________

===

Guardian's Name: ____

Custody: Physical - Yes / No - Legal - Yes / No Tel. (home): ( ) ________ - _____________

Tel. (cell): ( ) ________ - __________ Tel. (work): ( ) _________- _____________

Address: __________________________________ City: _____________________ State: ______ Zip:__________

Email:____

Mother's Name: ____

Custody: Physical - Yes / No - Legal - Yes / No Tel. (home): ( ) ________ - _____________

Tel. (cell): ( ) ________ - __________ Tel. (work): ( ) _________- _____________

Address: __________________________________ City: _____________________ State: ______ Zip:__________

Email:____

Father's Name: ____

Custody: Physical - Yes / No - Legal Yes / No Tel. (home): ( ) ________ - _____________

Tel. (cell): ( ) ________ - __________ Tel. (work): ( ) _________- _____________

Address: __________________________________ City: ______________________ State: ______ Zip: _________

Email:____

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Emergency Contact Person ____Tel. (   ) _______-____________

Address__________________________________ City: ______________________ State: ______ Zip: _________

Email:____

Insurance Company:

____

Address__________________________________ City: ______________________ State: ______ Zip: _________

Group Name: __________________________ Group #: ___________________ Cert.# / ID#: _______________

Subscriber Name: ____ D.O.B.:______/______/______

Relationship to Client: ___________________ Subscriber's Employer: __________________________________

Address__________________________________ City: ______________________ State: ______ Zip: _________

Responsible Party: (To whom bills should be addressed?)

Name: ____ Relationship to Client: __________________

Address____ City: __________________ State: ______ Zip:________

D.O.B.: _________/________/_________   Tel. (home): (   ) ________ - ____________

Tel. (cell): (   ) ________ - __________   Tel. (work): (   ) _________- ______________

Family Physician Name:___________________________________ Phone: (   ) _________- ______________

Business Address:____

==

Briefly describe the reason for your visit today: ____

____

____

____

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Family Dynamics

Guardian's Marital History

Current status: ___Married ___Single ___Divorced ___Widowed ___Separated ___Living with someone

Please list all current members living in the house hold and their relationship to the client.

1.) Name:____. Age:______ Relationship:______________________

2.) Name:____. Age:______ Relationship:______________________

3.) Name:____. Age:______ Relationship:______________________

4.) Name:____. Age:______ Relationship:_______________________

5.) Name:____. Age:______ Relationship:_______________________

Please list other significant family members the client Resides With or Receives Care From on a regular basis.

1.) Name:____. Age:______ Relationship:________________________

2.) Name:____. Age:______ Relationship:________________________

3.) Name:____. Age:______ Relationship:_________________________

Family History

Mother

What is the Client's mother's Name: ____ Age ________
Age at Clients Conception: ________
Is she primary care taker? ___Yes ____No If no, Please Explain:____

Mother's level of education & occupation____

Any known or suspected medical condition? ____

Any known or suspected psychiatric condition? ____

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Any difficulties during or after pregnancy? ____

Any known drug use or alcohol history during or near pregnancy? ____

Father

What is the Client's Father's Name: ____ Age: _______
Age at Clients Conception: _______
Is he primary care taker? ___Yes ____No If no, Please Explain: ____

Father's level of education & occupation: ____

Any known or suspected medical condition? ____

Any known or suspected psychiatric condition? ____

Any known drug use or alcohol history during or near pregnancy? ____

Family

Are there any unusual problems medical, academic, psychological problems associated with any of client's extended family (Uncles, Aunts, Grandparents, Cousins)? If yes please explain.

____

____

____

Clients Education History

Did the Client have any difficulties or delays with Developmental Mile Stones? If yes please explain:

____

____

Current School: ____ Current Grade: ______

Have there been any Educational difficulties in class currently or in the past? If yes please explain: _____________

____

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Have there been any Behavioral difficulties in class currently or in the past? If yes please explain:
____

____

Client's Strongest subject (s)? ____ Weakest? ____________________

Ever held back: __Yes No__ Special services: __Yes No__
Difficulty making/maintaining Friends: ___Yes No___

Recreation

Briefly list the types of recreational activities the Client enjoys: ____

____

____

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Medical History

__AIDS or HIV
__Allergies
__Arteriosclerosis
__Arthritis
__Blood disorder
__Brain disease or infection
__Cancer or chemotherapy
__Diabetes
__Hazardous substance exposure
__Head Trauma
__Heart disease
__Huntington's disease
__High Blood Pressure
__Kidney disease
__Liver disease
__Lung disease
__Malnutrition
__Meningitis
__Multiple sclerosis
__Parkinson's disease
__Polio
__Radiation therapy
__Seizures
__Senility (Dementia)
__Stroke or TIA
__Thyroid disease
__Venereal disease

Any other problems: ____

Has the Client ever witnessed any traumatic events? If yes please explain: ______________________________

____

Describe any medical hospitalizations or surgeries:

1. ____

2. ____

3. ____

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Psychiatric History

Has the Client had any prior psychological, psychiatric, or neuro-psychological evaluations or treatment?
Yes ___ No____

If yes, please complete this information:

1. Name of provider and specialty: ____

Address______________________________ City: _________________ State: ______ Zip: ______

Tel. (work): ( ) _________- _____________ Dates/Duration and reason for this evaluation: ___________

____

Findings of the evaluation: ____

2. Name of provider and specialty: ____

Address______________________________ City: _________________ State: ______ Zip: ______

Tel. (work): ( ) _________- _____________ Dates/Duration and reason for this evaluation: ___________

____

Findings of the evaluation: ____

____

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Psychiatric Medication List

Has the Client ever been on any psychiatric medications? If yes, please explain and list below.

Please check off medications used at any time (√):

Anxiolytics/Hypnotics	Mood Stabilizers
Alprazolam (Xanax) Buspirone (Buspar) Chlordiazepoxide (Librium, Livritabs, Mitran) Clonazepam (Klonopin) Clorazepate (Cloraze Caps, Gen-XENE, Traxene) Diazepam (Valium, Valrelease, Zetran) Estazolam (ProSom) Flurazepam (Dalmane)	Asenapine (Saphris) Carbamazepine (Epitol, Tegretol) Clozapine (Clozaril) Gabapentin (Neurontin) Haloperidol (Haldol) Lamotrigine (Lamictal) Lithium (Eskalith, Lithobid, Lithonate, Lithotabs) Lurasidone (Latuda)
Stimulants	**Antidepressants**
Dextroamphetamine (Dexedrine) Dextroamphetamine + amphetamine (Adderall) Methamphetamine (Desoxyn) Halazepam (Paxipam) Lorazepam (Ativan) Oxazepam (Serax) Praxepam (Centrax) Quazepam (Doral) Temazepam (Restoril) Zolpidem (Ambien) Chloral Hydrate (Noctec, Aquachloral Supprettes) Methylphenidate (Ritalin, Concerta, Metadate) Pemoline (Cylert) Atomoxetine (Strattera)	Amitriptyline (Elavil, Endip) Amoxapine (Asendin) Vilazodone (Viibryd) Bupropion (Wellbutrin) Doxepin (Sinequan) Citalopram (Celexa) Fluoxetine (Prozac) Clomipramine (Anafranil) Sertraline (Zoloft) Desipramine (Norpramin) Phenelzine (Nardil) Desvenlafaxine (Pristiq) Nefazodone (Serzone) Escitalopram (Lexapro) Fluvoxamine (Luvox) Duloxetine (Cymbalta) Trazodone (Desyrel) Imipramine (Janimine, Tofranil) Levomilnacipran (Fetzima) Maprotiline (Ludiomil) Tranylcypromine (Parnate) Mirtazapine (Remeron) Protriptyline (Vivactil) Nortriptyline (Aventyl, Pamelar) Paroxetine (Paxil – Paxil CR) Trimipramine (Surmontil) Venlafaxine XR (Effexor XR) Venlafaxine (Effexor)

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Substance Use History

(Please describe the Biological Parent or Adult Caretaker's History)
(Client's 10 & Older will complete this form with Therapist)

Alcohol

I started drinking regularly at age: less then 10 years old 10 – 15 16 – 18 19 – 21 over 21

I drink alcohol: rarely or never 1-2 days/week 3-5 days/week Daily

I used to drink but stopped date: ___________________________ Reason:____

Preferred type(s) of drinks: ____

Usual number of drinks I have at a time: ____

My last drink was: less than 24 hours ago___ 24 - 48 hours' ago___ Over 48 hour's ago___ Check all that apply:

___I can drink more than most people my age and size before I get drunk.

___I sometimes get into trouble (fights, legal difficulty, problems at work, conflicts with family, etc.) after drinking.

___I sometimes blackout after drinking.

___DUI.

___I have gone through drug or alcohol withdrawal.

___I have been in alcohol or drug treatment.

___There is a family history of drug or alcohol use. __Father __Mother __Brother __Sister _Grandparents

Drugs

Please check all the drugs you are now using or have used in the past:

Amphetamines (inc. diet pills)	___presently using	___used in past	___dependency
Barbiturates (downers, etc.)	___	___	___
Cocaine or Crack	___	___	___
Hallucinogenics (LSD)	___	___	___
Inhalants (glue, nitrous oxide)	___	___	___
Marijuana	___	___	___
Opiate narcotics (heroin)	___	___	___
PCP (angel dust)	___	___	___

Please list all other drugs: ____

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Early History

Were there any complications during pregnancy or at birth: ___Yes ___No If yes, describe :___________

____

Other problems: ____

____

Developmental progress Age?
Walking: ______ Language: ______ Toilet training: _____ Forming Sentences: ________ Reading: ________

Any conditions past or present? Please check all that apply (√).

__Attention problems
__Speech problems
__Vision problems
__Clumsiness
__Developmental delay
__Frequent ear infections
__Head injury
__Hearing problems
__Poison Exposure
__Hyperactivity
__Learning disability
__Muscle tightness
__Muscle weakness

Other:____

Any medical conditions past or present? Please check all that apply (√).

__Allergies
__Asthma
__Brain infection
__Cancer
__Cerebral palsy
__Chicken pox
__Colds (excessive)
__Diabetes
__Encephalitis
__Epilepsy or Seizures
__Fevers (104°F or higher)
__Heart problems
__Immune system disease
__Kidney problems
__Lung disease
__Measles
__Meningitis
__Pneumonia
__Poisoning
__Polio
__Rheumatic fever
__Scarlet fever
__Tuberculosis
__Whooping cough

Did you they require hospitalization?
____

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Symptom List

Please check all that apply or that you have noticed and are a concern.
***Symptoms**:*

__Depressed mood
__Lack of interest
__Lack of pleasure
__Hopelessness & Helplessness
__Excessive guilt
__Emptiness
__Low esteem
__Self critical
__Irritable

__Anger
__Mood swings
__Poor concentration
__Poor memory
__Circular thoughts
__Suicidal thoughts
__Suicidal plan
__Sleep disturbance
__Too much sleep

__Too little sleep
__Nightmares
__Early morning awakening
__Poor appetite
__Excessive eating
__Low energy
__Social withdrawal
__Seasonal cycles

Anxiety Symptoms

__Anxious mood
__Panic
__Dizzy
__Fear of going crazy
__Fear of no escape

__Short of breath
__Rapid heart rate
__Sense of floating
__Avoiding crowds
__House bound

__Muscle tension
__Excessive worry
__Headaches
__Bowel disturbance

Other Mood Symptoms

__Elated mood
__Expansive mood
__Racing thoughts

__Impulsive
__Risky behavior
__Spending money

__Little need for sleep
__PMS

ADHD Symptoms

__Distractible
__Fidgeting
__Easily frustrated
__Poor coordination
__Restless
__Impulsive

__Inattentive
__Sensitive
__Daydreams
__Sullen
__Destructive
__Steals

__Lies
__Explosive
__Isolative
__No sense of fair play

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Other Symptoms or Behaviors not listed: ____

____

Any other important information about the Client that you feel may be relevant: ___________________________

____

____

____

THIS FORM HAS BEEN COMPLETED BY: Guardian: _____ Client: ______ Other: ______________

Guardian Name: ___________________________ Signature: ______________________ Date:____________

Client Name: _______________________ Client Signature: ______________________ Date:_____________