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CLIENT INFORMATION FORM

Date: ______________________

Client Name: _________________________________ Date of Birth: _______________ Age:____
Address: _______________________ City ___________________ State ______ Zip _________

Patient's Social Security #: ______________________________

Contact Information:
Preferred Phone for Contact:
Phones
Home: ____
Cell: ____
Work: ____

E-Mail Addresses:
E-Mail: ____

Emergency Contact Name: ____
Phone Number(s): ____

Who were you referred by: ________________________________
May I contact this person to thank them: Yes: ___________ No: ___________

FOR CLIENTS 18 AND YOUNGER:

Legal Guardian Name: ___________________________________
Address: _______________________ City ___________________ State ______ Zip _________

Social Security # (of Legal Guardian):________________________________

School: ____ Grade: ______________

Primary Care Provider: ____
Address/Name of Practice:____Phone:____________________

Emergency Contact Name: ____
Phone Number(s): ____

Brian K Wise, MD, MPH OPERATES A PRIVATE PAY PRACTICE AND DOES NOT DIRECTLY BILL INSURANCE COMPANIES. PLEASE INDICATE IF YOU WILL BE SUBMITTING BILLING STATEMENTS TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT:

Yes: ___________ No: ____________

Child/Adolescent Patient Background

What concerns are you having currently? What brings you to our office now, rather than before?

What would you like to change in your life? What are your goals? (order of priority if possible)

Have you been in therapy or seen a psychiatrist before? How successful was it or how satisfied with services were you? How would you like this experience to be different?

Child/Adolescent Patient Background

General Background:

Demographics:

Where were you born? ______________________________

How long lived in CO?:______________________________

Current Marital Status (how long):______________________________

Previous Marriages:______________________________

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Who Lives with You:______________________________

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Any Children:______________________________

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Highest Education/Grades:______________________________

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Occupation:______________________________

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Religion/Spirituality:______________________________

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Past/Current Legal Problems:______________________________

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Any Additional Info?:______________________________

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Child/Adolescent Patient Background

Medical Background:

Current/Past medical illnesses (e.g. asthma, thyroid, diabetes, headache, etc.):
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Have you ever had any head injury, loss of consciousness, sports injury to the head, falls or concussion? – if so, when, how many times and effects you noticed (e.g. forgetful, harder to learn, change personality)
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Allergies to medication: (Please list medicine and the allergic response)
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Current medications (Please list any prescription & non-prescription meds, vitamins, supplements, or herbs; include name, dose, & what time(s) they are taken)
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Names/Addresses/Phone Numbers of any other health/therapy providers:
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Are you interested in Natural/Alternative/Complementary Therapies? ________

Child/Adolescent Patient Background

Family Medical/Psychiatric History:

Family "genetic" mental health history (who has what problem? If not diagnosed, anyone suspected of a mental illness? Any treatment?): (e.g. Maternal side – grandmother, depression, Prozac)

Maternal Side:____

Paternal Side:____

Siblings:____

Offsping:____

List any significant family medical illnesses or history (include neurological illnesses, seizures, diabetes, thyroid/endocrine, cardiac/heart attacks) in family members:

Drug and Alcohol Experience:

Drug	Treatment History? Past/Current	Amount of Current Use	Age Started	Age Stopped	What You Liked or Disliked About the Drug
Caffeine					
Nicotine					
Alcohol					
Marijuana					
Other:					

Developmental History:

Full Term/Early/Birth Weight:____

Pregnancy Complications/Exposures: _____________________________________
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Delivery Complications: ____
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Significant Medical Illnesses:____
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____

What were your initial response after the child was born?:
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____

Any difficulties or developmental delays in any of the following:

___ Regular sleep patterns
___ Feeding/Eating poorly
___ Excessive Crying
___ Low Frustration Tolerance
___ Crawling/"Cruising"
___ Walking
___ Interacting with Peers
___ Separation
___ Babbling
___ Phrases
___ Counting
___ Sensitive to sounds/lights
___ Excessive Fears
___ Holding things (i.e. cup, crayon)
___ Pretend Play/Fantasy
___ Difficult to Soothe by self
___ Difficult to Soothe by parent
___ Colicy
___ Social Smiling
___ Standing upsupported
___ Running/Jumping
___ Bonding with mom/dad
___ Dressing him/herself
___ Words
___ Full Sentences
___ Naming body parts
___ Sensitive to textures
___ Almost No Fear
___ Hearing
___ Imitating your words/actions