Welcome to **A New Approach**!

Date of first appointment: ________________________

Please take your time in providing the following information. The questions are designed to help me begin to understand you and/or your child so that our time together can be as productive as possible. All information provided is confidential.

Who were you referred by?

- Medical provider:_________________________
- Insurance provider:________________________
- School:__________________________________
- Psychology Today
- Family/Friend
- Online search
- Other:___________________________________

Have you or your child previously received any type of mental health or educational services?

- No
- Yes
  - Individual therapy
  - Group therapy
  - Medication
  - Hospitalization
  - Early intervention
  - IEP
  - Other:___________________________

Please provide location and provider, dates, and reason for services:

Briefly explain what brings you in today:

When did this first begin?

What areas of life have been affected by this?

Any significant life changes or stressful events you or your child have experienced recently?

What would you like to accomplish with therapy?

Family History

Please list parents and siblings

Name	**Age**	**Relationship**	**Where do they live now?**	**If decreased, age and cause of death**

Who else lives in the home?

Your or parent occupation(s)?

Your or parent marital status?

In the section below, please identify if there is a family history of any of the following.

	Circle	List family member
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Domestic violence	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Disorder	Yes / No	
Schizophrenia	Yes / No	
Attention Deficit Hyperactivity Disorder	Yes / No	
Suicide attempts	Yes / No	
Autism	Yes / No	
Development delay	Yes / No	
Any other diagnoses	Yes / No	

Physical Health

Please list any medications, herbs, or supplements you or your child are taking/have taken. Be sure to include the reason, as some medications are prescribed for off-label use. If you or your child have a complicated medical profile, it would be helpful for us if you would supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dose	Reason for Taking	Date Began/Stopped

How would you describe your/your child's current health?

- Poor
- Fair
- Good
- Very good

Any specific health concerns at this time?

How would you describe your/your child's sleep?

- Poor
- Fair
- Good
- Very good

Describe the specific sleep issue, if there is one.

How would you describe your/your child's eating habits?

- Poor
- Fair
- Good
- Very good

Describe the specific issue, if there is one.

Do you/your child exercise? How often?

Do you/your child use alcohol, cigarettes and/or recreational drugs? How much/often?

Additional Information

What are some of your/your child's interests/hobbies?

What are some of your/your child's strengths?

What are some of your/your child's weaknesses?

Specific things that bring about stress or difficult behavior?

Are you/your child spiritual or religious?

How does your child perform in school?