Christina Z. Atti, Psy.D.

Licensed Psychologist

NEW CLIENT INFORMATION

Client Name : _____ Today's Date: _____

Date of Birth: ___ /___ /_____ Age: _____ Gender: _____ Social Security # ____/____ /_____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell/Mobile Phone: _____ Home Phone: _____ Work Phone:_____

Email: _____ Fax: _____

THE BEST WAY TO REACH ME IS (circle one): Cell/Mobile Home Work Email

IS IT OK TO LEAVE MESSAGES REGARDING APPOINTMENT TIMES, ETC? (circle one): YES NO

IS IT OK TO SEND TEXT MESSAGES TO YOUR CELL/MOBILE? (circle one): YES NO

IS IT OK TO SEND MAIL TO THE ABOVE ADDRESS? (circle one): YES NO

IS IT OK TO SEND EMAIL'S TO THE ABOVE EMAIL? (circle one): YES NO

List limitations in communicating with you: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Handedness: _____

Current grade in school: _____ School: _____ Teacher: _____

Employed By: _____ Occupation: _____ City: _____

How were you referred to this office? (circle): Self-Referred Doctor Family Friend Ad Internet Other

Name of internet site/ad/treatment facility/other: _____

Whom may I thank for referring you? : _____

Emergency Contact Person: _____ Phone: _____

Name of person who filled out this form: _____

PLEASE DO NOT WRITE BELOW THIS LINE

Payment Due: $ _____ Diagnosis: _____

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CHILD FORM

Please fill out this form for your child as completely as possible. If your child is able to fill in certain information, please allow them to do so. It will help me in my work with them.

PRESENTING PROBLEM:

Please describe the main difficulty that has brought you to seek treatment at this time. Be as specific as you can.

_____

_____

CHILD'S MEDICAL CARE: (From whom or where does your child get medical care?)

Primary Care Doctor _____ Phone: _____ Fax: _____

Date of Last Visit: _____ Address: _____

Medical Problems: _____

Surgeries (for what and when?): _____

Current medications prescribed by this provider: _____

Describe reaction to medications: _____

List any allergies: _____

Other comments: _____

May we contact your primary doctor so that we can coordinate your treatment? (circle one): YES NO

Psychiatrist: _____ Phone: _____ Fax: _____

Date of Last Visit: _____ Address: _____

Psychiatric Problems: _____

Current medications prescribed by this provider: _____

Describe reaction to medications: _____

May we contact your psychiatrist so that we can coordinate your treatment? (circle one): YES NO

Has your child received previous psychological care? (circle one): YES NO

If YES, please indicate which type of treatment (circle): INPATIENT OUTPATIENT BOTH

When: _____ From Whom: _____ For What: _____

When: _____ From Whom: _____ For What: _____

When: _____ From Whom: _____ For What: _____

Describe outcomes of previous treatment(s): _____

_____

Other comments: _____

May we contact your previous psychological providers(s) for continuity of care? (circle one): YES NO

EDUCATION:

Academic Performance: _____

Behavior's in School: _____

What activities is your child involved in while at school? _____

How does your child interact with peers at school? _____

Has your child ever had to repeat a grade? (circle): YES NO If so, which grade(s)? _____

Has your child ever received special education services? (circle): YES NO If so, which grade(s)? _____

If your child currently has an IEP, please explain: _____

_____

If your child currently as a 504 Plan at school, please explain: _____

_____

Additional Comments about School: _____

_____

PRESENT RELATIONSHIPS:

Parents Marital Status (circle): MARRIED DIVORCED/SEPARATED WIDOWED SINGLE DATING OTHER _____

If in a relationship, for how long? _____ Quality of Relationship: _____

List all persons living at home other than child:

NAME	AGE	RELATIONSHIP TO CHILD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Father's Name: _____ Age: _____ Occupation: _____

Describe Father's Relationship with Child: _____

Mother's Name: _____ Age: _____ Occupation: _____

Describe Mother's Relationship with Child: _____

Step-Father's Name: _____ Age: _____ Occupation: _____

Describe Step-Father Relationship with Child: _____

Step-Mother's Name: _____ Age: _____ Occupation: _____

Describe Step-Mother's Relationship with Child: _____

How does your child get along with others in the home? _____

_____

What are your child's favorite activities, sports, hobbies? _____

_____

What are your child's responsibilities at home? _____

_____

Does your child have any behavioral problems? _____

_____

Describe how child is disciplined at home: _____

_____

How does child respond to form(s) of discipline? _____

_____

Any current or pending civil or criminal litigations, lawsuits or divorce/custody disputes? (circle one): YES NO

If YES, please explain: _____

_____

Who has legal custody of this child? _____

PREGNANCY, BIRTH, AND EARLY DEVELOPMENT:

What kind of delivery during birth? (circle): VAGINAL C-SECTION BREECH

Note any complications during delivery: _____

Note any complications during pregnancy: _____

Prescribed medications taken during pregnancy: _____

Substance use during pregnancy (include cigarettes): _____

Note any post-delivery complications: _____

Eating patterns during infancy: _____

Sleeping patterns during infancy: _____

Temperament: _____

How were developmental milestones met? (circle one): EARLY ON-TIME LATE

If late, please provide additional information here: _____

_____

Check any of the following that were present during the first few years of life:

_____ Did Not Enjoy Cuddling	_____ Frequent Head-Banging	_____ Mute
_____ Was Not Calmed by Being Held	_____ Difficulty Nursing	_____ Loss of Speech/Babbling
_____ Difficult to Comfort	_____ Constantly into Everything	_____ Lack of Facial Expression
_____ Colic	_____ Lack of Eye Contact	_____ No Body Gestures
_____ Excessive Restlessness	_____ Unresponsive	_____ Lack of Interest/Enjoyment
_____ Excessive Irritability	_____ Poor Appetite	
_____ Diminished Sleep	_____ Delayed Language	

FAMILY MEDICAL HISTORY:

Describe any illness that runs in the family (cancer, epilepsy, thyroid, etc.): _____

_____

_____

FAMILY HISTORY OF PSYCHIATRIC ISSUES: (Check any that apply to your family history):

_____ ADD/ADHD	_____ Dementia	_____ Phobia	_____ Other _____
_____ Addiction	_____ Depression	_____ Physical Abuse	_____ Other _____
_____ Alcoholism	_____ Delusions	_____ Psychosis	_____ Other _____
_____ Alzheimer's	_____ Dissociation	_____ PTSD/ Trauma	_____ Other _____
_____ Anger Management	_____ Domestic Violence	_____ Perfectionism	
_____ Anorexia	_____ Emotional Eating	_____ Schizophrenia	
_____ Antisocial	_____ History of Neglect	_____ Self-Control	
_____ Anxiety	_____ Homicidal	_____ Sexual Abuse	
_____ Bereavement	_____ Major Mental Illness	_____ Self-Harm	
_____ Bipolar	_____ Over-Exercise	_____ Suicide	
_____ Bullying	_____ Obsessions	_____ Treatment (inpatient)	
_____ Bulimia	_____ Panic Attacks	_____ Treatment (outpatient)	
_____ Conduct Problems	_____ Personality Disorder		

Past or Present Drug/Alcohol Use and Abuse (treatments, AA/NA): _____

_____

_____

Past or Present History of Abuse or Neglect (physical, emotional, sexual): _____

_____

_____

Suicide Attempt(s) or Violent Behavior (describe: ages, reasons, circumstances, how, etc.): _____

_____

_____

Friendships, Community, Religious or Spiritual Involvement (describe quality, frequency, etc.): _____

_____

_____

Strengths and Accomplishment (Please lists strengths, talents, skills, and accomplishments):

_____

_____

_____

_____

_____

OTHER:

What other information about yourself do you think would be important for us to know?

_____

_____

_____

_____ _____

PRINT Client Name Date

_____ _____

SIGNATURE of Client/Parent or Legal Guardian Date