



**CLIENT INFORMATION**

If you are completing this form on behalf of a minor child, the “client” is that child. If you are filling this out as an adult (ages 18 and over) seeking services for yourself, the “client” is you.

Client Name: \_\_\_\_\_  
Last First Date of Birth: (MM/DD/YYYY) Age

Address: \_\_\_\_\_  
City State Zip

Place of birth: \_\_\_\_\_

Client’s race (circle which applies) African-American Caucasian Native American Hispanic Asian  
Latino  
Other (specify)  
\_\_\_\_\_

Was the client adopted? Yes \_\_\_ No \_\_\_ If yes, at what age? \_\_\_ From where?  
\_\_\_\_\_

***I wish to be contacted in the following manner (initial all that may apply):***

- \_\_\_\_\_ Home Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_
- \_\_\_\_\_ Okay to leave a message with detailed information \_\_\_\_\_ Okay to leave a message with detailed information
- \_\_\_\_\_ Okay to leave a message with call-back number only \_\_\_\_\_ Okay to send appointment reminder via text message
- \_\_\_\_\_ Leave message with call-back number only

\_\_\_\_\_ Okay to be contacted through email. If so, please provide your email address: \_\_\_\_\_

**IN CASE OF EMERGENCY**

Name: \_\_\_\_\_  
Name Relationship Home Number Cell Number

How did you hear about us? \_\_\_\_\_

If online what website or search words did you use? \_\_\_\_\_

Were you referred? Circle YES or NO If so, who referred you? \_\_\_\_\_

Do you have any particular time/day preference for appointments?  
\_\_\_\_\_



**ASSESSMENT**

**DEVELOPMENTAL HISTORY**

Were there any complications with the client during the pregnancy? If yes, please explain:

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Any feeding problems?

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Sleeping problems?

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Any problems with growth or development of the client?

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Has the client ever been diagnosed with a developmental disorder?

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Other developmental concerns?

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Please write at what age the client first demonstrated each behavior. If you do not remember, please write a question mark:

Showned response to parent ____	Put several words together ____	Stayed dry at night ____
Rolled over ____	Spoke first word ____	Fed self ____
Sat alone ____	Became toilet trained ____	Rode tricycle ____
Crawled ____	Babbled ____	Dressed Self ____

**MEDICAL HISTORY**

Medical problems:

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Any allergies? Please list: \_\_\_\_\_

Nutritional problems? \_\_\_\_\_

Any disability or handicap? \_\_\_\_\_



## North Scottsdale Pediatrics

Has the client ever suffered from a concussion, head injury or had a seizure? If so, please describe:

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Any hospitalizations? If so, when and for what? \_\_\_\_\_

Please list all medications taken by the client at this time:

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Name of the client's Primary Care Provider:

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Date of last appointment with Primary Care Provider and for what was the client seen?

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### **MENTAL/BEHAVIORAL HEALTH HISTORY**

Has the client or anyone in your family been diagnosed with a mental/behavioral health disorder? If so, what was the diagnosis, when was it given and by whom? \_\_\_\_\_

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Has the client or anyone in your family received psychiatric, psychological or mental/behavioral health counseling previously? If so, please explain: \_\_\_\_\_

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Is the client currently experiencing any auditory or visual hallucinations? If yes, please explain:

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Is the client experiencing any bizarre or strange thought patterns? If yes, please explain:

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### **EDUCATIONAL HISTORY**

Name of your child's school:

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Highest grade level completed: \_\_\_\_\_

Has the client ever been held back a grade level? If so, please explain:

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Has the client ever been suspended or expelled from school? If so, please explain:

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## North Scottsdale Pediatrics

Any problems with school attendance? If so, please explain:

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Please circle the answer that best describes your child's current academic performance:

Excellent  
(mostly A's)

Good  
(mostly B's)

Average  
(mostly C's)

Below Average  
(mostly D's)

Poor  
(mostly F's)

Do you have any concerns about the client's academic performance at this time? If so, please explain:

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Does the client have an IEP/504 plan at school or receive any special education support? If yes, please explain: \_\_\_\_\_

Does the client have a job at this time? If so where and doing what? \_\_\_\_\_

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### **HISTORY OF ABUSE?**

Have as the client or a family member ever experienced physical or sexual abuse or witnessed violence?

Please explain if you feel comfortable or you can leave it blank if you're not comfortable explaining:

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### **LEGAL PROBLEMS?**

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### **DRUG USE OR ALCOHOL CONSUMPTION PAST OR PRESENT?**

Does the client or anyone in the family consume alcohol or any drugs? If so, what and how often? (This information is confidential):

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**FAMILY HISTORY OF ADDICTION?**

Has the client or anyone in your family ever had an addiction including addictions to alcohol, drugs, gambling, sex, pornography, video gaming, or struggled with an eating disorder? If yes, please explain:

**SUICIDAL OR ASSAULTIVE IDEATIONS?**

Has the client or a family member ever tried to commit suicide or been involved in physical violence? If so, please explain: \_\_\_\_\_

**RELIGIOUS OR SPIRITUAL AFFILIATION?**

Does the client or your family practice a formal religion or find strength from spiritual beliefs? If yes, please explain:

**FAMILY HISTORY**

**Parents/Step-Parents**

Mother's name: \_\_\_\_\_ Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Father's name: \_\_\_\_\_ Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Marital status of parents: \_\_\_\_\_

If parents are separated/divorced, how old was the client at the time of the separation? \_\_\_\_\_

Step-Parents Name: \_\_\_\_\_

Step-Parents Name: \_\_\_\_\_

With whom does the client live? \_\_\_\_\_



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Does the client have any siblings? If so, please list:

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Please list all people living in the home with the client at this time:

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### **HISTORY OF PRESENTING PROBLEM**

What are the issues or problems that brought you to seek counseling at this time? Why now? Please explain:

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How long has this problem been a concern to you?

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What seems to help the problem? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Has the client received evaluation or treatment for the current problem or similar problem? If so, when and where? \_\_\_\_\_

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## North Scottsdale Pediatrics

If you are the parent of minor child filling this form out on their behalf:

On a scale of 1-10 (1 being not very important and 10 being extremely important) how important is resolving this problem to your child? Please circle the number that applies:

1            2            3            4            5            6            7            8            9            10

How receptive is your child to coming to counseling (1 being not very receptive to 10 very receptive) Please circle the number that applies:

1            2            3            4            5            6            7            8            9            10

Is there anything not covered in this form that you would like for me to know about the client or presenting problem? If yes, please explain here:

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**If you are the parent of a minor child completing this form on their behalf, please complete the following Child Behavior Checklist.**



CHILD BEHAVIOR CHECKLIST

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Completed By: \_\_\_\_\_

Please circle Y = yes for behaviors that are a concern for your child, S = sometimes for behaviors that are sometimes a concern for your child and N = no for behaviors that are not a concern for your child.

ATTENTION

When symptoms began (date) \_\_\_\_\_

- Careless mistakes Y S N
Poor attention span Y S N
Doesn't listen Y S N
Doesn't finish tasks Y S N
Problems organizing Y S N
Avoids tasks requiring concentration Y S N
Loses needed items Y S N
Easily distracted Y S N
Trouble remembering/forgetful Y S N
Fidgets, squirms Y S N
Leaves seat when required to sit Y S N
On the go, seems driven Y S N
Runs, climbs excessively/restless Y S N
Talks all the time Y S N
Problems waiting turn Y S N
Interrupts Y S N

MOOD

When symptoms began (date) \_\_\_\_\_

- Weight changes/appetite changes Y S N
Energy level changes Y S N
Sleep disturbances Y S N
Difficulty concentrating Y S N
Crying spells Y S N
Loss of interest/pleasure Y S N
Hopeless feelings Y S N
Guilty feelings Y S N
Isolates self Y S N
Low self-esteem/self-hate Y S N
Gives things away Y S N
Wishes to be dead Y S N
Injures self Y S N
Thinks about death/violence often Y S N
Rage outbursts Y S N
Bizarre behaviors, hallucinations Y S N
Rapid, hard to follow speech/thoughts Y S N
Thinks s/he is the smartest, best person in the world Y S N

OPPOSITIONAL BEHAVIORS

When symptoms began (date) \_\_\_\_\_

- Touchy, easily annoyed Y S N
Argues Y S N
Defiant Y S N
Angry Y S N
Tantrums Y S N
Bothers others deliberately Y S N
Spiteful/mean Y S N
Blames others for own mistakes Y S N

ANXIETY/WORRY

When symptoms began (date) \_\_\_\_\_

- Worries something terrible will happen to self or important adults Y S N
Frequently refuses or is reluctant to go somewhere fear of separation Y S N
Avoids being alone Y S N
Nightmares about separation Y S N
Physical complaints about the time of separation transition Y S N
Worries about parent(s) leaving Y S N
Fearfulness of new situations, people or objects Y S N
Engages in repeated behaviors (counting, cleaning organizing, hand washing, etc.) Y S N
Excessive worry about everyday things Y S N
Fear/excessive worry about social situations Y S N

CONDUCT

When symptoms began (date) \_\_\_\_\_

- Bullies/threatens others Y S N
Starts fights Y S N
Used a weapon Y S N
Physically cruel to people/animals Y S N
Forcibly stolen from victim Y S N
Stolen without confronting victim Y S N
Forces sexual activity Y S N
Deliberately sets fires to cause damage Y S N

Further comments about any of the above: \_\_\_\_\_

CHILD'S STRENGTHS:

In school setting: \_\_\_\_\_

In social setting: \_\_\_\_\_

In home setting: \_\_\_\_\_

Special Interests/Hobbies: \_\_\_\_\_





**Fee Agreement**

By signing, I agree to have my visit for behavioral health services with Lauren Chatellier, MSW, LMSW, BHP be a cash visit. There will be no discount for the office visit and any administration fees. Payment is due at the time of service. I understand North Scottsdale Pediatrics will not be submitting the claim to my insurance, or I will not be submitting this claim to my insurance company.

- 1. Initial Consultations (\$100)
- 2. Individual/Family Therapy (\$150)
- 3. Missed appointments without 24-hour prior notification (\$50.00)

**Authorization for Debit/Credit Card Charges**

I \_\_\_\_\_ understand that North Scottsdale Pediatrics requires to have my credit card or debit card information on file in order to receive therapy services. Below is list of services provided by North Scottsdale Pediatrics that may be charged to my card if the services are provided. If a different method of payment is preferred, payment will be taken care of at the time of services. If payment is not made at the time of service, the amount of the service will be charged to the credit or debit card.

Name as it appears on the card: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Debit/Credit Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_

CVV (CSC) # \_\_\_\_\_ (For MasterCard or Visa, it's the last three digits in the signature area on the back of your card. For American Express, it's the four digits on the front of the card.)

Billing Address: \_\_\_\_\_  
Street Address Apt #

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date