# Adrienne Cress

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**(603) 312-2903 * ac@adriennecress.com**

## Demographic Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date Of Birth: _____ Gender: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone : ( ) _____ ok to leave a message? **Y N**

Alternative Phone: ( )_____ ok to leave a message? **Y N**

1. Parent/Guardian Name: _____ Relationship to client: _____
Mailing address: _____ [ ] same as client
Phone: _____

2. Parent/Guardian Name: _____ Relationship to client: _____
Mailing address: _____ [ ] same as client
Phone: _____
May I email parent/guardians? **Yes** **No** Email address: _____

**In case of an emergency, you have my permission to contact:**

Name:_____ Relationship: _____

Phone number (s) _____

Address: _____

## Presenting Concerns

Please provide a brief description of why your child is seeking therapy at this time and what goals you hope to achieve by coming here:

_____

_____

_____

_____

_____

Describe the youth's strengths and resources that will helpful to you in achieving the goals in therapy:

_____

_____(over)

_____

_____

Is your child currently or in the last 30 days have they experienced any of the following:

| | | | |
|---|---|---|---|
| □ sadness | □ helpless/hopeless | □ thoughts of dying | □ no motivation |
| □ feeling worthless | □ can't sleep | □ sleep too much | □ fatigue/low energy |
| □ can't concentrate | □ easily startles | □ fearful | □ nervous |
| □ nervousness | □ panic attacks | □ recurring nightmares | □ restlessness |
| □ feeling "on edge" | □ stressed | □ irritable/angry | □ "spacing out" |

□ physical symptoms (headache, stomachache, etc): _____

## Mental and Physical Health

Please list any previous therapy/psychiatric treatment: □ no previous treatment

Provider name: _____ Dates of treatment: _____

Provider name: _____ Dates of treatment: _____

Hospitalizations for mental illness: _____

Describe family history of mental illness: _____

_____

Primary Care Physician: _____Date of last visit:_____

Other current providers of care: _____

Current Medical Concerns/Conditions: _____

_____

_____

Current Medication Listing (use back of page if necessary):

| Name of Medication (prescribed, herbal or over the counter | Dose (how much & how often | Why was it prescribed? | Current or past medication? | Length of time on medication | Side effects experienced (if any) | List any benefits of the medication | Name of Prescriber |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## Personal and Social Information

Sexual Orientation: _____ Spiritual Orientation: _____

School: _____ Grade: _____ IEP or 504 Plan? _____

Has a significant person or family member enter or leave your life in the last 90 days? □ Yes □ No

_____

Please list all members of your household/family:

| NAME | AGE | RELATIONSHIP | OCCUPATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Child & Adolescent Developmental History

**Please answer the following questions as best you can. If you have difficulty completing this section, or if there are answers you would prefer to discuss in person, please let me know.**

1. Was the pregnancy planned? □ Yes □ No □ Don't Know
2. Was the pregnancy □ Normal □ Difficult □ Very Difficult □ Don't Know
   Comments: _____
3. What kind of experience was the pregnancy for:
   Parent A: _____
   Parent B: _____
4. How did the mother feel about the pregnancy and birth of this child? □ Pleased
   □ Excited □ Concerned □ Ambivalent □ Don't Know □ Other:
   Comments: _____
5. How old was the mother when the child was born? _____ □ Don't Know
6. Was the delivery □ Without Complications □ With Complications □ Premature
   □ Caesarian □ Forceps Delivery □ Don't Know □ Other: _____
   Comments: _____
7. Was there positive bonding between mother and newborn at birth? _____
8. Did mother experience any post-partum depression? □ Yes □ No □ Don't Know
   Comments: _____
9. When the child was an infant, did he/she have colic? □ Yes □ No □ Don't Know
   Comments: _____
10. Did the child have medical problems as an infant? □ Yes □ No □ Don't Know
    Comments: _____

11. How would you describe this child as an infant? (Check all that apply):

□ Easy □ Cuddly □ Demanding □ Easily Frightened □ Happy

□ Friendly □ Unhappy □ Always sick □ Very Fussy □ Withdrawn

□ Angry □ Restless □ Other:_____

12. How old was the child when they no longer had mid night awakenings? _____ □ Don't Know

13. The child now sleeps □ Normally □ Heavily □ Lightly □ Restlessly

14. Does the child experience:

Nightmares □ Almost never □ Occasionally □ Frequently □ Don't Know

Sleepwalking □ Almost never □ Occasionally □ Frequently □ Don't Know

Bed Wetting □ Almost never □ Occasionally □ Frequently □ Don't Know

15. At approximately what age did the child (if you don't recall you can check a box)

Smile _____ (Compared to average) □ Early □ On Time □ Late

Crawl _____ (Compared to average) □ Early □ On Time □ Late

Walk _____ (Compared to average) □ Early □ On Time □ Late

Become Toilet Trained _____ (Compared to average) □ Early □ On Time □ Late

16. How did the child feel about going to school? _____

17. How would you describe the child's friendships now?

□ Makes friends easily □ Changes Friends Often □ Has Few Friends

□ Has No Friends □ Has Many Older Friends □ Has Many Younger Friends

□ Fights Often With Friends □ Parents Don't Like Choice of Friends

18. Has the child ever been injured by anyone? □ Yes □ No □ Don't Know

19. Has the child ever had a serious accident? □ Yes □ No □ Don't Know

20. Has the child ever had a head injury? □ Yes □ No □ Don't Know

21. Has the child ever been sexually molested? □ Yes □ No □ Don't Know

Please comment on these and any other serious events that might have occurred in the child's life:

_____

_____

23. Do you feel you are doing a good job parenting? □ Yes □ No □ Don't Know

## Billing Information

**Party Responsible for Payment**

First Name: _____ Middle Initial: _____

Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (  ) _____ Work Phone: (  ) _____

**I hereby authorize Adrienne Cress, LCMHC to release any billing information to "Party Responsible for Payment"**

Parent/Guardian Signature: _____ Date: _____

**Name: _____**

* * * PLEASE GIVE THIS FORM TO YOUR CHILD TO COMPLETE * * *

**Hello! I'm excited to meet you and for us to get to know one another better. Before we do, you may feel more comfortable using writing to share some things with me. When you have completed this form, you may either give it to your parent (if you'd like to share it with them too) or you may hand it to me separately at our first appointment.**

Name: _____

How interested are you in doing individual therapy? (Check One) □ Not at all! □ Just a little
□ I could take it or leave it □ I think it's a good idea □ I'm eager to get started
□ Other (please explain) _____

Why might therapy be a good idea for you right now?

_____

_____

_____

_____

How will we know when you are done with therapy and that you don't need/want it anymore?

_____

_____

_____

Describe your strengths and resources that will be helpful to you in achieving your goals in therapy (if it feels like you are bragging then you are on the right track here)

_____

_____

_____

_____

Currently or in the last 30 days have you experienced any of the following?

| | | | |
|---|---|---|---|
| □ sadness | □ helpless/hopeless | □ thoughts of dying | □ no motivation |
| □ feeling worthless | □ can't sleep | □ sleep too much | □ fatigue/low energy |
| □ can't concentrate | □ easily startles | □ fearful | □ nervous |
| □ nervousness | □ panic attacks | □ recurring nightmares | □ restlessness |
| □ feeling "on edge" | □ stressed | □ irritable/angry | □ "spacing out" |

□ physical symptoms (headache, stomachache, etc): _____

What else might you want me to know about or talk more about during our time together?

_____

_____