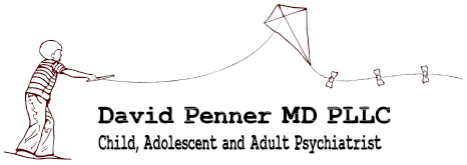

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Please bring all copies of outside records, psychological testing, individualized education plan documents, evaluations and other relevant materials in your possession to your initial visit. This information helps me assess the needs of your child or adolescent and guides my treatment recommendations. You may fill this form out and bring it to your initial appointment or you may fax it to 360.350.5610 prior to your appointment.

HISTORY AND BACKGROUND INFORMATION

DEMOGRAPHICS

Child/Adolescent's Name _____ _____ _____
Last First Middle

_____ _____ _____ _____
Date of Birth Age Sex Birthplace

_____ _____ _____ _____
Home address City State Zip

_____ _____ _____ _____
Mailing address if different City State Zip

_____
Email address (for emergencies only)

Please note, due to privacy, we do not use email routinely but under emergent circumstances may need to send you a "we cannot reach you by phone, please call our office" message if a scheduling issue comes up or you elect to receive reminders.

Please select how you would like to receive appointment reminders. You may choose multiple options:

Text☐ _____ Email☐ Phone Call☐ _____

Please note, automated reminders are provided as a courtesy. Missed appointments are under 24 hour cancellations will incur a cancellation / no-show fee.

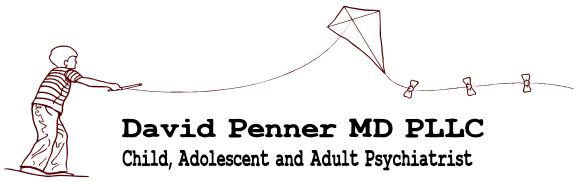
Phone / Name of Emergency Contact	Relationship to Patient	Type of Phone (Home/ Work/ Cell)	Okay to leave message? (Non-emergencies/ Routine)

Phone / Name of Emergency Contact	Relationship to Patient	Type of Phone (Home/ Work/ Cell)	Okay to leave message? (Non-emergencies/ Routine)

Who Referred You to Me? _____

Briefly, what is the primary reason for consultation/evaluation? (Concerning behaviors, sadness, learning problems, peer problems, etc.)

Name of person completing this form and relationship to child:



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MENTAL HEALTH HISTORY

HOSPITALIZATIONS FOR PSYCHIATRIC REASONS (if applicable) ☐ **N/A**

Please list all hospitalizations your child or adolescent has had, the dates, where and what for:

COUNSELING OR THERAPY SERVICES (if applicable) ☐ **N/A**

Please indicate any current or past counseling or therapy sessions your child or adolescent has had, and if so, with whom, when, for how long, and what for? Are you happy with the treatment (if current)

PAST PSYCHIATRIC MEDICATIONS (if applicable) ☐ **N/A**

Please list any psychiatric medications your child or adolescent has taken.

Name Dose (if known) What for ? Effective? Side-effects?

Please indicate any other mental health treatment outside the usual scope of usual 'medical' practice
(holistic treatments, church counseling, alternative treatments, dietary treatments, etc.)

Do you know, or have suspicions, that your child or adolescent has been physically, sexually, or verbally abused?
☐ Yes ☐ No If Yes Please explain:

Are you concerned or suspicious that your child or adolescent might be using tobacco products, alcohol, marijuana or other drugs?
☐ Yes ☐ No If Yes Please explain:

Has your child or adolescent ever attempted suicide or voiced thoughts about it?
☐ Yes ☐ No If Yes Please explain:

Has your child or adolescent ever engaged in cutting or other self-injurious behaviors?
☐ Yes ☐ No If Yes Please explain:

Has your child or adolescent ever said he/she hears voices that other people don't hear or sees things other people don't see?
☐ Yes ☐ No If Yes Please explain:

Does your child or adolescent complain about physical ailments more than you would expect?
☐ Yes ☐ No If Yes Please explain:

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mail: PO Box 23, Olympia, WA 98507-0023
office: 324 West Bay Dr NW #214, Olympia WA 98502

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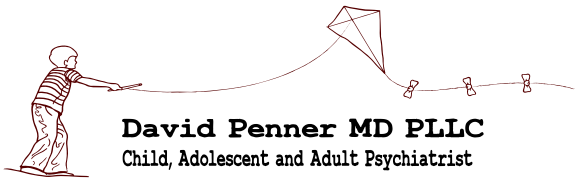

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MEDICAL INFORMATION

Allergies_____ ☐ (no known allergies)

Name and location of Pediatrician/Primary Care Provider:_____ _____
(name) (city/location)

Has your child or adolescent had any medical problems, medical hospitalizations or surgeries? Please list any:

_____

Does your child or adolescent currently take prescribed medications, over-the-counter medications, or supplements? If so please list:

Name	Dose (if known)	What for ?	Effective?	Side-effects?

Has your child ever had any of the following:

History of fainting or passing out	☐ Yes	☐ No
Heart murmurs	☐ Yes	☐ No
Heart abnormalities	☐ Yes	☐ No
Heart arrhythmia	☐ Yes	☐ No
Abnormal findings on an EKG (electrocardiogram)	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Meningitis	☐ Yes	☐ No
Head injuries	☐ Yes	☐ No
Is there a history in the child's family of sudden unexplained early deaths?	☐ Yes	☐ No

FAMILY COMPOSITION Parent(s) Are: ☐ Partnered/ Married ☐ Single ☐ Separated ☐ Divorced

Parent _____ _____ ____ _____
(name) (occupation) (age) (present health)

Parent _____ _____ ____ _____
(name) (occupation) (age) (present health)

Please list all biological siblings below.

Name	Age	(Brother/Sister/Step-)	At Home?	Grade

Please list the names and relationships of foster parents, adoptive parents, or step-parents below, as applicable:

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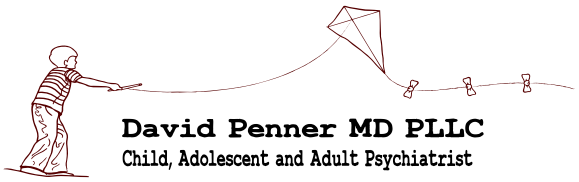

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FAMILY MENTAL HEALTH HISTORY

Has anyone in the child's immediate or extended family ever been diagnosed with a psychiatric illness, had a psychiatric hospitalization or suicide attempt, or struggled with issues involving drugs or alcohol? Please provide information about psychiatric medications taken if known: *(Please note that this information is highly confidential. I am asking these questions because the answers may help determine genetic risks. Additionally, responses to medications may run in families and this knowledge may help guide treatment. Examples of conditions are depression, anxiety, PTSD, ADHD, autism, OCD, schizophrenia, bipolar disorder, alcoholism or other substance dependence.)*

DEVELOPMENTAL AND BIRTH HISTORY

Duration of Pregnancy: _____months.

Did mother smoke during pregnancy? ☐Yes ☐No
Consume alcohol? ☐Yes ☐No
Was the baby discharged on time from the hospital? ☐Yes ☐No
When did your baby begin to walk? _____
When did your baby begin to say first words? _____
When did your baby begin to say phrases or sentences? _____
Did your baby appear to engage in appropriate play with similar-aged children? ☐Yes ☐ No
Did your baby receive early intervention services? ☐Yes ☐ No
Did your baby avoid eye contact? ☐Yes ☐ No
Did anyone express any concern about how your baby was developing? ☐Yes ☐ No

If Yes to any of the above, please provide details

SCHOOL INFORMATION

Name of School _____ Grade _____ City _____

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Has your child complained of or have you noticed any of the following:

Fatigue?	☐ No ☐ Yes:
Changes to vision?	☐ No ☐ Yes:
Changes to hearing?	☐ No ☐ Yes:
Palpitations/Chest Pain/Dizziness?	☐ No ☐ Yes:
Shortness of breath?	☐ No ☐ Yes:
Nausea or vomiting?	☐ No ☐ Yes:
Frequent urination?	☐ No ☐ Yes:
Muscle or joint pain?	☐ No ☐ Yes:
Rashes?	☐ No ☐ Yes:
Dry mouth?	☐ No ☐ Yes:
Headaches?	☐ No ☐ Yes:
Increased or decreased sweating?	☐ No ☐ Yes:
Easy bruising or bleeding?	☐ No ☐ Yes: