Nicole C Pernod, Psy.D.
153 Roebling Street
4th Floor, Suite 12
Brooklyn, NY 11211
(347) 470-7377

Child/Adolescent Client Information

Please feel free to leave blank any questions you are uncomfortable answering.

Demographic Information:

Name: ____ Date: _____________

Name of Parent(s)/Guardian(s): ____

Address: ____

____

Siblings (please include names and ages): _____________________________________

Home Phone: __________________ Work/Cell Phone: _________________________

Date of Birth: ________Age: ______Social Security Number: ______________________

School: ______________________________________Phone: __________________

Place of Birth: ____________________Ethnicity: ____________________________

Religious Identification (if any): ____

Health:

Name of Pediatrician/Physician: ________________________Phone: _______________

** I will not contact this provider without your written permission*

Date of Last Physical Exam: ____

Current & Past Medications: ____

Please mark your child's current physical health as one of the following:

Excellent: ____Very Good: ____Good: ____Fair: ____Poor: ____

Current Disabilities (Circle One): Yes/No

If YES:

Type of Disability:	Age of Onset:	Treatment:

Serious Illness (Circle One): Yes/No

If YES:

Type of Illness:	Age of Onset:	Treatment:

Has your child had any medical problems that required surgery? Yes ____No____

If yes, please describe: ____

Have your child had any serious accidents? Yes ____No____

If yes, please describe: ____

Current Speech/Motoric Development:

How is your child's gross motor coordination (e.g. walking, running, jumping)?
Good ____Fair ____Poor ____

How is your child's fine motor coordination (small muscle development – finger/hand dexterity)?
Good ____Fair ____Poor ____

How is your child's speech articulation (speech and language development)?
Good ____Fair ____Poor ____

Current Emotional Development:

How are your child's social skills (e.g. taking turns, asking questions, responding to others)?
Good ____Fair ____Poor ____

Please describe: ____

How does your child respond to limit setting/rules? ___________________________________

____

____

How does your child cope with stressful situations? ___________________________________

____

Previous Therapeutic Experiences (please list most recent first)**:**

Name of Provider: _________________________Credentials: ____________Length: ________

Address: _________________________________Phone: _______________________________

** I will not contact this provider without your written permission)*

Name of Provider: _________________________Credentials: ____________Length: ________

Name of Provider: _________________________Credentials: ____________Length: ________

Has your child ever been hospitalized for psychiatric reasons? If so, list dates and locations:

____

Is your child taking any medication(s)? If yes, please specify:

____

Prenatal History:

How was your (or child's mother's) health during pregnancy?

Excellent: ____Very Good: ____Good: ____Fair: ____Poor: ____

Did you (or his/her mother) have any illness or complications during pregnancy with this child?

If yes, what type? ____

How old were you (or child's mother) when (s)he was born? _________

Do you recall any of the following substances or medications being used during pregnancy?

Beer or wine ____ How many times? _____
Coffee or other caffeine (Cokes, etc.) How many times? _____
Hard liquor? ______ How many times? _____
Cigarettes? _____ How many times? _____

Were any of the following substances ingested during pregnancy?

____ Valium (Librium, Xanax)
____ Tranquilizers
____ Anti-seizure medications (e.g., Dilantin)
____ Antibiotics (for viral infections)
____ Sleeping pills
____ Other (please specify) _________________

Was the pregnancy planned or unplanned? Please describe: _____________________________

____

____

Was there anything unusual about the delivery or birth? ________________________________

____

Was (s)he born on schedule? What was the duration of labor? ___________________________

____

____

Your child's birth weight and height: ____

Postnatal History:

Were there early infancy feeding problems? Yes__ No__

If yes, please describe: ____

Was the child colicky? Yes__ No__

If yes, please describe: ____

Were there early infancy sleep pattern difficulties? Yes__ No__

If yes, please describe: ____

Developmental Milestones:

At what age did (s)he sit up?
3-6 months. ____
7-9 months. ____
DK ____

At what age did (s)he crawl?
6-12 months. ____
13-18 months. ____
Over 18 months. ____
DK____

At what age did (s)he walk?
Under 1 year____
1-2 years____
2-3 years____
DK____

At what age did your child speak single words (other than mama or dada)? __________________

At what age did your child string two or more words together? ____________________________

At what age was your child toilet trained (bladder control)? _______________________________

At what age was your toilet trained (bowel control)? ____________________________________

Approximately how much time did toilet training take from onset to completion? _____________

Substance Abuse/Trauma:

Is there any suspicion of alcohol or drug use? Please describe: ___________________________

____

____

Is there any history of physical/sexual abuse? Please describe: ___________________________

____

Clinical Concerns:

Has your child ever felt so sad that he/she believed life was not worth living? Yes ____No ____

Has your child ever had suicidal thoughts? Yes ____No ____

If yes, when did these thoughts last occur? ____

Have your child ever made a suicide attempt? Yes ____No _____

Briefly describe your reasons for seeking therapy for your child at this time: ________________
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Signature ____ Date ___________________