

**Cognitive and Behavioral Consultants  
Of Westchester, LLP**  
1 North Broadway, Suite 704  
White Plains, New York 10601  
914-385-1150

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**PATIENT INFORMATION (CHILD/ADOLESCENT):**

Child's Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Legal Guardian's Name (if applicable): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

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

Phone: Home: \_\_\_\_\_ Parent's Work: \_\_\_\_\_

Parent's Cell: \_\_\_\_\_ Child's Cell: \_\_\_\_\_

School: \_\_\_\_\_ School Phone: \_\_\_\_\_

Grade: \_\_\_\_\_ If special education, please specify: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of person/s who referred you: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

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**For Office Use Only:**

Diagnosis: Axis I:

Axis II:

Fee: \$

**FAMILY INFORMATION**

Please list all individuals who are currently living in child's primary residence:

Name	Relationship to Child	Age

Mother's Occupation: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Child's parents are (circle):

married/domestic partners    divorced    separated    never married

If divorced or separated, who has legal/physical custody? \_\_\_\_\_

Have there been any deaths of /separations from family members or friends with whom patient was close or had frequent contact? If so, please explain (include dates, relationship to child):

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Have any family members had emotional or psychiatric problems? Y/N

If yes, who? What was the nature of the difficulties? Was treatment sought?

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**DEVELOPMENTAL / MEDICAL HISTORY**

Pregnancy/Delivery/Developmental History:

Please list any complications the child's mother had during pregnancy:

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Complications during delivery:

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Child was born (circle):

pre-term by # \_\_\_\_\_ days

on time

post term by # \_\_\_\_\_ days

At what age did your child achieve these developmental milestones?

Crawling: \_\_\_\_\_ Walking: \_\_\_\_\_

Toilet Training: \_\_\_\_\_ Talking (single words): \_\_\_\_\_ (sentences): \_\_\_\_\_

Any problems during the first year?

Excessive Crying	Y/N	Hyperactivity	Y/N
Feeding Problems	Y/N	Underactivity	Y/N

Please describe sleep patterns at the present time: \_\_\_\_\_

Other important information about your child's development:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Issues:

Please list your child's medical problems (from infancy to present time):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations / Surgeries:

Dates	Reason for Hospitalization / Surgery
_____	_____
_____	_____

Current Medications:

_____	_____
_____	_____

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**EDUCATION**

Has your child ever skipped/repeated (please circle) a grade? If so, when? \_\_\_\_\_

Does your child receive special services in school? \_\_\_\_\_

Last date of IEP: \_\_\_\_\_

Has your child been diagnosed with a learning disability Y/N? \_\_\_\_\_

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**PSYCHO-SOCIAL TREATMENT HISTORY**

Is your child receiving mental health services of any kind? Y / N

Please list all present and previous mental health services your child has received below in chronological order:

Mode of Treatment	Dates	Reason for Treatment
Outpatient Psychotherapy:		
individual	_____	_____
family	_____	_____
group	_____	_____
other	_____	_____
Psychiatric Hospitalizations	_____	_____
	_____	_____
	_____	_____
Psychotropic Medications	_____	_____
	_____	_____
	_____	_____
Other	_____	_____

If your child is currently on psychotropic medication, please write the name and phone number of the psychiatrist or doctor who prescribes it:

\_\_\_\_\_

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**REASON FOR REFERRAL**

Describe why you are seeking treatment for your child/adolescent:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did these difficulties begin? Did any specific event occur prior to them beginning?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check off which problems / symptoms apply to your child/adolescent currently:

- |   |   |
|---|---|
| <input type="checkbox"/> sad/depressed mood           | <input type="checkbox"/> hyperactivity                          |
| <input type="checkbox"/> anxious/tense                | <input type="checkbox"/> stealing                               |
| <input type="checkbox"/> panic attacks                | <input type="checkbox"/> alcohol use                            |
| <input type="checkbox"/> angry outbursts              | <input type="checkbox"/> drug use                               |
| <input type="checkbox"/> withdrawn                    | <input type="checkbox"/> physical aggression/fighting           |
| <input type="checkbox"/> fatigue                      | <input type="checkbox"/> problems with the law                  |
| <input type="checkbox"/> decreased appetite           | <input type="checkbox"/> truancy                                |
| <input type="checkbox"/> increased appetite           | <input type="checkbox"/> suicidal thoughts                      |
| <input type="checkbox"/> excessive weight loss        | <input type="checkbox"/> suicide attempt                        |
| <input type="checkbox"/> excessive weight gain        | <input type="checkbox"/> self-injurious behavior (e.g. cutting) |
| <input type="checkbox"/> purging                      | <input type="checkbox"/> auditory hallucinations                |
| <input type="checkbox"/> increased sleep              | <input type="checkbox"/> visual hallucinations                  |
| <input type="checkbox"/> difficulty falling asleep    | <input type="checkbox"/> inappropriate sexual behavior          |
| <input type="checkbox"/> early morning waking         | <input type="checkbox"/> poor peer relationships                |
| <input type="checkbox"/> nightmares                   | <input type="checkbox"/> poor family relationships              |
| <input type="checkbox"/> poor attention/concentration |   |

Please use this space to describe any other issues, questions, or concerns you have about your child/adolescent.

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AUTHORIZATION TO **RECEIVE** AND **RELEASE** INFORMATION

DATE: \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_ at Cognitive & Behavioral Consultants of Westchester, LLP to discuss my child's (Name of Child: \_\_\_\_\_) information and treatment (includes any pertinent psychological and medical background information and current issues) with the following parties:

1. Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

2. Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

3. Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

I understand this authorization will expire without my express revocation 90 days from the date written below.

I hereby consent that this communication can take place through:

\_\_\_\_\_ *telephone*      \_\_\_\_\_ *fax*      \_\_\_\_\_ *email*      \_\_\_\_\_ *mail*

I understand that email is not a confidential method of communication and that there is a risk that email communications may be intercepted by a 3<sup>rd</sup> party or may be transmitted to unintended parties. I am aware that the staff of CBCW will take all necessary measures to avoid using identifying information in email communications.

Date: \_\_\_\_\_

Name of Authorized Patient Representative (Print): \_\_\_\_\_

Signature of Authorized Patient Representative: \_\_\_\_\_

Authorized Representative's Relation to Patient: \_\_\_\_\_

Name of Party Accepting Authorization (Print): \_\_\_\_\_

Signature of Party Accepting Authorization: \_\_\_\_\_