Biofeedback, Mental Health Counseling & Creative Arts Therapy, PLLC
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Today's Date: __________

IDENTIFYING INFORMATION

Child's Name: ____ Sex: (M)_____ (F) _____

DOB: ____________Hospital/City/State ______________________Grade in school:_____ Age: _______

Mother's Name: ____ DOB: _________________
Natural parent: ______ Relative: _____
Step Parent: ______ Adoptive Parent: ______
Father's Name: ____ DOB: _________________
Natural parent: ______ Relative: _____
Step Parent: ______ Adoptive Parent: ______

Address (Number and Street): ____
City: __________________________ State: ____________________ Zip: _________________________

Home Telephone: ____________________ Mom Work: _________________ Dad Work: _____________

Cell Phone: ______________________ E-mail:____

Emergency Contact/Relation: ____________________ Emergency Phone #: ________________________

Primary Care Physician: ______________________ Insurance Provider: ____________________________
Please provide Insurance card to front office
Social Security Number: ______________________________ Referred By: ________________________

For what are you seeking help with today? ____
____
____.

Presenting Problems (check all that apply):

__ Temper outbursts	__ Impulsive	__ Shy	__ Other (explain):
__ Withdrawn	__ Stubborn	__ Strange behavior	___________________
__ Daydreaming	__ Disobedient	__ Stealing	___________________
__ Fearful	__ Infantile	__ Lying	___________________
__ Clumsy	__ Mean to others	__ School trouble	___________________
__ Overactive	__ Destructive	__ Bowel/bladder control	
__ Short attention span	__ Bed wetting	__ Feeding/Eating problems	
__ Distractible	__ Self mutilating	__ Sleeping problems	
__ Peer conflict	__ Head banging	__ Drug/Alcohol use	
__ Phobic	__ Rocking	__ Sickly	

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MEDICAL HISTORY

Has the child ever been hospitalized for illness, physical ailments, emotional problems etc? Y___ N___
If yes, please explain where, when, and what for? ____
____
____.

Has the child ever taken, or is he/she currently taking any medications? Y____ N ____
If yes, please list medication name and frequency of dosage _____________________________________
____.

Does the child have any allergies that you are aware of (i.e. latex, peanut, soy, etc.)? ________________
____.
Describe your child's eating and drinking habits and what he/she eats & drinks:
____
____

Describe your child's bedtime routine including bedtime and sleeping arrangements:____
____
Name and address of primary care Physician ____
____
____.

LIVING ARRANGEMENTS

Number of moves in child's life ________ Ever placed, boarded, or lived away from family? Y ___ N ___
Explain: ____

Present home: Renting ______ Buying ______ House_____ Apartment ______

List all members of your household presently and indicate their relation to the patient: ______________
____
____
____.

Are you interested in counseling services for yourself or any of your family members? Y_____ N _____

DEVELOPMENTAL HISTORY

Did mother have any illness or complications before delivery? Y____ N____ If yes, please explain
____
____
____.

Did mother abuse alcohol or drugs during pregnancy? Y____ N____

Length of pregnancy: _________________ Full Term? Y____ N ____ Birth Weight ____lbs _____oz

Complications at birth? (Explain)____
____
____.

As far as you know, did your child meet developmental milestones at an appropriate age (i.e. rolling, sitting up, babbling, and eating)? Y____ N ____
____
____.

EDUCATIONAL HISTORY

Name of School/Daycare ____
Types of classes: ___ Regular ___ Inclusion ___ESE ___EDB (Emotionally Disturbed Behavior)
___Other (explain): ____

Does the child receive special services at school? Y ____ N ____ If yes, which services and what is the frequency/duration of each?
____ Occupational Therapy ____ / week for ____ minute sessions
____ Physical Therapy _____ / week for ____ minute sessions
____ Speech Therapy _____ / week for ____ minute sessions
____ Counseling _____/ week for ____ minute sessions

SOCIAL HISTORY

Does the child attend extracurricular activities? ____
____.

In school, how many friends does the child have? ____
____.

__________________________________/___________________ ___________________
Name of person completing information/relationship to child Date

Other information you think would help me to better understand your child and your family:
(please use other side if more space is needed) Thank you.

EYBERG CHILD BEHAVIOR INVENTORY

Child's Name: __________________________ Birthdate: ______________Child's Age: _____
Rater's Name: ______________________ Date of Rating: _______________________
Relationship to Child: ______________________

Directions:
Below is a series of phrases that describe a child's behavior. Please:
(1) circle the number describing how often the behavior occurs with your child and
(2) circle either "yes" or "no" to indicate whether the behavior is currently a problem.

(1)-Never (2)-Almost Never (3)-Seldom (4)-Sometimes (5)-Often (6)-Almost Always (7)-Always
Is this a Problem Now? (Y/N)

Behavior									
1. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
3. Has Poor table manners	1	2	3	4	5	6	7	Yes	No
4. Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
5. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
6. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
7. Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
8. Does not obey house rules on his own	1	2	3	4	5	6	7	Yes	No
9. Refuses to obey until threatened w/ punishment	1	2	3	4	5	6	7	Yes	No
10. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
11. Argues with parents about rules	1	2	3	4	5	6	7	Yes	No
12. Gets angry when doesn't get own way	1	2	3	4	5	6	7	Yes	No
13. Has temper tantrums	1	2	3	4	5	6	7	Yes	No
14. Sasses adults	1	2	3	4	5	6	7	Yes	No
15. Whines	1	2	3	4	5	6	7	Yes	No
16. Cries easily	1	2	3	4	5	6	7	Yes	No
17. Yells or screams	1	2	3	4	5	6	7	Yes	No
18. Hits parents	1	2	3	4	5	6	7	Yes	No
19. Destroys toys or other objects	1	2	3	4	5	6	7	Yes	No
20. Is careless with toys and other objects	1	2	3	4	5	6	7	Yes	No
21. Steals	1	2	3	4	5	6	7	Yes	No
22. Lies	1	2	3	4	5	6	7	Yes	No
23. Teases or provokes other children	1	2	3	4	5	6	7	Yes	No
24. Verbally fights with friends his own age	1	2	3	4	5	6	7	Yes	No
25. Verbally fights with brothers and sisters	1	2	3	4	5	6	7	Yes	No
26. Physically fights with friends	1	2	3	4	5	6	7	Yes	No
27. Physically fights with brothers and sisters	1	2	3	4	5	6	7	Yes	No
28. Constantly seeks attention	1	2	3	4	5	6	7	Yes	No
29. Interrupts	1	2	3	4	5	6	7	Yes	No
30. Is easily distracted	1	2	3	4	5	6	7	Yes	No
31. Has short attention span	1	2	3	4	5	6	7	Yes	No
32. Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes	No
33. Has difficulty entertaining himself alone	1	2	3	4	5	6	7	Yes	No
34. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes	No
35. Is overactive or restless	1	2	3	4	5	6	7	Yes	No
36. Wets the bed	1	2	3	4	5	6	7	Yes	No

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RELEASE OF INFORMATION

You may consent for personal information contained within your clinical record held by **Biofeedback, Mental Health Counseling & Creative Arts Therapy, PLLC** to be disclosed to the persons and/or agencies identified below for the following reasons:

- Planning and monitoring appropriate treatment.
- Case review and consultation with your physician and/or health care providers.
- Support and/or Involvement of family member(s) or significant other in treatment.
- Information that is required to file a claim with your insurance company or managed care company.

Your signature indicates that you authorize Susan Antelis to release/receive information to the parties named below. You may revoke this consent at any time by providing written notice. Please refer to the HIPAA guidelines for additional privacy information.

1. Name of the person ***who referred you*** for services: ____
   Address: ____
   Phone: _______________________________________

2. Name of primary ***physician*** (if different from above): ____________________________________
   Address: ____
   Phone: _______________________________________

3. Any other parties ***(i.e. attorney, employer, community agency)*** that you authorize Susan Antelis to give/receive information regarding your treatment:
   ____
   ____
   ____

4. ***Family member(s)/significant other*** who may participate in your therapy. Please indicate relationship to client.
   ____
   ____

Print Client's Name: _____________________________________ DOB: ________________________

Client's Signature: _______________________________________ Date: _________________________

Parent/Guardian Signature: _________________________________ Date: _________________________

Witnessed By: ____ Date: _________________________