THE ANXIETY & AGORAPHOBIA TREATMENT CENTER
112 BALA AVENUE
BALA CYNWYD, PA 19004
Phone: (610) 667-6490 Fax: (610) 667-1744
www.aatcphila.com

CHILD/ADOLESCENT CLINICAL HISTORY QUESTIONNAIRE

Child's Name_____Date of Initial Visit_____

Date of Birth_____Age_____Grade_____Gender_____

Address_____

City, State_____Zip_____

Referred by_____

Parent 1/Guardian Name_____

Address (if different)_____

Phone: (Home) _____ OK to call/leave message at this #? Yes No
(Work) _____ OK to call/leave message at this #? Yes No
(Cell) _____ OK to call/leave message at this #? Yes No

Email _____ OK to contact you via email?* Yes No

**There are inherent confidentiality risks in communicating by email. While safeguards are in place to ensure your privacy, you should not use email communication if you are concerned about any breaches of privacy that might inadvertently occur.*

Parent 2/Guardian Name_____

Address (if different)_____

Phone: (Home) _____ OK to call/leave message at this #? Yes No
(Work) _____ OK to call/leave message at this #? Yes No
(Cell) _____ OK to call/leave message at this #? Yes No

Email _____ OK to contact you via email?* Yes No

Please note we are an out-of-network provider for insurance. *We will assist you as much as possible with insurance reimbursement. However, please note that your insurance company makes all final decisions regarding eligibility when they process your claim. If you have any concerns about coverage, you should contact your insurance company directly. We cannot be held responsible for decisions insurance companies make regarding coverage.*

Privacy of Health Information: I have received a Notice of the Psychologists' Policies and Practices to Protect the Privacy of my Health Information and I authorize the release of any Protected Health Information as described only for the purpose of treatment, payment and health care operations. I understand that I will be required to sign an additional authorization before any more specific information is released.

In signing this document I also give my permission and consent to the Anxiety and Agoraphobia Treatment Center to provide psychotherapeutic treatment to me and/or_____, who is my child. I understand the rules and limits of confidentiality.

I accept responsibility for payment in full for all services rendered at the Anxiety and Agoraphobia Treatment Center. I understand at least 24 hours notice is required to cancel or change an appointment or I will be charged for the time.

Signature_____Date_____

FOR OFFICE USE ONLY:
Intake completed by: _____Availability:_____

Therapist:_____Dx:_____

1. GENERAL INFORMATION

What questions/concerns are you hoping will be addressed by our seeing your child?

_____

_____

2. FAMILY INFORMATION

Parent 1/Guardian Name_____Date of Birth_____

Education_____Occupation_____

Employer_____

Parent 2/Guardian Name_____Date of Birth_____

Education_____Occupation_____

Employer_____
Parents' Marital Status: _____Married _____Never Married _____Separated _____Divorced _____Widowed
If separated/divorced, date of separation/divorce:_____

Who has legal custody of the child _____
**Please note if parents are divorced & have joint legal custody, both parents must provide consent for treatment*

If parents are divorced, with whom does child live/what is the visitation schedule?

_____

Please list name(s), age(s) & grade(s) of child's siblings
_____

_____

Name/relationship of anyone else with whom your child spends a significant amount of time

_____

3. ACADEMIC HISTORY

Current School_____Grade_____

School District_____

Teacher_____School Phone_____

Does your child like school? Yes No

Child's areas of academic strength_____

Child's areas of academic weakness_____

Average amount of time spent on homework each day? _____

Are there any challenges with finishing homework? Yes No
*If yes, please describe*_____

Please share any concerns about academic performance or behavior at school _____

_____

Are there any concerns about your child's school attendance? Yes No
*If yes, please describe*_____

Please list any special education services your child receives (e.g., OT, Speech, Gifted, 504 plan, IEP)

_____

Please list any additional support your child receives outside of school (e.g., speech therapy, tutoring)

_____

Has your child had any psychological/psychoeducational testing in or out of school? Yes No
If yes, please provide a copy of the written report

4. SOCIAL/BEHAVIORAL HISTORY

What are your child's strengths? _____

List your child's favorite hobbies or free-time activities (e.g., sports, art, computer) _____

_____

How much time does your child spend on screens (video games/TV/computer)?
_____ hours/per day on weekdays _____ hours/per day on weekends

Please share any concerns about your child's behavior at home _____

_____

Please describe your child's social interactions, including any concerns (e.g., outgoing, well-liked, shy, difficulty making friends, difficulty understanding social cues, stressful friendships, bullying, etc.)

_____

_____

5. DEVELOPMENTAL HISTORY

Were there any medical problems during pregnancy or delivery? Yes No
If yes, please specify _____

Were there any medical problems during the child's first year? Yes No
If yes, please specify _____

What was your child like as a baby/young child?_____

Did your child exhibit any signs of anxiety as a young child?_____

6. CURRENT MEDICAL STATUS

Child's Height_____ft_____in Weight_____

Pediatrician/Doctor's Name_____

Address_____Phone_____

_____

Psychiatrist's Name (if applicable)_____

Address_____Phone_____

_____

Please list any current or past medical/mental health conditions:
Diagnosis: Age when Diagnosed: Diagnosed By Whom:

_____

_____

_____

_____

Please list any medications your child is **currently** taking:
Medication/Dosage: How long? Prescribed for (diagnosis): Prescribed By:

_____

_____

_____

Does your child have frequent physical complaints? Yes No
*If yes, please describe*_____

Do you have any concerns about your child's sleep? Yes No
*If yes, please describe*_____

Do you have any concerns about your child's eating habits? Yes No
*If yes, please describe*_____

Please list all medications your child has been prescribed **in the past** for a mental health/psychiatric condition
Medication/Dosage: Dates Taken: Prescribed for (diagnosis): Prescribed By:

_____

_____

_____

7. PREVIOUS TREATMENT

Please list any previous counseling or therapy your child has had
Dates of Treatment: Type of Therapy/Therapist's Name: Reason/Diagnosis:

_____

_____

_____

8. FAMILY HEALTH HISTORY

Has anyone in the child's immediate or extended biological family ever had any of the conditions listed below?

	Yes	No	Relationship to Child
Hyperactivity/Attention Issues (ADHD)	____	____	_____
Learning Difficulties	____	____	_____
Autism Spectrum Disorder/Asperger's	_____	____	_____
Anxiety Disorder	____	____	_____
OCD	____	____	_____
Depression	____	____	_____
Bipolar Disorder	____	____	_____
Schizophrenia	____	____	_____
Alcohol/Substance Abuse	____	____	_____
Other Family Mental Health History	____	____	_____

If yes, please specify diagnosis(es)_____

Any additional information you'd like to share about family health history_____

_____

Are there any current/past family stressors of which you'd like us to be aware? _____

_____

9. ADDITIONAL INFORMATION

Please use the space below to share any additional information that may be relevant

_____

_____

_____

_____

Dear Parent or Guardian,

For continuity of care, we will notify your child's pediatrician or other relevant providers that your child was seen for an initial evaluation. If you would like us to do so, please provide your child's pediatrician's name and address and sign below, giving us permission to share this information. Please note we will not share any specific information about your child's visit without obtaining additional consent to do so.

I give the Anxiety and Agoraphobia Treatment Center permission to inform persons indicated below that my child was seen for an initial intake evaluation. I understand that no additional information about my child's visit will be shared without my additional consent.

Child's Name:_____Date of Birth:_____

Pediatrician/Doctor's Name: _____

Address: _____

_____

_____

Additional Provider's Name: _____

Address: _____

_____

_____

_____ _____

Parent/Guardian's Signature Date