NHCC ASSESSMENT and HISTORY INFORMATION
This information will help you and your therapist begin to clarify therapy goals.

Patient’s Name: ___________________________ Date: ___________________________

☐ YES  ☐ NO  Has/Is child ever been treated by a psychiatrist? Who? ___________________________

If yes, would you give consent to therapist to communicate with psychiatrist? Yes ______ No ______

☐ YES  ☐ NO  Has child ever been treated by a counselor? Who? ___________________________

Patient’s Physician: ___________________________

Would you give consent to therapist to communicate with PCP (Primary care Physician)? Yes ___ No ___

Last time seen by physician: ___________________________

Reason for visit: ___________________________

Is patient on medication? Y ~ N  If yes, what medication(s) ___________________________

☐ YES  ☐ NO  Has child been diagnosed with developmental problems?

☐ YES  ☐ NO  Any speech impairment problems?

☐ YES  ☐ NO  Has child been exposed to trauma?

☐ YES  ☐ NO  Any mental health problems on fathers/mothers family?

If yes, please indicate who and what diagnosis? ___________________________

☐ YES  ☐ NO  Any complications during pregnancy?

☐ YES  ☐ NO  Any complications at birth?

Briefly describe your reasons for seeking counseling services: ___________________________

What kind of things have you tried so far to handle this situation? ___________________________