NHCC ASSESMENT 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? _____

_____