Laura van Riper, LCSW, SEP
Phone 203.554.3853 Fax 12037170756
Email: lvrshrink@gmail.com

Today's Date_____

Child's Name_____ Date of Birth_____

Grade_____ School_____

How did you find me? _____

What are your present concerns about your child?

_____

_____

_____

_____

When did these challenges start? _____

What do you think is causing these challenges?

_____

_____

_____

What are your child's interests? _____

What are your child's strengths? _____

How do you hope I can help?

_____

_____

_____

Child's pediatrician_____ Phone number_____

May I contact your child's pediatrician?_____

Is your child on any medications?

_____

Child's teacher's name_____ Phone number_____

May I contact your child's teacher?_____

Has your child been in therapy before?_____

If yes, provider name and contact information_____

May I contact your child's previous provider? _____

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Family Information

Mother 's name _____ Address_____ _____ _____ Home Phone_____ Mobile _____ Email _____ Date of Birth _____ Education _____ Profession or type of work_____ _____ Married Since_____ _____Separated Since_____ _____Divorced Since_____ Previous Marriage? From _____ to _____	Father's name_____ Address_____ _____ _____ Home Phone_____ Mobile _____ Email _____ Date of Birth _____ Education _____ Profession or type of work_____ _____ Married Since_____ _____Separated Since_____ _____Divorced Since_____ Previous Marriage? From _____ to _____

OTHER CHILDREN

Name	Age	Grade/School	Living at Home?	Biological/Step?

EARLY CHILDHOOD HISTORY

1. Did mother or child experience any difficulties during pregnancy? _____

_____

2. Did labor occur spontaneously or was it induced? _____

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3. Was your child born by C-section? _____4. Was your child born prematurely or at a low birth weight? _____

5. Did your child or family have any health challenges or unusual stressors in the child's first year of life?

_____

6. Has your child had any major health problems since birth? _____

If so, please describe

_____

7. Has your child had surgery(ies)?

_____

8. Has your child had any of the following challenges?

Eating_____ Sleeping_____ Speaking_____ Separation from parent_____

Relating to other children_____ Fears_____

If so, please describe_____

_____

_____

_____

9. Do you have any concerns that your preteen or teen is using or abusing alcohol or drugs?

_____

_____

SCHOOL

1. Does your child like school? _____
2. Have there been any recent sudden or dramatic changes in school performance or interest level?

_____

_____

_____

3. What else should I know about your child and his or her school experiences so far?

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_____

_____

_____

FAMILY HISTORY **CHILD'S HISTORY**

*trauma_____ *trauma_____

*Includes death of a family member, friend, teacher or pet, natural disasters, violence/witnessing violence, accidents, bullying, upsetting medical procedures, physical, verbal or emotional abuse, assaults, terrorism, war, moving to a new location

depression _____ depression _____

anxiety _____ anxiety _____

bi-polar disorder_____ bi-polar disorder_____

substance abuse/addiction_____ substance abuse/addiction_____

AD/HD_____ AD/HD_____

gambling or other addiction_____ gambling or other addiction_____

thyroid problems_____ thyroid problems_____

schizophrenia_____ Lyme disease_____

eating disorder_____ eating disorder_____

ARE THERE ANY FIREARMS IN YOUR HOME? YES_____ NO_____

Please feel free to share any other information that you believe is important for me to know about your child and your family, and how I can help your family.

_____

_____

_____

If your child is age 14-17 they may benefit by being able to contact me directly, and if clinically indicated, I may want to periodically send them an email or call them. If you are comfortable with this, please provide your teen's email address and phone number.

Email_____ Phone_____

Thank you