

1911 Keller Andrews Road Sanford, NC 27330 919.777.9355

www.wellcenteredcounseling.com

				Today's dat	e:	
Patient Information:				•		
Individual Name:				Date of	Birth:	Age:
(fir	st)	(last)				
Gender M/F			Ethnic	city (optiona	l):	
Name of Person complet	ing this f	Orm:				
Relationship to individua						
Residence of child: (circle		gical parents				
Patient Contacts:						
Mother's name:					Ag	le:
(fir	st)	(last)				
Father's name:					Age	e:
(fir	st)	(last)				
Marital Status of Parents:	(circle)	Married	Divorced	Separated	Widowed	
Mother's Address:						
(str	eet)		(city)	(stat	te)	(zip code)
Father's Address:						
(sti	reet)		(city)	(stat	te)	(zip code)
Contact phone number:						
Name/Relationship:				Numbe	r:	
Who has legal/physical c	ustody?			Туре:		
Presenting Problem:						
What concerns you mos	t about th	nis individual?				
•						

Whe	n did you first	t notice this problem?
How At ho		lem affected his/her functioning?
At sc	hool/work:	
Com	munity:	
Do y	ou have other	r concerns you want addressed?
What	t are your goa	als/expectations for treatment?
Have	you recently	worried that your child has (please circle items relevant to your child):
Yes	No	DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)
Yes	No	MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)
Yes	No	ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)
Yes	No	BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)
Yes	No	ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)
Yes	No	ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

Yes	No	SOCIAL /	ANXIETY	(shy an	d/or af	raid to be	around other	ers)			
Yes	No	REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent									
		memorie	s, etc.)			·	_				
Yes	No	AUTISM	(social and	d langua	ade imt	airments,	rigidity)				
Yes	No		PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)								
Yes	No		DISSOCIATION (feeling outside your body or things are not real, etc.)								
Yes	No			_	•	•	ntionally? A			larmed	
103	110	•						-	4 saidiqui i i	igi ii /cq	
		Others:									
Sleep	Pattern His	tory:									
Total	hours of sle	eep per night: .			_ Usua	l Schedule		to			
	d	L. I									
Does	the individu	ual take naps d	uring the	day!	Yes	No					
If Ves	how many	hours in a typ	nical day?								
11 103	, 110W 111q11y	110013 117 q Cy	picai dayi_			(Change in th	ne past six	x(6) month	15?	
Diffic	ulty falling	asleep:	Yes	No			Yes	re past sir	No		
	ient awaken	•	Yes	No			Yes		No		
Snori			Yes	No			Yes		No		
	essness/Mov	vements:	Yes	No			Yes		No		
Early	morning av	vakening:	Yes	No			Yes		No		
	tmares:	5	Yes	No			Yes		No		
_	rested:		Yes	No			Yes		No		
_											
If yes	to any of th	he concerns lis	sted above	, please	describ	e:					
Dast I	Psychiatric H	History:									
1 450 1	sycing the r	nscory.									
Please	e list any pre	evious psychiat	tric hospita	alizatio	ns, resid	ential, or	day treatme	nt progr	ams (includ	ling any	
		treatment pro			. ,	, , ,	,,,	. 1 2		, .,,	
Diagi	5	1	9	th of St	ay			Treatn	nent Respoi	7 <i>5</i> e	
									, 		
	•	rrent or prior	•		atrists a	nd therap	ists your chil				
Nam	e Tit	tle	Loca	tion				How L	.ong?		

Please list this in	ndividual's current psychiatrio	c medications.	
Name	Dosage	Duration	Response
Please list this in	ndividual's current non-psyc	niatric medications.	
Name	Dosage	Duration	Response
Please list all the Name Example:	e psychiątric medicątions tha <i>Highest Dosąge</i>	t have been tried in the past Duration Response	Reason for Stopping
Dexedrine	5 mg twice daily	09/98-11/98 good	poor sleep

Drug and Alcohol History:

Substance	Date of Problems related to use			Treatment required		
Substance	last use	Yes	No	Yes	No	
Benzodiazapenes						
(Valium, Xanex, Ativan)						
Alcohol						
OTC - Over the counter						
(Benadryl, Nyquil, Dramamine)						
Designer Drugs						
(Club Drugs: G, Ecstasy)						
Cocaine/Crack						
Opiates/Methadone						
(Vicodin, OxyContin, Heroin)						
Methamphetamines						
(Speed, Ice, Ritalin)						
Hallucinogens						
(Marijuana/LSD/Mushrooms)						
Inhalants						
(Gasoline, Glue, Aerosol)						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						

	510.0.00									
	Tranquilizers									
	Sleeping Pills									
	Diet Pills									
Tc	Tobacco Use none or Amount per day:									
ls	there anything else we	e should kno	w about a	ny drug history	·?					

Family History:

Consider this individual's immediate family and all of their relatives on both sides (parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins)

Review the list below – if any relative has one of these disorders, check the disorder and describe their relation to your child (such as "Maternal Uncle") and their treatment history (if applicable). Maternal is mother's side of the family and Paternal is father's side of the family.

Depression			
Anxiety			
ADHD			
Bipolar (manic depressive)			·
Schizophrenia			
Alcohol/Drug Problems			
Learning Disabilities			
Autism/Asperger/Pervasive Developmental Dison	rder		
Mental Retardation			
Psychiatric Hospitalizations			
Suicide (or attempts)			
Panic Disorder			
PTSD (Post Traumatic Stress Disorder)			
OCD (Obsessive Compulsive Disorder)			
Seizures	·		
Migraines			
Heart or lung problems			
Thyroid			
Immunological disorders (lupus, scleroderma, int	flammatory bowel	disease)	
Cancer			
Other			
Developmental History: Did your child achieve the following milestones early (E his/her age (please explain if late): Language (age at first using words, sentences, e Fine motor skills (building towers with cubes, e Gross motor skills (rolling over, standing, walke) Toilet training?	etc)? drawing circle)?	ate (L) compared	with others
Has your child experienced any regression of these? If yes, explain:	Yes	No	

Is you		your biological cl		Yes	No		
		t age was he/she a	•				
	,	contact with their	5	•			
	,	our child born an					
•		ld moved a numb			No		
If yes	, please	list their age at tir	ne of mov	ve and location	:		
———Paren	nts: (Inc	luding Step-Moth	ner and Ste	p–Father, if app	plicable)		
Nam		Education		upation	Hrs/Wk	Relationsh	nip with Child (quality)
Please	e list the	e other children ir	the famil	y and other ho	usehold meml	pers who may	also be living in your
home	2:						
Nam	е	Age	Live.	s at Home?	Relation to	Child Rei	lationship with Child
	e Histo	•		Ι.,			
,		ld ever been the v		5		No)
		vas the nature of t			,	c 1	
Physi Othe		Emotional N	leglect	Accidents	Disasters	Sexual	Witnessing violence
		ıggling with your ı	marital rel	ationship or pa	renting?	Yes	No
		describe:			_		
Has v	your chi	ld ever been invol	ved with t	he following?			
•				ne ronowing:			
Yes Yes	No No	Child Protective Children's Ment					
Yes	No No	Probation/Juve		tion/Detention	1		
Yes	No	Boys and Girls C		along Description	,		
Yes	No	Youth Services					
Yes	No	Head Start					
Yes	No	Early Intervention	on Services	s (ages 0-3)			

Educational Hist	•	. t. l. b									
		end school?									
		e?									
What are his/her typical grades? What are your child's academic strengths?											
		emic strengths!									
Has there been a	change in	your child's performance	at school?	Yes	 No						
If yes, please des		your child's perioringnees	ge schools	1 C3	NO						
ii yes, pieqse qes	CHEC.										
Has your child re	eceived IQ	or Academic testing?	Yes	No							
,		5?									
Does or has you	r child part	icipated in any of the follo	wing?								
Yes	No	Resource									
Yes	No	Accelerated or Honors p	programs								
Yes	No	504 Plan									
Yes	No	Individual Education Pla	n (IEP)								
Yes	No	Virtual Academy									
Has your child h	nad problen	ns with any of the followin	ıg?								
Yes	No	Truancy									
Yes	No	Fights									
Yes	No	Absenteeism									
Yes	No	Detention									
Yes	No	Suspension									
Yes	No	School refusal									
What are your c	:hild's favor	ite activities?									
Peers:											
	•	ty relationships with other	children?	Yes	No						
If no, please exp	lain:										
Culture:											
Do you have a re	eligious pre	eference in the household?	Y	'es	No						
If yes, what is the	at preferen	ce?									
Has your child e	experienced	any problems related to ra	ace, religion,	or culture?	Yes	No					
If yes,please expl	lain:		 								

TEEN/YOUNG ADULT SECTION Do you have any concerns regarding your adolescent's friendships? Yes No (Please circle all that apply.) Too old Too young Too few Too many Truant (explain): Gang(explain): Fringe(explain): Drug/alcohol use(explain):_____ Violence(explain):_____ Sexual Promiscuity(explain): Too much time together(explain):_____ Other Has your adolescent had a recent change in friendships? Yes No If yes, what changes, if any are concerning to you? Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? Yes If yes, please describe: Are you concerned about your child's sexual activities? Yes No Is your adolescent sexually active? Yes No Does your adolescent have a job? Yes No Has your adolescent's behavior ever resulted in police, detention, or court involvement? No If yes, please explain:_____ Is there anything else you would like us to know about your child?

Adderall® (dextroamphetamine +

amphetamine)

Abilify® (aripiprazole) Adipex-P® (phentermine)

Ambien® (zolpidem) amitriptyline (Elavil®)

Amoxapine

Antabuse® (disulfiram)
Anafranil® (clomipramine)

Aricept® (donepezil) Ativan® (lorazepam) Aventyl® (nortriptyline)

Benadryl® (diphenhydramine)

Buspar® (buspirone)

Carbatrol® (carbamazepine)

Catapres® (clonidine) Celexa® (citalopram) Chloral hydrate Clozaril® (clozapine)

Cogentin® (benztropine) Concerta® (methylphenidate) Cymbalta® (duloxetine)

Cylert® (pemoline)
Dalmane® (flurazepam)

Depakote®/Depakene® (valproic acid/

valproate)

Dexedrine® (dextroamphetamine)

Didrex® (benzphetamine)
Dilantin® (phenytoin)

Dolophine®/Methadose® (methadone)

Effexor XR® (venlafaxine) Elavil® (amitriptyline)

Ephedra_®

Eskalith® (lithium) Evening primrose oil

Focalin® (dexmethylphenidate)

Gabitril® (tiagabine) Geodon® (ziprasidone)

Ginkgo biloba Ginseng

Halcion® (triazolam)
Haldol® (haloperidol)
imipramine (Tofranil®)
Inderal® (propranolol)
Keppra® (levetiracetam)
Klonopin® (clonazepam)
Lamictal® (lamotrigine)
Lexapro® (escitalopram)
Librium® (chlordiazepoxide)

Lithobid® (lithium)
Loxitane® (loxapine)
Luminal® (phenobarbital)
Luvox® (fluvoxamine)

Melatonin

Mellaril® (thioridazine)
Marplan® (isocarboxazid)
Meridia® (sibutramine)

Metadate® (methylphenidate)

Methylin® (methylphenidate)

Moban® (molindone)
Mysoline® (primidone)
Nardil® (phenelzine)
Navane® (thiothixene)
Neurontin® (gabapentin)

Norpramin® (desipramine)

nortriptyline (Pamelor®)
Omega fatty acids
Orap® (pimozide)
Pamelor® (nortriptyline)
Parnate® (tranylcypromine)

Paxil® (paroxetine)

Periactin® (cyproheptadine)
Prolixin® (fluphenazine)
propranolol (Inderal®)
ProSom® (estazolam)
protriptyline (Vivactil®)
Provigil® (modafinil)
Prozac® (fluoxetine)
Remeron® (mirtazapine)
Restoril® (temazepam)
ReVia® (naltrexone)
Risperdal® (risperidone)

Ritalin® (methylphenidate)

SAM-e

Saint john's wort
Sarafem® (fluoxetine)
Serax® (oxazepam)
Seroquel® (quetiapine)
Serzone® (nefazodone)
Sinequan® (doxepin)
Sonata® (zaleplon)

Stelazine® (trifluoperazine)
Strattera® (atomoxetine)
Subutex® (buprenorphine)
Suboxone® (buprenorphine +

naloxone)

Symbiax® (olanzapine + fluoxetine)

Tegretol® (carbamazepine)
Tenex® (guanfacine)
Tenuate® (diethylpropion)
Thorazine® (chlorpromazine)
Tofranil® (imipramine)
Topamax® (topiramate)

Topamax® (topiramate)
Tranxene® (clorazepate)
trazodone (Desyrel®)
Trilafon® (perphenazine)
Trileptal® (oxcarbazepine)

Valerian

Valium® (diazepam)
Vistaril® (hydroxyzine)
Wellbutrin® (bupropion)
Xanax® (alprazolam)
Zarontin® (ethosuximide)
Zoloft® (sertraline)
Zonegran® (zonisamide)
Zyprexa® (olanzapine)
Zydis® (olanzapine)