Milwaukee Area Psychological Services, S.C. (MAPS)
401 E. Kilbourn Avenue, Suite 402
Milwaukee, WI 52302
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New Child/Adolescent Client Information

Directions: To the best of your ability, please answer all of the questions. Your responses to the following questions will help your psychologist better understand you and your situation. This will facilitate the best possible treatment. Please answer all questions as completely as possible.

Form completed by: ________________________________ **Relationship to child** ______________________

Date: _________________

Child's Name: _______________________________ Child's Date of Birth ____________________________

Address: ___________________________________ City/State/Zip: _________________________________

Parent/Guardian Contact Information:

Address: ___________________________________ City/State/Zip: _________________________________

Work phone number: _______________________ Home phone number: _____________________________

Cell phone number: ________________________ Preferred phone number: ___work ___cell ___home

It is okay for my MAPS therapist to leave a message/voicemail at my preferred phone number (circle one)
Yes No

I have contact/communication concerns (circle one) Yes No
If yes, please specify: ____

Emergency contact: ________________________________ Emergency contact phone: _____________________

Referred to MAPS by ____

Please fill in the blanks listed below, or check the "prefer not to answer" box.

Child's Gender: ____ or €prefer not to answer

Child's Race: ____ or €prefer not to answer

Child's Ethnicity: _______________________________________ or €prefer not to answer

Religious or Spiritual Orientation: ____ or €prefer not to answer

Other aspects of child's identity which are important to you (please list):

____

____

PRESENTING CONCERNS

In your opinion, what led to this referral? Check all that apply

- ☐ Developmental delays
- ☐ Symptoms of anxiety
- ☐ Thinking problems
- ☐ Adjustment to parents divorce
- ☐ Suspected abuse
- ☐ Suspected autism spectrum disorder
- ☐ Reading difficulties
- ☐ Behavior problems at home
- ☐ Symptoms of depression
- ☐ Suicidal thoughts
- ☐ Difficulties with parents
- ☐ Problems with peers/poor social skills
- ☐ Refusal to attend school
- ☐ Fears/Anxiety
- ☐ Academic difficulties
- ☐ Behavior problems at school

How severe is/are the problem(s)? ____

____

When were these problems first noted? ____

____

What concerns you most about your child's behaviors or well-being? ____

____

What do you find most difficult about raising your child? ____

____

What is the best thing about your child? ____

____

Has your child ever experienced any emotional, verbal, physical, or sexual abuse? _______________________________________

____

Any additional information? ____

FAMILY INFORMATION

Please list all persons residing with the family and their relationship to the child.

Name	Age	Gender	Relationship to child

Mother's Name:	**Father's Name:**
Occupation:	Occupation:
Employer:	Employer:
Highest Grade Completed:	Highest Grade Completed:

If parents are divorced, separated, or not with the child, who has custody? ___________________________________
____

If child is not living with a parent, does s/he see this parent ☐ Yes ☐ No
If so, how often? ____

Important parent identities (e.g., race, ethnicity, sexual, gender)? ______________________________
____

MEDICAL INFORMATION

Please check any of the following that your child has had, and indicate the age?

		Age			Age
☐	Measles	__________	☐	German Measles	__________
☐	Mumps	__________	☐	Rheumatic Fever	__________
☐	Chicken Pox	__________	☐	Diphtheria	__________
☐	Tuberculosis	__________	☐	Meningitis	__________
☐	Whooping Cough	__________	☐	Encephalitis	__________
☐	Anemia	__________	☐	Seizures	__________
☐	Diabetes	__________	☐	Asthma	__________
☐	Rashes	__________	☐	Hay fever	__________
☐	Eczema	__________	☐	Seasonal allergies	__________
☐	Broken Bones	__________	☐	Pneumonia	__________
☐	Food allergies	__________	☐	Frequent headaches	__________
☐	Stomach aches	__________	☐	Other	__________

Current medications, indicate dosage:
________________________________ ________________________________
________________________________ ________________________________

Previous medications (Indicate when s/he stopped taking them):
________________________________ ________________________________
________________________________ ________________________________

Primary care physician:____

Has your child ever had psychological or psychiatric exam? ☐ **Yes** ☐ **No**
Provider's name: _____________________________________
When: _____________________________________
Reason: _____________________________________

Has your child ever had psychological counseling or therapy? ☐ **Yes** ☐ **No**
Therapist's name:_____________________________________
When: _____________________________________
Reason: _____________________________________

Has your child ever had a neurological exam? ☐ **Yes** ☐ **No**
Neurologist's name:_____________________________________
When: _____________________________________
Reason: _____________________________________

Describe any hospitalizations and/or surgeries and the dates: _____________________________________
____

Sleep

Past	Present	
☐	☐	No sleep difficulties
☐	☐	Trouble falling asleep
☐	☐	Wakes up frequently at night
☐	☐	Still tired after a good night's sleep
☐	☐	Does not get enough sleep
☐	☐	Restless in bed
☐	☐	Nightmares
☐	☐	Night terrors
☐	☐	Refuses to go to bed
☐	☐	Change in sleep pattern
☐	☐	Sleeps too much
☐	☐	Wakes up too early
☐	☐	Falls asleep in school
☐	☐	Refuses to get up in the morning
☐	☐	Snores
☐	☐	Sleeps with parent or sibling
☐	☐	Sleep Apnea (appears to hold breath when asleep)

Appetite

Past	Present	
☐	☐	Normal increase in weight/height
☐	☐	Unusual weight gain _____lbs.
☐	☐	Unusual weight loss _____lbs.
☐	☐	Concerns about height/growth?
☐	☐	Increase in appetite
☐	☐	Decrease in appetite
☐	☐	Gags on certain textures
☐	☐	Purposely throws up after eating
☐	☐	Food allergies ________________
☐	☐	Eats excessively
☐	☐	Picky eater
☐	☐	Will only eat certain types of food.__________________
☐	☐	On a special diet_________

Please indicate if your child has ever had any of the following? If so describe.

☐ Seizure disorder _______________________________________
☐ Accident prone _______________________________________
☐ Bites nails or cuticles _______________________________________
☐ Sucks thumb _______________________________________
☐ Grinds teeth _______________________________________
☐ Has tics or twitches _______________________________________
☐ Bangs head _______________________________________
☐ Rocks back and forth _______________________________________
☐ Fever over 104 degrees _______________________________________
☐ Head injury _______________________________________
☐ Loss of consciousness _______________________________________

Please indicate if any family members have had the following and specify that person's relationship to the child.

☐ Cancer _____________
☐ Diabetes _____________
☐ Epilepsy _____________
☐ Migraine headaches _____________
☐ Physical handicap _____________
☐ Tuberculosis _____________
☐ Huntington's chorea _____________
☐ Muscular dystrophy _____________
☐ Sickle cell anemia _____________
☐ Tay-sachs disease _____________
☐ Tourette's syndrome _____________
☐ Cerebral palsy _____________
☐ Birth defect _____________
☐ Alcohol abuse _____________
☐ Drug abuse _____________
☐ Behavior disorder _____________
☐ Emotional problems _____________
☐ Mental illness _____________
☐ Intellectual disability _____________
☐ Nervousness _____________
☐ Reading problems _____________
☐ Learning disability _____________
☐ Speech problem _____________
☐ Language problem _____________
☐ Severe head injury _____________
☐ Other _____________

TEMPERAMENT, BEHAVIOR, AND RELATIONSHIPS:

Which describe your child's temperament before the age of two?

☐ Calm	☐ Active	☐ Sociable	☐ Withdrawn
☐ Alert	☐ Unhappy	☐ Happy	☐ Tired
☐ Affectionate	☐ Crying	☐ Difficult	☐ Irritable
☐ Angry	☐ Fearful	☐ Cranky	☐ Playful
☐ Other________			

Which describe your child now?

☐ Calm	☐ Active	☐ Sociable	☐ Withdrawn
☐ Tired	☐ Cries a lot	☐ Irritable/Cranky	☐ Playful
☐ Affectionate	☐ Difficult	☐ Distracted	☐ Funny
☐ Withholds affection	☐ Happy	☐ Sad	☐ Impulsive
☐ Tearful	☐ Overreacts	☐ Moody	☐ Worries
☐ Self-conscious	☐ Gets mad easily	☐ Easily upset by changes in routine	
☐ Even tempered	☐ Hides Feelings	☐ Easily over stimulated	
☐ Lacks self control	☐ Difficult to calm	☐ Other _______________	

What makes your child angry?____

Does your child have any specific fears? ☐ **Yes** ☐ **No**

Describe:____

Does your child engage in any ritualistic or compulsive behavior? ☐ **Yes** ☐ **No**

Describe:____

Who is mainly in charge of discipline at home?_______________________________________

Do all caregivers agree on discipline?____

Which of the following methods of discipline are used at home?

☐ Verbal Reprimands	☐ Time out	☐ Loss of privileges
☐ Rewards	☐ Physical punishment	☐ Give in to child
☐ Ignore behavior	☐ Discuss behavior	☐ Earn privileges

☐ Other ____

What discipline techniques are effective?____

What discipline techniques are ineffective?____

Has your child engaged in any of the following behaviors?

☐ None	☐ Stolen with confrontation
☐ Stolen without confrontation	☐ Tries to Run away
☐ Lies often	☐ Deliberate fire-setting
☐ Hits other children	☐ Hits adults
☐ Destruction of property	☐ Cruel to animals
☐ Used/tried to use a weapon in a fight	☐ Often initiates physical fights
	☐ Drugs or alcohol

How does your child relate to others? Check all that apply

- ☐ Has many close friends
- ☐ Has several close friends
- ☐ Has few close friends
- ☐ Has no close friends
- ☐ Makes friends easily
- ☐ A leader
- ☐ A follower
- ☐ Fights with playmates
- ☐ Prefers to play alone
- ☐ Prefers younger children
- ☐ Prefers older children
- ☐ Prefers adults
- ☐ Interacts well with siblings
- ☐ Difficulty with siblings
- ☐ Teased by others
- ☐ Teases others
- ☐ Feels rejected by peer group
- ☐ Is jealous of others
- ☐ Has friends who get in trouble
- ☐ Wants friends, but doesn't know how to make or keep them

Does your child ever say? check all that apply

- ☐ I like my friends
- ☐ I like sitting with friends at lunch
- ☐ Kids hate me
- ☐ Kids are fun
- ☐ No one likes me
- ☐ Kids make fun of me
- ☐ I like my classmates
- ☐ I don't have any friends
- ☐ Kids pick on me
- ☐ I like recess
- ☐ I wish kids talked to me

How does your child spend his/her free/play time? ____

____

____

Has your child experienced any of the following stressful events during the past year? Check all that apply

- ☐ Parents separated or divorced
- ☐ Family accident or illness
- ☐ Death in the family
- ☐ Parent changed jobs
- ☐ Changed schools
- ☐ Family moved
- ☐ Family financial problems
- ☐ Chronic health problems
- ☐ Other:_______________________

How many moves has your child had within the last three years? ________________

ACADEMIC INFORMATION

List the schools your child has attended? ____

____

Has your child been in a bi-lingual classroom? ☐ No ☐ Yes. If yes – how long? _______________________

Which of the following did your child attend? Check all that apply

- ☐ Infant day care
- ☐ Kindergarten
- ☐ Preschool
- ☐ None

Which of the following describe your child's kindergarten and first grade years? Check all that apply

- ☐ Enjoyed school
- ☐ Felt neutral about school
- ☐ Afraid of school
- ☐ Complained of being sick to avoid school
- ☐ Always in trouble at school
- ☐ Disliked school
- ☐ Got along well with the teacher
- ☐ Got along poorly with the teacher
- ☐ Frequently absent
- ☐ Aggressive
- ☐ Active
- ☐ Distractible
- ☐ Disobedient
- ☐ Cooperative
- ☐ Liked to help the teacher
- ☐ Lost temper easily

If applicable ,which of the following describe your child's experiences since the first grade?
Check all that apply

- ☐ Good grades
- ☐ Failing grades
- ☐ Average grades
- ☐ Cooperative student
- ☐ Suspended, ______number of times
- ☐ Expelled, ______number of times
- ☐ Frequently absent
- ☐ Tested for special education
- ☐ Tested for the gifted program
- ☐ Tutored
- ☐ Retained, what year__________
- ☐ Loses temper easily

What are your child's current subject strengths?

- ☐ None
- ☐ Spelling
- ☐ Music
- ☐ Math
- ☐ Social Studies
- ☐ Athletics/PE
- ☐ History
- ☐ English
- ☐ Reading
- ☐ Art
- ☐ Science
- ☐ Other

What are your child's current subject weaknesses?

- ☐ None
- ☐ Spelling
- ☐ Music
- ☐ Math
- ☐ Social Studies
- ☐ Athletics/PE
- ☐ History
- ☐ English
- ☐ Reading
- ☐ Art
- ☐ Science
- ☐ Other

Which are your child's current skill strengths? Check all that apply

- ☐ None
- ☐ Concentration
- ☐ Organization
- ☐ Memorization
- ☐ Papers and reports
- ☐ Handwriting
- ☐ Checking work carefully
- ☐ Paying attention
- ☐ Getting assignments done
- ☐ Vocabulary/expression
- ☐ Understanding concepts
- ☐ Pleasing the teacher
- ☐ Reading speed
- ☐ Reading comprehension
- ☐ Working hard
- ☐ Completing homework
- ☐ Intelligence
- ☐ Behaving correctly
- ☐ Spelling
- ☐ Taking tests
- ☐ Turning in homework
- ☐ Test preparation
- ☐ Other

Which are your child's current skill weaknesses? Check all that apply

- ☐ None
- ☐ Concentration
- ☐ Organization
- ☐ Memorization
- ☐ Papers and reports
- ☐ Handwriting
- ☐ Checking work carefully
- ☐ Paying attention
- ☐ Getting assignments done
- ☐ Vocabulary/expression
- ☐ Understanding concepts
- ☐ Pleasing the teacher
- ☐ Reading speed
- ☐ Reading comprehension
- ☐ Working hard
- ☐ Completing homework
- ☐ Intelligence
- ☐ Behaving correctly
- ☐ Spelling
- ☐ Taking tests
- ☐ Turning in homework
- ☐ Test preparation
- ☐ Other

What time does your child usually go to bed on school nights? ____

GOALS

What goals would you like your child to accomplish in treatment?

1) ____

____

2) ____

____

3) ____

____

4) ____

____

Parent/Guardian Signature: ____ Date: _______________

Psychologist Signature: ____ Date: _______________