Kenneth Cole Counseling

Doctor of Psychology

Office use only

ID#

MINOR Patient Information

Today's Date: ___________________ Referred by: __________________________________

Client's Personal Information

Name: Last __________________________ First _______________________ Middle ___________________

Address: ________________________________ City _______________ State _____ Zip: ______________

DOB: ____/_____/_______ Age ____ Grade: _____ Gender: Male Female Other

I give my permission to be contacted at the following numbers/emails regarding appointments:

Home: ____________________Cell _____________________Work _________________ Ext ____________

Email: ____

May we leave messages? (Please circle all that apply) Email Home Cell Work

Parents/Legal Guardian Name(s):	**Relationship**
________________________________	_______________________________
________________________________	_______________________________
________________________________	_______________________________
________________________________	_______________________________

Parent/Legal Guardian Information

Mother's Name: Last ______________________________ First ______________________ Middle _______

Address: ____________________________________ City _______________ State _____ Zip __________

Phone: Home ________________Cell/Work _______________DOB ___/___/_____ Male ____Female ___

Employer/Occupation ____

Father's Name: Last ______________________________ First _______________________ Middle ______

Address: ____________________________________ City ________________ State _____ Zip __________

Phone: Home _______________ Cell/Work _______________ DOB ___/___/_____ Male ___ Female ____

Employer/Occupation ____

Developmental History

Person Completing Form: _________________________________ Relationship _______________________

Primary Language Spoken in the Home: English ____ Spanish ____ Other (Specify) __________________

Current Diagnosis: ____

____

Do you have any Vision or Hearing Impairments? Yes ___ No ____ (If yes, Specify) ________________

____

Ethnic /Cultural Information

Are there any spiritual or religious affiliations? Yes ____ No ____

If yes, how might they affect the your/client's treatment experience? ______________________________

____

____

Are there any cultural factors that may impact treatment?

If yes, please describe: ____

____

____

____

Persons who live in the home with the child:

Name	Gender	Age	Relationship
	Male Female		
	Male Female		
	Male Female		
	Male Female		
	Male Female		
	Male Female		

Persons close to the child who DO NOT live in the home:

Name	Gender	Age	Relationship
	Male Female		
	Male Female		
	Male Female		

Do both parents live in the home with the child? Yes ____ No ____

(If no, Please explain) ____

____

Are there any legal issues that affect your child (i.e. divorce, adoption?) Yes ____ No ____

(If yes, Please explain) ____

____

During the past 12 months, has your family experienced any of the following? (Please circle all that apply)

Death in the family Serious illness Unemployment Marital problems Moved residences

Family member moved away Other: (Please explain) ____

____

Family History

Family History of:		Relationship to Client	Notes:
Mental Retardation	Yes No		
Speech-Language Delays	Yes No		
Learning Disabilities	Yes No		
Autism Spectrum	Yes No		
Attention Deficit/Hyperactivity Disorder	Yes No		
Depression	Yes No		
Bi-polar	Yes No		
Obsessive Compulsive Disorder	Yes No		
Anxiety Disorder	Yes No		
Schizophrenia	Yes No		
Other	Yes No		

Early Developmental History:

Was the pregnancy full term? Yes ____ No ____

(If No, please explain) ____

Were medications, alcohol, or cigarettes used during pregnancy? Yes ____ No ____

(If yes, please explain) ____

Were there any complications during the pregnancy and/or delivery? Yes ____ No ____

(If yes, please explain) ____

Child's weight at birth: lbs. ____ oz. _____

When did your child independently….. (Please express age in months)

Begin sitting up? Age _______________

Begin crawling? Age _______________

Begin walking? Age _______________

Say his/her first meaningful word? Age _______________

Put 2-3 words together? Age _______________

Toilet trained (Urinary)? Age _______________

Toilet trained (Bowel)? Age _______________

Did you feel or were you told that your child was delayed in achieving the above developmental milestones? Yes ____ No ____
(If yes, Please explain) ____

Does your child smile in response to your smile? Yes ____ No ____

Does your child approach other children to play? Yes ____ No ____

Does your child appropriately greet familiar others? Yes ____ No ____

Does your child have difficulty with eye contact? Yes ____ No ____

Does your child have difficulty with transitions or changes in routine? Yes ____ No ____

Do your child display behaviors you feel are typical for his/her age? Yes ____ No ____

How does your child cope with upset? ____

Does your child have any unusual sensory responses? (i.e. noise, touch, smell, taste, etc.)

Medical History:

Diagnosis	Doctor who made diagnosis	Date diagnosis was made
____________________	____________________________	______________________
____________________	____________________________	______________________
____________________	____________________________	______________________

Has the child ever been hospitalized for an injury or illness? Yes ____ No ____

(If yes, please explain)

____

____

Current Medications	Dosage	Reason for Prescription	Start Date	Prescribing Doctor
__________________	______	___________________	__________	____________________
__________________	______	___________________	__________	____________________
__________________	______	___________________	__________	____________________
__________________	______	___________________	__________	____________________
__________________	______	___________________	__________	____________________

Social/Emotional/Behavioral History:

Is the child currently seen for counseling or therapy? Yes ____ No ____

(If yes, Please explain) ____

____

What are you child’s strengths? ____

____

____

What does your child enjoy doing to occupy his/her free time? ______________________________

____

____

What areas are you most concerned about for your child? __________________________________

____

____

School History

Did your child go to preschool? Yes ____ No ____

(If yes) Where? ____ When? ______________________

What school is your child currently enrolled in? ____

What grade is he/she in? _________

Is your child on an Individualized Education Plan (IEP)? Yes ____ No ____

(If yes, under what category of special education)? ____

____

Please list all schools your child has attended in the order in which he/she attended those schools.

School Name	Yrs. Attended	Grade	School District

Interventions	Reg. School or Private School?			Age
Speech-Language Therapy	(Circle one)	Regular	Private	_______
Occupational Therapy	(Circle one)	Regular	Private	_______
Physical Therapy	(Circle one)	Regular	Private	_______
Behavior Therapy	(Circle one)	Regular	Private	_______
Social Skills Therapy	(Circle one)	Regular	Private	_______
Counseling	(Circle one)	Regular	Private	_______

Anything else you feel we should know about your child that has not been asked? ________________

____

____

____

Client Name: ________________________ DOB: __/__/____

Acknowledgement of Office Policies, Privacy Practices, Consent for Treatment & Payment Responsibility

I have received a copy and had the opportunity to review the Office Policies, Electronic Communications Policy, Client Rights, and Privacy Practices provided to me by Kenneth Cole, PsyD. I have had the opportunity to have answered any questions I might have about these policies.

I give my permission for Kenneth Cole, PsyD to provide treatment to me (13 years and older) or my child. If I am 13 or older, I understand that I have a right to seek and consent to outpatient mental health treatment without a guardian (according to Washington law, RCW 71.34.530). However, I also understand that regular parent/guardian involvement is an important part of my treatment.

I have read and understand the Financial Agreement information contained in this form. I certify that the information I provided is correct to the best of my knowledge and I acknowledge that I am responsible for payment of the services rendered by Kenneth Cole, PsyD. I authorize Kenneth Cole, PsyD and his administrative and billing staff and/or any collection agencies used by Kenneth Cole, PsyD, to contact me by phone and/or mail for billing activities or payment arrangements.

_________________________________ ________________

Client Signature (if 13 years old or above) Date

_________________________________ ________________

Parent/Guardian Signature (for all minors) Date