DR. JEFFREY A. FISHBEIN & ASSOCIATES, PC

NEW CLIENT INFORMATION

1) CLIENT:

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ EMAIL: _____

2) FOR CLIENTS UNDER AGE 18:

MOTHER'S NAME: _____ CELL: _____ EMAIL: _____

FATHER'S NAME: _____ CELL: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS OF PARENTS: (Circle One) Married Separated **Divorced*** Widowed

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***If Divorced:** *Custody:* _____

Visitation: _____

Child's Main Residence: _____

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3) DOES THE CLIENT HAVE A HISTORY OF, OR IS THERE ANY FAMILY HISTORY OF THE FOLLOWING? (PLEASE NOTE RELATIONSHIP TO THE CLIENT):

DEPRESSION: ☐YES ☐NO _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: ☐YES ☐NO _____

ANXIETY: ☐YES ☐NO _____

ADHD: ☐YES ☐NO _____

AUTISM: ☐YES ☐NO _____

DEVELOPMENTAL DELAYS: ☐YES ☐NO _____

SELF-INJURY: ☐YES ☐NO _____

ATTEMPTED/COMPLETED SUICIDE: ☐YES ☐NO _____

ALCOHOLISM/SUBSTANCE ABUSE: ☐YES ☐NO _____

LEARNING DISABILITIES: ☐YES ☐NO _____

PSYCHIATRIC HOSPITALIZATION: ☐YES ☐NO _____

HEAD INJURY/CONCUSSIONS: ☐YES ☐NO _____

HEART PROBLEMS: ☐YES ☐NO _____

DIABETES: ☐YES ☐NO _____

SEIZURE: ☐YES ☐NO _____

ALLERGIES: ☐YES ☐NO _____

4) OTHER PROVIDERS:

a) OTHER THERAPIST OR OTHER MENTAL HEALTH PROVIDER:
May we contact this person for the purposes of treatment coordination? ☐ YES ☐NO

NAME: _____ OFFICE PHONE: _____

b) PRIMARY CARE PHYSICIAN/PEDIATRICIAN:
May we contact this person for the purposes of treatment coordination? ☐ YES ☐NO

NAME: _____ OFFICE PHONE: _____

5) CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on bottom of page if needed)

MEDICATION NAME	DOSAGE	SCHEDULE (e.g AM, PM)	REASON

6) CURRENT SCHOOL IF APPLICABLE:

SCHOOL: _____ GRADE: _____

IS THERE A 504 PLAN IN PLACE? YES ☐ NO ☐ IS THERE AN IEP IN PLACE? YES ☐ NO ☐

HAS PSYCHOLOGICAL OR PSYCHOEDUCATIONAL TESTING EVER BEEN ADMINISTERED? YES ☐ NO ☐

IF IN HIGH SCHOOL, DO YOU CURRENTLY HAVE A COLLEGE COUNSELOR? YES ☐ NO ☐

7) REFERRAL SOURCE: _____

8) MISCELLANEOUS: _____