Abby Sarrett-Cooper, MA, LPC
Partners in Counseling
103 Park Street, Suite 2D
Montclair, NJ 07042
(973) 568-0647

DATE: _____

IDENTIFYING INFORMATION:

Name:_____ Date of Birth:_____ Wt/Ht:_____

Address: _____ Home phone: _____
_____ Cell phone: _____
_____ Email: _____

Social Security # _____

Relationship to Insured: Self ___ Spouse ___ Child ___ Other ___

Marital Status: Single ____ Married ____ Other _____

Emergency Contact: Name: _____ Relationship: _____
Phone number: _____

IF MINOR:

Age:_____ Grade:_____ School:_____

☐ *Check if parent/guardian information same as above*

Parent 1/Guardian Name: _____ Home phone: _____
Address: _____ Cell phone: _____
_____ Work phone: _____
Email:_____
Parent 2/Guardian Name: _____ Home phone: _____
Address: _____ Cell phone: _____
_____ Work phone: _____
Email:_____

PRIMARY CONCERNS: Please give a brief description of your reason for seeking treatment.

_____
_____
_____
_____
_____
_____
_____
_____

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PREVIOUS PSYCHIATRIC TREATMENT:

☐ Previous psychiatrists (list names, dates, reason)

_____
_____
_____

☐ Previous therapists (list names, dates, reason)

_____
_____
_____

☐ Psychiatric hospitalizations or emergency room visits (list names, dates, reason)

_____
_____
_____

☐ Previous medication trials (list names, dates, reason, and response)

_____
_____
_____

☐ History of self-injury: ☐ Yes (please describe if any) ☐ No

_____
_____
_____

☐ History of suicide attempts: ☐ Yes (please describe if any) ☐ No

_____
_____
_____

☐ History of aggression: ☐ Yes (please describe if any) ☐ No

_____
_____
_____

☐ History of alcohol or drug use: ☐ Yes (please describe if any) ☐ No

_____
_____
_____

☐ History of trauma or abuse: ☐ Yes (please describe if any) ☐ No

_____
_____

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MEDICAL HISTORY:
Primary doctor's name: _____ Phone # : _____

Medical problems:

☐ Asthma
☐ Seizures
☐ Thyroid disease
☐ High blood pressure
☐ Headaches
☐ Diabetes
☐ Hearth disease
☐ Stomachache/nausea/diarrhea/constipation
☐ Liver disease
☐ Head trauma
☐ Other (please describe) _____
☐ Lowest and Highest weights _____

ALLERGIES (to food or medication): _____

CURRENT MEDICATIONS (include prescription and over-the-counter medications and vitamins):

Medication Name	Medication Dose	Reason

MEDICAL HOSPITALIZATIONS OR EMERGENCY ROOM VISITS:

_____
_____

FAMILY PSYCHIATRIC HISTORY: Please report history of psychiatric illness in all family members, including parents, siblings, grandparents, aunts, uncles, and cousins:

	Relative	Treatment (if known)
☐ Depression	_____	_____
☐ Bipolar disorder	_____	_____
☐ Anxiety disorder	_____	_____
☐ Schizophrenia	_____	_____
☐ Other psychotic disorder	_____	_____
☐ ADHD	_____	_____
☐ Behavior problems	_____	_____
☐ Learning disorder	_____	_____
☐ Autism spectrum disorder	_____	_____
☐ Substance abuse	_____	_____
☐ Legal problems	_____	_____

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FAMILY MEDICAL HISTORY: _____
_____
_____
_____

DEVELOPMENT:
Length of pregnancy: _____
Please describe any medical issues or complications during pregnancy, labor, and delivery:
_____
_____
_____

Walking: Age _____
First word: Age _____
2 word sentences: Age _____
3 word sentences: Age: _____
Toilet training: Age: _____

Please describe any delays in your child's development:
_____
_____
_____

SCHOOL:
☐ Regular Education
☐ Special Education – reason: _____

Please describe any special services received in school:
_____
_____
_____

Please describe any difficulties with friends and/or peers:
_____
_____
_____

Office Use:
Axis: I _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____