

Adria O'Donnell, Psy.D. PSY19207

Clinical and Consulting Psychology

adria@dronnell.com

12625 High Bluff Dr. Suite 215, San Diego, CA 92130 · Phone (858) 518-6949 · Fax (858) 792-8333

CLIENT REGISTRATION: CHILD FORM

1 Personal Information

Today's Date:

Child's Full Name:

Date of Birth: Age: Family's Religious Affiliation:

Address:

City: State: Zip:

Home Phone: Child/Teen Cell:

Parent Cell: Other:

E-mail (if applicable):

Grade: School:

Favorite / Best Subject:

Least Favorite Subject:

Activities involved in (sports; dance):

2 Responsible Party Information

Name of Responsible Party:

Address (if different than client's):

Relationship: Birth Date: SS#:

Place of Employment: Length of Employment:

Home Phone: Work Phone:

Cell Phone: Child's Legal Guardians:

• Payment Authorization

I understand that it is my responsibility to pay for the fee established for professional services rendered to the above client. I hereby authorize payment directly to Adria O'Donnell, Psy.D. In addition, 24 hours notice is required to cancel an appt. in order to avoid late charges.

Signature of Responsible Party

Date

3 Current Living Situation

Please fill in the chart below, including everyone who currently lives in your home.

First Name	Age	Relation to Child	Grade in School / Occupation

5 Family Background

Please check and fill in blanks.

Father

☐ Living ☐ Deceased

If alive, age?

Occupation:

If deceased, age at time of death:

Mother

☐ Living ☐ Deceased

If alive, age?

Occupation:

If deceased, age at time of death:

Where was your child born?

Where has your child lived?

Did you have frequent moves? ☐ Yes ☐ No If so, briefly describe:

6 Health History

Please list any serious illnesses that your child currently has (i.e.: diabetes, asthma):

Please describe any medical issues your child has had in the past. Include all major surgeries:

Please list any medication that your child currently takes (prescribed or over the counter.):

Medication Name	Dosage	Reason for Medication

Prescribing Doctor:

*Doctor's Contact Information:

*(Collaboration among professionals working with you will assist in your care. A signed Authorization form will be requested to consult with this professional.)

7 Psychological History

Is your child currently seeing a counselor/therapist? ☐ Yes ☐ No

Has s/he ever been in therapy before? ☐ Yes ☐ No

If so, previous therapist(s):

If so, briefly describe the issues of your previous counseling:

Did you find the counseling helpful? ☐ Yes ☐ No

Previous Hospitalizations ☐ Yes ☐ No

If so, when:

Where:

8 Current Situation

Please briefly describe the reasons for seeking help at this time:

When did these issues arise?

Please describe some goals you hope to achieve in coming here:

Please include any additional information that might be helpful in this process: