Scanned ___

All Things New Therapy Services, Inc.
111 Arizona Ave. NW
Orange City, IA 51041
P: 712.737.9444
F: 712.737.9445
office@allthingsnewtherapy.org
www.allthingsnewtherapy.org

New Patient Information - Adolescent

Ages 12 - 17

Dear Parent: To help your clinician understand and help your child, please answer the questions on this form and bring it with you to your child's first appointment. Please print using black or blue ink.

Child's Legal Name: _____ Date of birth: _____

Form completed by: _____ Relationship to child: _____

Did anyone refer you to All Things New? _____ Today's date:_____

PRESENTING PROBLEM/REASON FOR TREATMENT

What is your primary reason for having your child come to All Things New? _____

_____

_____

Please check any concerns you may have about your child in the boxes below :

☐ Sad or unhappy most of the time ☐ Cries a great deal ☐ Decreased energy ☐ Feelings of being worthless/helpless ☐ Apathy—doesn't seem to care ☐ Frequently negative thinking ☐ Loss of interests-doesn't enjoy things ☐ Thoughts of suicide or self-harm ☐ Angry/easily irritated	☐ Temper tantrums ☐ Frequently Lies ☐ Frequently Swears ☐ Talks back to adults ☐ Is aggressive/confrontational to adults ☐ Rarely follows instructions ☐ Can't be trusted ☐ Unmotivated ☐ Runs away from home	☐ Bites nails/pulls own hair ☐ Lots of aches and pains ☐ Difficulty sleeping (e.g.: can't fall asleep, nightmares, sleep walks) ☐ Does not get enough sleep (stays up late) ☐ Self-mutilates ☐ Body image difficulties ☐ Substantial recent change in weight or appetite
☐ Afraid of many things ☐ Very shy ☐ Panic attacks ☐ Avoids going places/being with others ☐ Checks things repeatedly ☐ Needs things to be perfect ☐ Sensitive to criticism ☐ Excessive or senseless worries ☐ Lacks confidence in abilities ☐ Dependent/needs a lot of reassurance	☐ Picks on other children ☐ Tries to boss others around ☐ Has few or no friends ☐ Is seen as weird or different by peers ☐ Isolates self away from others ☐ Poor loser ☐ Afraid of rejection ☐ Doesn't trust other people ☐ Victim of bullies ☐ Physical fights with other children	☐ Exhibits inappropriate sexual behavior ☐ Trouble with knowing what is real ☐ Demonstrates bizarre behavior (e.g.: hearing voices/seeing things) ☐ Rapid mood changes without cause ☐ Extreme risk taking or impulsivity ☐ Recurrent intrusive thoughts ☐ Cruel to animals ☐ Immature ☐ Dating problems
☐ Concentration difficulties ☐ Daydreams ☐ Needs lots of reminders ☐ Doesn't finish things ☐ Can't sit still/very active ☐ Acts without thinking ☐ Easily distracted ☐ Demands too much attention	☐ Has problems learning in school ☐ Hates going to school ☐ Seems afraid of going to school ☐ Difficulty following school rules ☐ Often skips school ☐ Has conflicts with teachers ☐ Performs below his/her ability ☐ Problems with homework	☐ Concerns with alcohol ☐ Concerns with drug use ☐ Has been in trouble with the law ☐ Has had problems with pornography ☐ Steals ☐ Breaks things ☐ Has used a weapon ☐ Has been the victim of abuse

Are there other concerns (not listed above) that you want to discuss? _____

_____

How have these concerns impacted your child's daily life?_____

_____

Is there anyone that you want All Things New to be working with regarding your child's treatment (e.g.: teacher, pediatrician, probation, court)? _____

_____

All Things New Therapy Services, Inc.
111 Arizona Ave. NW
Orange City, IA 51041
P: 712.737.9444
F: 712.737.9445
office@allthingsnewtherapy.org
www.allthingsnewtherapy.org

New Patient Information - Adolescent

RACE & ETHNICITY

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Two or more races ☐ White

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

YOUR CHILD'S FAMILY AND SUPPORTIVE RELATIONSHIPS

Are parents divorced or separated? ☐ Yes ☐ No
If yes, how long? ________________________________

What are the current custody/visitation arrangements? ____
____

Please tell us about the household/family with whom your child spends the majority of his/her time (or who currently lives with your child). List primary household information first, then list other living situations/supportive relationships:

Name	Age	Relationship (e.g. Father, Mother, Brother, Sister, Step-Sibling, Aunt)	Quality of Relationship	Living with you?
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No

Do you have significant concerns about your child's relationship with a family member? ☐ Yes ☐ No ☐ Not Sure
(e.g.: sibling, step-parent, extended family)

If so, please describe your concerns ____
____

ALL THINGS NEW
THERAPY SERVICES, INC.

All Things New Therapy Services, Inc.
111 Arizona Ave. NW
Orange City, IA 51041
P: 712.737.9444
F: 712.737.9445
office@allthingsnewtherapy.org
www.allthingsnewtherapy.org

New Patient Information - Adolescent

YOUR CHILD'S BIRTH AND EARLY DEVELOPMENT

Is this child adopted? ☐ Yes ☐ No If yes, at what age? _____

Were there any complications with the pregnancy of this child that might have impacted his/her prenatal health or development? (e.g.: mother had significant illness, smoked, drank alcohol, experienced severe bleeding, etc.)

☐ Yes ☐ No

Were there significant problems with this child's health or development in the first few years of his/her life? (e.g.: needed to be revived at birth, failure to thrive, missed significant developmental milestones)

☐ Yes ☐ No

If yes, please explain: _____

_____

If necessary, your therapist may ask you to complete a more extensive history of your child's early development.

YOUR CHILD'S LIFE STORY

What are a few areas where your child excels? (e.g.: personal strengths, favorite things to do) _____

_____

EDUCATIONAL HISTORY:

Where does your child attend school? _____

What is the highest grade level of school your child has completed? _____

What have been your child's usual report card grades? _____

What have been your child's most recent grades? _____

Has your child experienced any of the following in school? ☐ Learning Problems ☐ Discipline Problems ☐ Social Problems ☐ Emotional Problems

Has there been any academic or psychological testing done at school or elsewhere? ☐ Yes ☐ No

If yes, when? _____

Results: _____

PREVIOUS COUNSELING TREATMENT HISTORY:

Has your child ever received previous counseling, therapy, or psychiatric treatment? ☐ Yes ☐ No
If yes, can you please describe: (When, where, for what purpose, the results, and reason for terminating treatment)

When	Where	Name of Mental Health Professional	Purpose of Treatment	Results	Reason for Terminating Treatment

ALL THINGS NEW
THERAPY SERVICES, INC.

All Things New Therapy Services, Inc.
111 Arizona Ave. NW
Orange City, IA 51041
P: 712.737.9444
F: 712.737.9445
office@allthingsnewtherapy.org
www.allthingsnewtherapy.org

New Patient Information - Adolescent

ABUSE HISTORY

Has your child ever been the victim of abuse or neglect? ☐ Yes ☐ No

If yes, was the abuse: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Verbal

LEGAL HISTORY

Please list any contacts your child has had with the courts (including Friend of the Court): _____

_____

TOBACCO USE HISTORY

Has your child ever: Used chewing tabacco? ☐ Yes ☐ No Smoked? ☐ Yes ☐ No

Explain any 'Yes" answers above (including if daily or occasional use): _____

_____

SUBSTANCE USE HISTORY

Has your child ever had a problem with alcohol or other drugs? ☐ Yes ☐ No

Explain any 'Yes" answers above: _____

_____

SPIRITUAL DEVELOPMENT

What is your child's present religious affiliation? _____

Does your child have any spiritual concerns that should be addressed? ☐ Yes ☐ No ☐ Not sure

Describe _____

MEDICAL HISTORY

Does your child have any current medical concerns? _____

_____

Has your child had any past surgical procedures? ☐ Yes ☐ No

If yes, please list: _____

Has your child been exposed to any contagious diseases such as Tuberculosis? ☐ Yes ☐ No

If yes, to what and when did the exposure take place?: _____

Are immunizations current? ☐ Yes ☐ No

Please list all current medications and/or supplements your child is currently taking:
(attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

ALL THINGS NEW
THERAPY SERVICES, INC.

All Things New Therapy Services, Inc.
111 Arizona Ave. NW
Orange City, IA 51041
P: 712.737.9444
F: 712.737.9445
office@allthingsnewtherapy.org
www.allthingsnewtherapy.org

New Patient Information - Adolescent

MEDICAL INFORMATION

Please check all **medical issues** for which your child has had treatment:

__ Allergies
(e.g., allergic reactions, seasonal allergies, etc)

__ Blood disease
(e.g., anemia, bleeding disorders, etc)

__ Bone disease
(e.g., osteoporosis, arthritis, broken bones, etc)

__ Digestive system disease
(e.g., ulcers, heartburn, Celiac Disease, IBS, etc)

__ Endocrine disease
(e.g., diabetes, hypothyroid, low testosterone, etc)

__ Genetic disease
(e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc)

__ Head and brain illness or injury
(e.g., fainting, concussion, seizures, dementia, etc)

__ Heart/cardiovascular disease
(e.g., heart arrhythmia, heart attack, high blood pressure)

__ Immune disease
(e.g., serious infections, MRSA, Rheumatoid Arthritis, etc)

__ Lungs and breathing disease
(e.g., asthma, COPD, emphysema, etc)

__ Mouth and teeth disease
(e.g., gum disease, cold sores, canker sores, etc)

__ Muscle and movement disease
(e.g., tremors, tics, Restless Legs, Parkinson's, etc)

__ Poisoning & chemical exposure
(e.g., overdose, lead exposure, work fumes, etc)

__ Serious injuries and wounds
(e.g., burns, cuts, stabs, crushed limbs, etc)

__ Other _____

Check all areas where your child has had past **surgeries**:

__ Cancer
(e.g., procedures for cancer treatment)

__ Cardiac / Vascular
(e.g., procedures for heart, blood clot, stroke)

__ Ear, Nose, Throat
(e.g., tonsillectomy, thyroidectomy, etc)

__ Gastroenterology (digestive system)
(e.g., stomach, gall bladder, liver, etc)

__ Obstetrics & Gynecology
(e.g., hysterectomy, c-section, abortion, etc)

__ Orthopedic
(e.g., joint replacement, bones, spinal fusion, etc)

__ Plastic surgery
(e.g., reduction, implant, reconstruction, etc)

__ Neurosurgery
(e.g., brain surgery, spinal fusion, etc)

__ Urology
(e.g., kidney stones, hypospadias, erectile dysfunction, etc)

__ Vision
(e.g., LASIK, eye muscle correction, etc)

__ Weight loss
(e.g., gastric bypass, band, sleeve, etc)

__ Other:
_____

Comments: _____

_____

Does your child have any current or ongoing medical concerns? _____

_____

Does your child have problems with pain? ☐ Yes ☐ No

Severity of pain? (low) 1 2 3 4 5 6 7 8 9 10 (high)
Location of pain?_____

Has your child's medical concerns interfered with daily life activities such as school, work, or other activities?

☐ Yes ☐ No

If yes, please explain _____

ALL THINGS NEW
THERAPY SERVICES, INC.

All Things New Therapy Services, Inc.
111 Arizona Ave. NW
Orange City, IA 51041
P: 712.737.9444
F: 712.737.9445
office@allthingsnewtherapy.org
www.allthingsnewtherapy.org

New Patient Information - Adolescent

YOUR CHILD'S BIRTH AND EARLY DEVELOPMENT

Has your child ever had an allergic reaction to medication(s)? ☐ Yes ☐ No

Name of medication _____ Explain reaction _____

_____ _____

FAMILY/MEDICAL HISTORY

Biological Father's Name: _____ Age: _____ Education: _____
Occupation: _____ Deceased? ☐ Yes ☐ No If yes, when? _____
Description of relationship between father and child: _____

Biological Mother's Name: _____ Age: _____ Education: _____
Occupation: _____ Deceased? ☐ Yes ☐ No If yes, when? _____
Description of relationship between mother and child: _____

Has anyone in your child's extended family (ex: parent, grandparent) had a psychiatric illness? ☐ Yes ☐ No

If yes, please describe to the best of your ability (Who, symptoms/diagnosis, were they hospitalized?) _____
_____

Has anyone in your child's family attempted suicide? ☐ Yes ☐ No
If yes, who? _____

Has anyone in your child's family had a problem with or treated for substance abuse problems? ☐ Yes ☐ No
If yes, who? _____
Feel free to list any additional information you feel may be helpful to the clinician working with your child:
_____
_____
_____
_____

Completed by: _____ Date: _____
(please sign your name)

THANK YOU!

All Things New Therapy Services, Inc.
111 Arizona Ave. NW
Orange City, IA 51041
P: 712.737.9444
F: 712.737.9445
office@allthingsnewtherapy.org
www.allthingsnewtherapy.org

New Patient Information - Adolescent

PRE-TREATMENT MEDICATION CHECKLIST

Please indicate all the medications your child has ever been prescribed, include comments on effectiveness and reasons for discontinuing the medication.

ANTIDEPRESSANTS

☐ Anafranil (Clomipramine) _____
☐ Celexa (Citalopram) _____
☐ Cymbalta (Duloxetine) _____
☐ Desyrel (Trazodone) _____
☐ Effexor, (Venlafaxine) _____
☐ Elavil (Amitriptyline) _____
☐ ENSAM Transdermal Patch (Selegiline) _____
☐ Lexapro (Escitalopram) _____
☐ Luvox, (Fluvoxamine) _____
☐ Nardil (Phenelzine) _____
☐ Norpramin (Desipramine) _____
☐ Pamelor (Nortriptyline) _____
☐ Parnate (Tranylcypromine) _____
☐ Paxil, (Paroxetine) _____
☐ Pristiq (Desvenlafaxine) _____
☐ Prozac; Sarafem (Fluoxetine) _____
☐ Remeron, (Mirtazapine) _____
☐ Serzone (Nefazodone) _____
☐ Sinequan (Doxepin) _____
☐ Surmontil (Trimipramine) _____
☐ Tofranil (Imipramine) _____
☐ Vivactil (Protriptyline) _____
☐ Wellbutrin, (Bupropion)/Zyban _____
☐ Zoloft (Sertraline) _____

ANTI-ANXIETY and INSOMNIA MEDICATIONS

☐ Ambien, (Zolpidem) _____
☐ Ativan (Lorazepam) _____
☐ Benadryl (Diphenhydramine) _____
☐ BuSpar (Buspirone) _____
☐ Dalmane (Flurazepam) _____
☐ Halcion (Triazolam) _____
☐ Klonopin (Clonazepam) _____
☐ Librium (Chlordiazepoxide) _____
☐ Lunesta (Eszopiclone) _____
☐ Noctec (Chloral hydrate) _____
☐ ProSom (Estazolam) _____
☐ Restoril (Temazepam) _____
☐ Rozerem (Ramelteon) _____
☐ Serax (Oxazepam) _____
☐ Sonata (Zaleplon) _____
☐ Tranxene (Clorazepate) _____
☐ Unisom (Doxylamine) _____
☐ Valium (Diazepam) _____
☐ Vistaril, Atarax (Hydroxyzine) _____
☐ Xanax (Alprazolam) _____

OTHER MEDICATIONS NOT LISTED ABOVE

_____
_____
_____

STIMULANT MEDICATIONS

☐ Adderall _____
☐ Concerta, Daytrana TD Patch, Metadate, Ritalin (Methylphenidate) _____
☐ Dexedrine (Dextroamphetamine) _____
☐ Focalin (Dexmethylphenidate) _____
☐ Provigil _____
☐ Strattera (Atomoxetine) _____
☐ Tenex (Guanfacine) _____
☐ Vyvanse (Lisdexamfetamine) _____

MEDICATIONS FOR SIDE EFFECTS

☐ Artane (Trihexyphenidyl) _____
☐ Benadryl (Diphenhydramine) _____
☐ Cogentin (Benztropine) _____
☐ Inderal (Propranolol) _____
☐ Parlodel (Bromocriptine) _____

MOOD STABILIZERS

☐ Carbatrol, Equetro, Tegretol (Carbamazepine) _____
☐ Depakote, (Divalproic Acid) _____
☐ Eskalith, Lithobid (Lithium) _____
☐ Lamictal (Lamotrigine) _____
☐ Topamax (Topiramate) _____
☐ Trileptal (Oxcarbazepine) _____

ANTIPSYCHOTICS

☐ Abilify, (Aripiprazole) _____
☐ Clozaril, Fazaclo (Clozapine) _____
☐ Geodon, (Ziprasidone) _____
☐ Haldol (Haloperidol) _____
☐ Invega (Paliperidone) _____
☐ Loxitane (Loxapine) _____
☐ Mellaril (Thioridazine) _____
☐ Moban (Molindone) _____
☐ Navane (Thiothixene) _____
☐ Prolixin (Fluphenazine) _____
☐ Risperdal, (Risperidone) _____
☐ Serentil (Mesoridazine) _____
☐ Seroquel, (Quetiapine) _____
☐ Stelazine (Trifluoperazine) _____
☐ Thorazine (Chlorpromazine) _____
☐ Trilafon (Perphenazine) _____
☐ Zyprexa, (Olanzapine) _____

MEMORY

☐ Aricept (Donepezil) _____
☐ Exelon (Rivastigmine) _____
☐ Namenda (Memantine) _____
☐ Reminyl (Galantamine) _____