Oria Health and Wellness Inc.
FLORENCE MALMGREN, LMFT
11858 BERNARDO PLAZA COURT, SUITE 210, SAN DIEGO, CA 92128
PHONE 858-524-4300
WWW.ORIATHERAPY.COM

Child/Adolescent Information Form

Please complete the following information about your child to the best of your ability. Your child's therapist will go over this information with you when you meet to help clarify your answers.	
Child Name:	**Date:**
Date of Birth:	**Child's Age**

Mother Name:	**Father Name:**	**Caregiver Name:**
Parental Status:		
☐ Biological Parent	☐ Step-parent/co-parent	☐ Legal Guardian
☐ Foster Parent	☐ Adoptive Parent	☐ Other
Parent Marital Status		
☐ Married ☐ Separated ☐ ivorced ☐ idowed		
If parents are divorced, who has legal custody?		
☐ Mother ☐ Father ☐ hared ☐ ther		
Employment status:		

Home Address(es):	City:	Zip:
Home Phone:	Cell Phone:	
Email: ☐ Ok to send me an email ☐ Encrypted only		
Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email		
OK to send automatic SMS reminders? ☐ Yes ☐ No		
OK to leave a message with name and call back # on answering machine/voicemails? ☐ Yes ☐ No		

Emergency Contact: please identify an individual that we may contact in the event of an emergency		
Name:		Relationship to You:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	

Insurance Information (if applicable)		
Insured Person Name:		
Is address of patient same as that of Insured person? ☐ Yes ☐ No		
If No, please write address of insured person:		
Patient's relationship to insured person:		
Name of Primary Insurance:		
Insurance Policy #:		
ID#	Group#	Effective date:
Insurance Address:		Phone:
City:	State:	Zip:
Person to be billed for fees:		
Address same as above? ☐ yes		Relationship to Child:

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Current Presenting Problem/ Concern: (Please describe what is the main problem you are seeking help for)

Concerning Behaviors or Problems					
Problems with reading	☐ Yes	☐ No	Defiant	☐ Yes	☐ No
Problems with math	☐ yes	☐ No	Blames others	☐ Yes	☐ No
Problems with writing skills	☐ Yes	☐ No	Problems with eating	☐ Yes	☐ No
Problems with body coordination	☐ Yes	☐ No	Tics	☐ Yes	☐ No
Problems with self-expression	☐ Yes	☐ No	Unable to control bowels	☐ Yes	☐ No
Problems with understanding others	☐ Yes	☐ No	Wets the bed	☐ Yes	☐ No
Problems with speech	☐ Yes	☐ No	Has trouble being alone	☐ Yes	☐ No
Stuttering	☐ Yes	☐ No	Trouble being away from home	☐ Yes	☐ No
Inattentive	☐ Yes	☐ No	Refuses to talk at times	☐ Yes	☐ No
Hyperactive	☐ Yes	☐ No	Problems expressing affection	☐ Yes	☐ No
Aggressive towards others	☐ Yes	☐ No	Using drugs or alcohol	☐ Yes	☐ No
Destroys property	☐ Yes	☐ No	Appears depressed	☐ Yes	☐ No
Stealing	☐ Yes	☐ No	Mood changes easily	☐ Yes	☐ No
Lying	☐ Yes	☐ No	Appears anxious or fearful	☐ Yes	☐ No
Tries to break rules	☐ Yes	☐ No	Obsesses about things	☐ Yes	☐ No
Loses temper easily	☐ Yes	☐ No	Wants to be the opposite sex	☐ Yes	☐ No
Argues a lot	☐ Yes	☐ No	Problems with sleep	☐ Yes	☐ No
Child's Strengths (Please List):					

Psychological History:			
Has your child ever seen a Therapist or a Psychiatrist?			
Psychiatrist name:	Phone:	Dates:	
Address:	City:	State:	Zip:
Therapist Name:	Phone:	Dates:	
Address:	City:	State:	Zip:
Please list the reasons for seeking help and how the services helped or did not help you?			

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Has your child ever been "diagnosed" with any of the following:							
Attention Deficit	☐ No	☐ Yes		Speech and language Delay	☐ No	☐ Yes	
Hyperactivity DX	☐ No	☐ Yes		Autism	☐ No	☐ Yes	
Learning Disability	☐ No	☐ Yes		Pervasive Developmental Disorder	☐ No	☐ Yes	
Depression							
Has your child ever attempted suicide?	☐ No	☐ Yes	When and how?				
Has your child ever had psychological testing?	☐ No	☐ Yes	When and with whom?				
For What reasons?			Which Tests (if known)?				

Family History					
Has any of the child's parent or guardian had the following mental health conditions?					
Drug Abuse	☐ No	☐ Yes	Suicide ideation	☐ No	☐ Yes
Attention problems	☐ No	☐ Yes	Learning problems	☐ No	☐ Yes
Manic depression	☐ No	☐ Yes	schizophrenia	☐ No	☐ Yes
Alcohol Abuse	☐ No	☐ Yes	Psychiatric hospitalizations	☐ No	☐ Yes
Depression	☐ No	☐ Yes	Psychiatric medications	☐ No	☐ Yes
Suicide Attempts	☐ No	☐ Yes	Therapy or counseling	☐ No	☐ Yes

Child Siblings						
Name	Age	Gender		Relationship		
		☐ M	☐ F	☐ Half	☐ Full	☐ Step
		☐ M	☐ F	☐ Half	☐ Full	☐ Step
		☐ M	☐ F	☐ Half	☐ Full	☐ Step
		☐ M	☐ F	☐ Half	☐ Full	☐ Step
		☐ M	☐ F	☐ Half	☐ Full	☐ Step

Developmental History (answer what you can or we can discuss this together at an appointment time)					
During the mother's pregnancy, did any of the following occur? (answer what you can, we can discuss this together)					
Child was premature	☐ No	☐ Yes	Delayed crying	☐ No	☐ Yes
Complicated labor	☐ No	☐ Yes	Baby given oxygen or transfusion	☐ No	☐ Yes
Breech, caesarian or forceps deliveries	☐ No	☐ Yes	Baby placed in incubator	☐ No	☐ Yes
Fetal distress	☐ No	☐ Yes	Baby remained in hospital after mother went home	☐ No	☐ Yes

Were there any special problems, delays or events regarding your child's					
Holding head up	☐ No	☐ Yes	Bowel or bladder training	☐ No	☐ Yes
Learning to bond	☐ No	☐ Yes	Feeding self with a soon	☐ No	☐ Yes
Learning to sit up alone	☐ No	☐ Yes	Tying shoes	☐ No	☐ Yes
Learning to crawl	☐ No	☐ Yes	Dressing independently	☐ No	☐ Yes
Sleeping through the night	☐ No	☐ Yes	Writing his or her name	☐ No	☐ Yes
Learning to walk	☐ No	☐ Yes	Ability to make or get along with friends	☐ No	☐ Yes

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Learning to talk	☐ No	☐ Yes	other	☐ No	☐ Yes

Has your child ever been physically abused?	☐ No	☐ Yes	When?
Has your child ever been neglected?	☐ No	☐ Yes	When?
Has your child ever been sexually abused or molested?	☐ No	☐ Yes	When?
Has your child ever witnessed Violent acts?	☐ No	☐ Yes	When?
Has there been any other events which you would consider traumatic?	☐ No	☐ Yes	When?

Health History		
Primary Physician Name:	Phone:	Last exam:
Address:		
City:	State:	City
Does your child have any chronic or recurrent medical problems or disabilities?	☐ Yes	☐ No
Please list:		
Health History Continued		
Does your child have any recent serious illness or injuries?	☐ Yes	☐ No
Please List:		
Has your child ever been hospitalized? Give reason		
More Health Info: (allergies, Thyroid function, etc..)		
Current Medications (prescribed/over the counter/holistic)		

Medications	Reason	Dosage	Side effects	Helpful?

Has your child ever had any of the following medical conditions?					
Birth defects	☐ No	☐ Yes	Eating disorder	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Pregnancy	☐ No	☐ Yes
Stomach problems	☐ No	☐ Yes	Kidney problems	☐ No	☐ Yes
Dizziness or fainting/head injury	☐ No	☐ Yes	Bedwetting	☐ No	☐ Yes
Asthma, hay fever, hives, rash	☐ No	☐ Yes	Soiling	☐ No	☐ Yes
Serious illnesses	☐ No	☐ Yes	Sleep problems	☐ No	☐ Yes
Epilepsy, convulsions, seizures	☐ No	☐ Yes	Speech therapy	☐ No	☐ Yes
Frequent or severe headaches	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Back, muscle or joint problems	☐ No	☐ Yes	Hearing impairment	☐ No	☐ Yes
Hepatitis, jaundice or liver problems	☐ No	☐ Yes	Vision impairment	☐ No	☐ Yes

School History (answer what you can or we can discuss this together at an appointment time)					
Your child's current grade level:			School:		
Has your child ever been given an IEP or any other type of Special learning?		☐ No			☐ Yes
If yes, please explain:					
Has your child ever had:					
Problems learning certain subjects?	☐ No	☐ Yes	Disruptive class behavior?	☐ No	☐ Yes
Problems with paying attention?	☐ No	☐ Yes	Suspensions or	☐ No	☐ Yes

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				transfers?			
Problems getting along with teachers?	☐	No	☐ Yes	Special educations?	☐	No	☐ Yes
Problems with studying?	☐	No	☐ Yes	Special day classes?	☐	No	☐ Yes
Problems with grades?	☐	No	☐ Yes	Tutoring?	☐	No	☐ Yes
Problems with truancy?	☐	No	☐ Yes	Other?	☐	No	☐ Yes

Social History:
Extracurricular activities? Please list

Other History							
Has your child ever							
Been in trouble with the law?	☐	No	☐ Yes	Used any weapons?	☐	No	☐ Yes
Has anyone close to them die?	☐	No	☐ Yes	Experimented with sex?	☐	No	☐ Yes
Been removed from the family?	☐	No	☐ Yes	Been sexually active?	☐	No	☐ Yes
Been in foster care?	☐	No	☐ Yes	Been on birth control?	☐	No	☐ Yes
Been involved in a gang?	☐	No	☐ Yes	Used drugs or alcohol?	☐	No	☐ Yes