

Parkaire Consultants, Inc.

4939 Lower Roswell Road • Building C • Suite 201 • Marietta, GA 30068 • (770) 578-1519 • fax (770) 578-0860

The information you provide will help us understand your problems and can be released only with your consent.

Date: _____ Referred by: _____

Client Name: _____ DOB: _____ Age: _____
Last First Middle

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____ Male: _____ Female: _____

E-mail Address: _____

Emergency Contact: _____ Phone #: _____

In case of emergency, may we call this number?: Yes No

Relationship to you: _____

School: _____ Grade: _____

Teachers: _____

List all people living in household with client: include siblings, step-children, other relatives, foster children, friends, etc.:

Name	Relationship to Client	Age	Unusual Problems (i.e. coordination, behavior, emotional problems, etc.)

Client's parents marital status: Single Married Separated Divorced Widowed Other

Client's/Parents/Guardian employer: _____ Phone: _____

Diagnosis if available: _____

Please list medications client is currently taking:

Med/Dosage	Condition Requiring Meds	Doctor Who Prescribed Meds	Doctor's Phone	Date Meds Started

Brief Symptom Inventory (BSI)

Using the chart below, how much has each of the following problems distressed or bothered your child in the last 7 days including today?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Faintness or dizziness	0	1	2	3	4
2. Feeling no interest in things	0	1	2	3	4
3. Nervousness or shakiness inside	0	1	2	3	4
4. Pains in heart or chest	0	1	2	3	4
5. Feeling lonely	0	1	2	3	4
6. Feeling tense or keyed up	0	1	2	3	4
7. Nausea or upset stomach	0	1	2	3	4
8. Feeling blue	0	1	2	3	4
9. Suddenly scared for no reason	0	1	2	3	4
10. Trouble getting your breath	0	1	2	3	4
11. Feelings of worthlessness	0	1	2	3	4
12. Spells of terror or panic	0	1	2	3	4
13. Numbness or tingling in parts of your body	0	1	2	3	4
14. Feeling hopeless about the future	0	1	2	3	4
15. Feeling so restless you couldn't sit still	0	1	2	3	4
16. Feeling weak in parts of your body	0	1	2	3	4
17. Thoughts of ending your life	0	1	2	3	4
18. Feeling fearful	0	1	2	3	4
19. Other:	0	1	2	3	4

Has the client received any mental health services in the past? No Yes If yes, where? _____

What type? Individual Therapy Psychiatric Care Group Therapy Couples/Family Therapy
Outpatient Hospitalization Inpatient Hospitalization

Date began: _____ Reason: _____

Was it helpful?: _____

Please list any therapies client is currently receiving: _____

Is the client currently having school problems? Yes No

If yes, explain: _____

Is the client currently having social difficulties? Yes No

If yes, explain: _____

Please check any special services client has received:

- | | |
|--|--|
| <input type="checkbox"/> LD Resource | <input type="checkbox"/> Visual Therapy |
| <input type="checkbox"/> LD Self-contained | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> BD Resource | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> BD Self-contained | <input type="checkbox"/> Adaptive Physical Education |
| <input type="checkbox"/> MI Resource | <input type="checkbox"/> Orthopedic Handicapped Services |
| <input type="checkbox"/> MI Self-contained | <input type="checkbox"/> Handicapped Kindergarten |
| <input type="checkbox"/> MO Self-contained | <input type="checkbox"/> Gifted Program |
| <input type="checkbox"/> Hearing Impaired Resource | <input type="checkbox"/> Other Health Impaired |
| <input type="checkbox"/> Hearing Impaired Self-contained | <input type="checkbox"/> Remedial Help |
| <input type="checkbox"/> Speech/language Therapy | <input type="checkbox"/> Tutoring |
| <input type="checkbox"/> Audiology Services | <input type="checkbox"/> Other: _____ |

Please give a comprehensive statement of your concerns, listing those of greatest importance first:

Approximate date the current problem began: _____

Has the problem gotten worse, gotten better, or stayed the same since it began? Please be specific.

Please describe any particular disorder or problem that preceded the current difficulty and might have been associated with its onset.

Who felt the client should be seen at this time? _____

Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
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Printed Name/Credentials of Clinician	Signature/Credentials of Clinician	Date
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