

# 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

---

Printed Name/Credentials of Clinician

Signature/Credentials of Clinician

Date