Parkaire Consultants, Inc.

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

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:

- ☐LD Resource
- ☐LD Self-contained
- ☐BD Resource
- ☐BD Self-contained
- ☐MI Resource
- ☐MI Self-contained
- ☐MO Self-contained
- ☐Hearing Impaired Resource
- ☐Hearing Impaired Self-contained
- ☐Speech/language Therapy
- ☐Audiology Services
- ☐Visual Therapy
- ☐Occupational Therapy
- ☐Physical Therapy
- ☐Adaptive Physical Education
- ☐Orthopedic Handicapped Services
- ☐Handicapped Kindergarten
- ☐Gifted Program
- ☐Other Health Impaired
- ☐Remedial Help
- ☐Tutoring
- ☐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