CANALSIDE THERAPEUTIC ARTS

EMILY GENOVESE
MS, ATR-BC, LCAT

Name of Child: _____ Date: _____
What do they prefer to be called? _____

Name of Parent/Guardian (If under 18): _____

Birth Date: _____ Age: _____ Gender: ☐M ☐F

Parent/Caregiver Marital Status:
☐Never Married ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Number of Children in the Home: _____

Family Composition (Please list individuals residing in your home):
Name: Age: Relationship:

_____
_____
_____
_____
_____
_____

Local Address: _____
_____

Primary Phone: _____ May we leave a message? ☐Yes ☐No
Okay to text? ☐Yes ☐No
Secondary Phone: _____ May we leave a message? ☐Yes ☐No

Email: _____ May we email you? ☐Yes ☐No
**Please be aware that email my not be confidential.*

Referred by: _____

Is the family currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? ☐Yes ☐No

Has the family had previous psychotherapy? ☐Yes ☐No

Previous therapist's name? Dates:

_____
_____
(Names of therapists, dates, reason for leaving, progress made?)

Is your child currently taking medication (antidepressants, antianxiety, ADHD, etc.)?
☐Yes ☐No If yes, please list: _____
If no, has your child previously been prescribed psychiatric medication? Were they helpful?
☐Yes ☐No If yes, please list: _____

HEALTH & SOCIAL INFORMATION

How is your child's physical health at present?
☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Name of Primary Care Physician _____ Phone # _____
Last Physical _____
Allergies _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____
Delivery: ☐Normal ☐Breech ☐Cesarean ☐Full-term ☐Premature
If premature, number of weeks: _____
Birth Weight: _____
Problems at birth: (e.g.: infant given oxygen, blood transfusion, placed in an incubator, etc.)
_____

Vision problems? ☐Yes ☐No
Hearing problems? ☐Yes ☐No
Dental problems? ☐Yes ☐No
Any head injuries or loss of consciousness? ☐Yes ☐No
Child's history of serious illness, injury, handicaps, or hospitalization? ☐Yes ☐No
If yes, describe and give dates: _____
Are there any foods that you limit or do not give this child? ☐Yes ☐No
List: _____
About how many hours does this child watch TV, videos, games, etc. per day: _____
How do you discipline your child? _____

In the first two years, did your child experience: ☐Separation from mother ☐Out of home care
☐Disruption in bonding ☐Depression of mother ☐Abuse ☐Neglect
☐Chronic pain ☐Chronic Illness ☐Parental Stress

Is your child having any problems with their sleep habits? ☐Yes ☐No
If yes, check where applicable:
☐Sleeping too much ☐Sleeping too little ☐Poor quality sleep ☐Disturbing dreams
☐Frequent waking ☐Not sleeping in own bed ☐Other

How many times per week does your child exercise? _____ # of minutes? _____

Is your child having any difficulty with appetite or eating habits? ☐Yes ☐No
If yes, check where applicable:
☐Eating less ☐Eating more ☐Binging ☐Purging ☐Restricting ☐Picky eater
Has your child experienced significant weight changes in the last two months? ☐Yes ☐No

Does anyone in the family regularly use alcohol? ☐Yes ☐No
Concerned about the use of alcohol or drugs by anyone in the home? _____
Concerned about the use of alcohol or drugs by someone close to you? _____
How often do parents/caregivers engage in recreational drug use?
☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never
Mother used during pregnancy: ☐Alcohol ☐Drugs ☐Cigarettes ☐Vaping
Does anyone in the household smoke/vape? ☐Yes ☐No
Do you think your child's use of chemicals is a problem? ☐Yes ☐No
Type: ☐Alcohol ☐Marijuana ☐Other drugs: _____
Comments: _____

In the last year, have you or your child experienced any significant life changes, or stressors?
☐Yes ☐No If yes, please list: _____

Please check any of the following problems which concern you: If you check one, please describe in detail:

☐Depression
☐Lack of interest in activities
☐Talks excessively/interrupts
☐Hallucinations
☐Frequent body complaints
☐Homicidal thoughts
☐Repetitive thoughts (i.e. obsessions)
☐Morbid thoughts
☐Inferior feelings/Emptiness/Boredom
☐Shyness
☐Nightmares
☐Stomach issues/Health problems
☐Stress
☐Eating disorder/Appetite
☐Difficulty making/keeping friends
☐Fatigue/low energy
☐Short attention span
☐Can't sit still/Impulsive
☐Picked on/Bullied by peers
☐Mood swings
☐Anxiety/Panic/Nervousness/Fears
☐Phobias
☐Separation/Loss
☐Body image problems
☐Suicidal thinking/attempt/threats
☐Repetitive behaviors (i.e. compulsions)
(e.g. frequent checking, hand washing)
☐Relationships
☐Self-control
☐Decision making/Concentration problems
☐Assertiveness
☐Anger/Temper/Aggressive behavior
☐Loneliness
☐Self-esteem
☐Cries easily
☐Easily distracted
☐Not interested in peers
☐Problems completing school work/attendance

Anything else? _____

Has your child had suicidal thoughts recently?
☐Frequently ☐Sometimes ☐Rarely ☐Never
Have you or anyone in your family been hospitalized for emotional difficulties? ☐Yes ☐No
In the past year have you taken your child to the emergency department for mental health evaluation or psychiatric hospitalization? ☐Yes ☐No
If yes, please explain:

Please list any people with whom we can share your medical information:

PARENT/CAREGIVER OCCUPATIONAL INFORMATION
Are you currently employed? ☐Yes ☐No

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

RELIGIOUS & SPIRITUAL INFORMATION
Do you consider your family to be religious? ☐Yes ☐No
If yes, what is your faith? _____
If no, do you consider your family to be spiritual? ☐Yes ☐No

LEGAL HISTORY
Are you or any of your family members currently experiencing any legal difficulties (PINS, Probation, Parole, Divorce, Custody, Arrests)? ☐Yes ☐No
If yes, please explain: _____

SCHOOL HISTORY

Present School: _____ Grade: _____

Teacher: _____

Has child ever repeated any grade? ☐Yes ☐No

Is child in special education services? ☐Yes ☐No ☐IEP ☐504

Please describe academic or other problems your child has had in school: _____

_____

_____

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (immediate family members or relatives) experienced difficulties with the following? (Check any/all that apply and list family member; e.g. sibling, parent, uncle, cousin, etc.)

DIFFICULTY	FAMILY MEMBER
☐Depression	_____
☐Bipolar Disorder	_____
☐Anxiety Disorder	_____
☐Panic Attack	_____
☐Schizophrenia	_____
☐Alcohol/Substance Abuse	_____
☐Eating Disorder	_____
☐Learning Disability	_____
☐Trauma History	_____
☐Suicide Attempt	_____

TRAUMA HISTORY

Has your child had an unwanted sexual experience? ☐Yes ☐No

Has your child experienced violence or had a traumatic experience? ☐Yes ☐No

Are you afraid someone you know may injure/harm this child? ☐Yes ☐No

Please list any traumatic events or losses you or your family have endured: _____

_____

_____

_____

_____

Have you or a member of your family been exposed to verbal or physical abuse in the last year:

☐Yes ☐No Please explain: _____

_____

_____

Are there any weapons in your home? ☐Yes ☐No

If yes, please list: _____

OTHER INFORMATION

What do you consider to be your child's strengths? _____

_____

_____

_____

_____

What does your child like most about themself, and what do you like most about your child? _____

_____

_____

_____

_____

What are effective coping strategies that you or your child have learned?

What are your goals for therapy?

Is there any additional information you would like to share with me today?

Signature of person completing form / relationship to client:

Signature (name/relationship) Date

Thank you for taking the time to complete this form.

Phone: 585.210.9177
canalsidetherapeuticarts@gmail.com

3 Railroad Street, Suite D3
Fairport, NY 14450