ROYALTON
PSYCHOLOGICAL
ASSOCIATES, LLC

Youth – Client Information Sheet

Client Name:_____ Date of Birth:_____

Address:_____

Email:_____

Phone with area code: Cell:_____Home:_____

Parent/Guardian #1 Name:_____ Date of Birth:_____

Address:_____

Email:_____

Employer / Position:_____

Phone with area code: Cell:_____Home:_____

Parent/Guardian #2 Name:_____ Date of Birth:_____

Address:_____

Email:_____

Phone with area code: Cell:_____Home:_____

Employer / Position:_____

Youth Current School:_____ Grade:_____

Pediatrician Name and Number:_____

Names and Ages of Children in the Home:_____

_____

How did you learn about Royalton Psychological Associates:_____

Emergency Contact: Name:_____ Phone:_____

Preferred Hospital in Case of Emergency:_____

What brings you to Royalton Psychological Associates?

_____

_____

_____

_____

_____

Client Name:_____

Please list any current medications:

Medication	Dosage	Prescriber	When began?

Please list any current or past health problems, operations, and hospitalizations:

_____

_____

_____

Please provide the names of past mental health providers and dates of treatment:

_____

_____

_____

Please list any developmental concerns you might have about the youth:

_____

_____

Please list any substance such as tobacco, alcohol, marijuana, pain medication, etc. the youth has used or is currently using:_____

_____

_____

Please list the youth's interests and what he/she takes pride in:_____

_____

_____

_____

Client Name:_____

Please indicate if the youth is currently or has experienced of the following issues::

Concern:	Currently:	In the past:
Thoughts of hurting or killing self		
Thoughts of hurting or killing someone else		
Experienced a traumatic event		
Loss of a loved one		
Physically abused		
Sexually abused		
Lack of interest in activities		
Worthlessness or excessive guilt		
Daily sadness for more than 2 weeks		
Frequent crying		
Says negative things about self		
Difficulty falling or staying asleep		
Complains of being tired		
Irritable / cranky		
Restlessness or tense muscles		
Difficulty concentrating		
Excessive worries or fears		
Difficulty separating from caregiver		
Somatic / bodily complaints		
Startles easily		
Uncomfortable meeting new people		
Nightmares		
“Anxiety attacks”		
Obsessed with something		
Compulsions / ritualistic behaviors		
Racing thoughts		
High risk behaviors		
Problems sustaining attention		
Disorganized		
Loses things		
Easily distracted		
Decrease in academic performance		
Fidgets / squirms in seat		
Talks excessively		
Impulsive		
Physically hurts other people		
Frequently argues with adults		
Refuses to follow instructions		
Breaks objects on purpose		
Has made self vomit to lose weight		
Worries something is wrong with their body		
Binges on food		
Other:		