Lisa Blum, Psy.D.
Clinical Psychologist
CA LIC# PSY19790
323-633-6138

Child's Full Name:_____ **Today's Date:** _____

Date of Birth: _____ **Age**: _____ **Gender:**_____ **Ethnicity:**_____

Name of Parent(s) / Legal Guardian(s):_____

Names/ages of siblings:_____

Home Address:_____

Other Home Address (if approp.): _____

E-mail addresses (please print clearly):

Parent 1:_____ ☐ OK to use e-mail for communication

Parent 2:_____ ☐ OK to use e-mail for communication

Phone:
Parent 1 Home:_____ Work: _____ Cell:_____

Parent 2 Home:_____ Work: _____ Cell:_____

Minor's Cell (if applicable):_____

Calls will be discrete, but in the event that I need to reach either parent, please indicate the best place to leave a message:

Parent 1: Cell ☐ Home ☐ Work ☐ Parent 2: Cell ☐ Home ☐ Work ☐

School Name and Address: _____

Primary Teacher:_____ **School Counselor:**_____

Child's Primary Care Physician and Contact info:_____

Who referred you to me? _____ May I thank this person? _____

Responsible Party/Billing Information: Responsible Party Name:_____

Address:_____

Responsible Party's Social Sec. #: _____

Employed □ No □ Part- time □ Full-time Employer: _____

Do you wish to receive a monthly statement for your records? ☐ Yes ☐ Not necessary
May I send this statement to you as a pdf attachment in an email? ☐ Yes ☐ No, prefer hard copy

Emergency Contact Information:

Name: Relationship:

Phone:

Today's Date: _____

Your responses to the following "yes/no" questions will serve as a springboard for further discussion when we meet. I have not asked for written details here because in most cases it is more useful for us to dialogue about these issues. Please note:

- **Your answers will be treated with confidence.**
- **Please respond only to those questions you feel comfortable answering.**

Thank you!

1. Has your child/teen ever worked with a counselor or therapist before? Yes / No
2. Has your child/teen ever been given one or more psychological tests? Yes / No
3. Has your child/teen ever been hospitalized for psychological or emotional problems? Yes / No
4. Is your child/teen currently taking any prescription medications? Yes / No

   If yes, what are they? _____

   Prescribed by whom? _____
5. Has your child/teen ever taken any medications for psychological difficulties? Yes / No
6. Has your child/teen ever attempted suicide? Yes / No
7. Has your child/teen ever been diagnosed with a serious medical illness? Yes / No
8. Does your child/teen have any medical conditions that may affect his/her mental health treatment? Yes / No

   If yes, please describe: _____
9. Is your child/teen physically active? Yes / No
10. Is your child/teen experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Yes / No
11. Has your child/teen ever been in a 12-step program? Yes / No
12. To your knowledge, does your child/teen ever drink alcohol? Yes / No
13. To your knowledge, has your child/teen used street drugs or controlled substances not prescribed by a doctor? Yes / No
14. Do you have any specific goals with regard to your child/teen's therapy/counseling (please describe)?

    _____

    _____
15. Do you have any particular concerns or fears with regard to therapy/counseling?

    _____

    _____