Saul and Saul, LLC
CONSULTING PSYCHOLOGIST: SUZANNE C. SAUL, PhD

ADOLESCENT REGISTRATION FORM (PLEASE PRINT)

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in the strictest confidence within legal limits.

Information Supplied By:____
Relationship:____________________________Today's Date:______________________

PERSONAL HISTORY

Child's Name:____
Name They Like to Be Called:____
Age:________Date of Birth:_______________________SSN:________________________
Street Address:____
City:____Zip:__________________________
Child's Home Phone:____________________Child's Cell Phone:__________________
School:____Grade:____________
Type of Classes: ☐ Regular ☐ LD ☐ SED ☐ DD ☐ Other:____________________
Mother's Name:____________________________Date of Birth:_____________________
Mother's SSN:________________________Preferred Phone (H/W/C):_______________
Mother's Street Address:____
City:____Zip:__________________________
Father's Name:____________________________Date of Birth:_____________________
Father's SSN:________________________Preferred Phone (H/W/C):_______________
Father's Street Address:____
City:____Zip:__________________________

Previous Counseling/Dates:____

Describe the reasons for counseling at this time:_______________________________
____
____
____

Please provide a family history of mental health:_______________________________
____
____
____

1115 Bethel Road • Columbus, OH 43220
Phone: 614-638-8115 • Fax: 614-670-5095
www.saulandsaul.com

REVIEW OF SYSTEMS

VISUAL: ☐ No problem State problem:____
HEARING: ☐ No problem State problem:____

RESPIRATORY: ☐ No problem ☐ Asthma ☐ Hay Fever ☐ Congestion
☐ Shortness of breath ☐ Cough up blood ☐ Emphysema ☐ Wheezing

CARDIOVASCULAR: ☐ No problem ☐ High blood pressure ☐ Low blood pressure
☐ Chest pain ☐ Palpitations

EXCRETORY: ☐ No problem ☐ Urinary infections ☐ Bladder infections ☐ Bowel problems

NEUROLOGICAL: ☐ No problem ☐ Seizures ☐ Frequent headaches ☐ Migraines
☐ Dizziness ☐ Tremors ☐ Memory problems ☐ One-sided body weakness
☐ Pins and needles sensation ☐ Past history of head injuries

REPRODUCTIVE: ☐ No problem ☐ Sexually transmitted disease ☐ High risk for HIV/AIDS
☐ HIV+ ☐ Sexual worries ☐ Birth control issues ☐ Genital Herpes

SEXUAL ORIENTATION: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

ENDOCRINE: ☐ No problem ☐ Diabetes ☐ Hypoglycemia ☐ Thyroid dysfunction
☐ Edema or swelling

GASTROINTESTINAL: ☐ No problem ☐ Abdominal pain ☐ Frequent nausea
☐ Frequent vomiting ☐ Weight _____ Loss _____ Gain How much? ____________________
Appetite _____ Poor _____ Ravenous ☐ Frequent constipation ☐ Frequent diarrhea
☐ Food intolerance

MUSCULOSKELETAL: ☐ No problem ☐ Muscle impairment/tenderness ☐ Joint pain
☐ Back pain, Region _______________________________________ ☐ Restricted movement

MEDICATIONS CURRENTLY IN USE: (prescribed or over the counter): ☐ None used

MEDICATION	DOSAGE	SCHEDULE	FREQUENCY	LAST USED

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FAMILY HISTORY

Number of brother(s): ______ Their ages: ____

Number of sister(s): ______ Their ages: ____

Child Number ______ being in a family of ______ children.

Parent's marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is the child adopted or raised with parents other than biological parents? ____________________

____

Please rate your opinion of the child's development (compared to others the same age in the following areas:

Social: ☐ Below average ☐ About average ☐ Above average

Physical: ☐ Below average ☐ About average ☐ Above average

Language: ☐ Below average ☐ About average ☐ Above average

Intellectual: ☐ Below average ☐ About average ☐ Above average

Emotional: ☐ Below average ☐ About average ☐ Above average

For each of type of development that you rated above as below average, please describe current area of concerns: ____

____

____

Briefly describe the child's relationship with brothers, sisters, and/or step-siblings: ____________

____

____

Briefly describe the child's relationship with peers: ____

____

____

Briefly describe the style of parenting (discipline/rewards, etc.) used in the household: ________

____

____

____

____

Date: ______________________ Signed: ____

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SYMPTOM CHECKLIST

CHECK ANY SYMPTOM THAT YOU OBSERVE YOUR CHILD EXPERIENCING:

☐ Agitated	☐ Restless	☐ Anxious	☐ Appetite increase
☐ Fearful	☐ Worry a lot	☐ Depressed	☐ Appetite decrease
☐ Cry often	☐ Don't fit in	☐ Confused	☐ No appetite
☐ Hopeless	☐ Helpless	☐ Sad	☐ Self-harm How? ______
☐ Withdrawn	☐ Desperate	☐ Guilt	☐ Feeling "out of control"
☐ Suicidal	☐ Overly tired	☐ Distracted	☐ Personality changes
☐ Loses time	☐ Hear voices	☐ See "things"	☐ Can't concentrate
☐ Mood swings	☐ Demanding	☐ Suspicious	☐ Impairments in performance
☐ Overactive	☐ Rapid speech	☐ Combative	☐ Other:______
☐ Hostile	☐ Angry	☐ Aggressive	☐ Passive
☐ Irritable	☐ Racing thoughts	☐ Other:______	

How long have these symptoms been present? (Check one)

☐ Less than a week ☐ One week to one month ☐ Several months

☐ At least a year ☐ Several years ☐ Since childhood

SLEEP-REST PATTERNS: (Check all that apply)

☐ Awaken early ☐ Insomnia ☐ Hard to get to sleep ☐ Sleep too much

☐ Excessive fatigue ☐ Night terrors ☐ Sleep walking ☐ Nightmares

# of hours of sleep at night: ______

ENERGY LEVEL: ☐ Tire easily ☐ Average energy ☐ High Energy

MEDICAL HISTORY

Primary Care Physician:______

Most recent physical exam:______Results:______

List any major illnesses and/or operations:______

______

Identifying body marks:______

Previous hospitalizations:______

Phone:______