Tracy Lamperti, LMHC, BCETS

26 Wampum Dr.
PO Box 1924
Brewster, MA 02631

Phone 774-722-5919
Email lamperticc@gmail.com

IDENTIFYING INFORMATION

Child's Name: _____ DOB: _____

Mother's Name: _____ DOB: _____

Address (Number and Street): _____

City: _____ State: _____ Zip: _____

Mom Phone: _____ Mom Email:_____

Father's Name: _____ DOB: _____

Address (Number and Street): _____

City: _____ State: _____ Zip: _____

Dad Phone: _____ Dad E-mail:_____

Emergency Contact/Relation: _____ Emergency Phone #: _____

Referred By: _____

For what are you seeking help with today?

_____
_____
_____
_____.

Presenting Problems (check all that apply):

__ Temper outbursts __ Impulsive __ Shy __ Other (explain): _____

__ Withdrawn __ Stubborn __ Strange behavior

__ Daydreaming __ Disobedient __ Stealing

__ Fearful __ Infantile __ Lying

__ Clumsy __ Mean to others __ School trouble

__ Overactive __ Destructive __ Bowel/bladder control

__ Short attention span __ Bed wetting __ Feeding/Eating problems
__ Distractible __ Self mutilating __ Sleeping problems
__ Peer conflict __ Head banging __ Drug/Alcohol use
__ Phobic __ Rocking __ Sickly

Is the child currently experiencing sadness, grief, or depression?
□ No
□ Yes
If yes, for approximately how long?
_____

Has there ever been a report filed on behalf of the child to a child welfare office such as the Department of Children and Families (DCF)?
_____
_____
_____

MEDICAL HISTORY

How would you rate your child's current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems your child is currently experiencing:
_____

How would you rate your child's current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems your child is currently experiencing:
_____

How many times per week does your child generally exercise? _____

What types of exercise? _____

Please list any difficulties your child is experiencing with appetite or eating patterns:

_____

Has the child ever been hospitalized for illness, physical ailments, emotional problems etc? Y___ N___
If yes, please explain where, when, and what for?
_____
_____
_____
_____.

Has the child ever taken, or is he/she currently taking any medications? Y____ N ____

If yes, please list medication name and frequency of dosage
_____
_____
_____.

Does the child have any allergies that you are aware of (i.e. latex, peanut, soy, etc.)?
_____
_____
_____.

LIVING ARRANGEMENTS

Parent's Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Number of moves in child's life _____ Ever placed, boarded, or lived away from family? Y ___ N ___
Explain:
_____
_____

Present home: Renting _____ Buying _____ House_____ Apartment _____

List all members of your household presently and indicate their relation to the patient:
_____
_____
_____
_____
_____.

Are you interested in counseling services for yourself or any of your family members?
Y_____ N _____

DEVELOPMENTAL HISTORY

Did mother have any illness or complications before delivery? Y____ N____ If yes, please explain
_____
_____
_____
_____.

Did mother abuse alcohol or drugs during pregnancy? Y____ N____

Length of pregnancy: _____ Full Term? Y____ N ____ Birth Weight ____lbs _____oz

Complications at birth?
(Explain)_____

_____
_____
_____.

As far as you know, did your child meet developmental milestones at an appropriate age (i.e. rolling, sitting up, babbling, eating, walking, riding a bike, holding a pencil…)?
Y____ N ____
_____
_____
_____
_____.

EDUCATIONAL HISTORY

Name of School/Daycare
_____
Types of classes: ___ Regular ___ Inclusion ___Taken out for services ___EDB (Emotionally Disturbed Behavior)
___Other (explain):
_____

Does the child receive special services at school? Y ____ N ____ If yes, which services and what is the frequency/duration of each?
____ Occupational Therapy ____ / week for ____ minute sessions
____ Physical Therapy _____ / week for ____ minute sessions
____ Speech Therapy _____ / week for ____ minute sessions
____ Counseling _____/ week for ____ minute sessions

SOCIAL HISTORY

Does the child attend extracurricular activities?
_____
_____
_____.

In school, how many friends does the child have?
_____
_____
_____.

Does the child have local access to adults that are close family friends or relatives?
_____
_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	

Anxiety	yes/no
Depression	yes/no
Domestic Violence	yes/no
Eating Disorders	yes/no
Obesity	yes/no
Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no
Suicide Attempts	yes/no

ADDITIONAL INFORMATION:

Do you consider yourself/your family to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

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

_____
_____
_____
_____

What do you consider to be some of your child's weaknesses?

_____
_____
_____
_____

What would you like your child to accomplish in therapy?

_____
_____
_____

_____/_____
_____
Name of person completing information/relationship to child Date

EYBERG CHILD BEHAVIOR INVENTORY

Child's Name: _____ Birthdate: _____Child's Age: _____
Rater's Name: _____ Date of Rating: _____
Relationship to Child: _____

Directions:
Below is a series of phrases that describe a child's behavior. Please:
(1) circle the number describing how often the behavior occurs with your child and
(2) circle either "yes" or "no" to indicate whether the behavior is currently a problem.

(1)-Never (2)-Almost Never (3)-Seldom (4)-Sometimes (5)-Often (6)-Almost Always (7)-Always
Is this a Problem Now? (Y/N)

1. Dawdles in getting dressed 1 2 3 4 5 6 7 Yes No
2. Dawdles or lingers at mealtime 1 2 3 4 5 6 7 Yes No
3. Has Poor table manners 1 2 3 4 5 6 7 Yes No
4. Refuses to eat food presented 1 2 3 4 5 6 7 Yes No
5. Refuses to do chores when asked 1 2 3 4 5 6 7 Yes No
6. Slow in getting ready for bed 1 2 3 4 5 6 7 Yes No
7. Refuses to go to bed on time 1 2 3 4 5 6 7 Yes No
8. Does not obey house rules on his own 1 2 3 4 5 6 7 Yes No
9. Refuses to obey until threatened w/ punishment 1 2 3 4 5 6 7 Yes No
10. Acts defiant when told to do something 1 2 3 4 5 6 7 Yes No
11. Argues with parents about rules 1 2 3 4 5 6 7 Yes No
12. Gets angry when doesn't get own way 1 2 3 4 5 6 7 Yes No
13. Has temper tantrums 1 2 3 4 5 6 7 Yes No
14. Sasses adults 1 2 3 4 5 6 7 Yes No
15. Whines 1 2 3 4 5 6 7 Yes No
16. Cries easily 1 2 3 4 5 6 7 Yes No
17. Yells or screams 1 2 3 4 5 6 7 Yes No
18. Hits parents 1 2 3 4 5 6 7 Yes No
19. Destroys toys or other objects 1 2 3 4 5 6 7 Yes No
20. Is careless with toys and other objects 1 2 3 4 5 6 7 Yes No
21. Steals 1 2 3 4 5 6 7 Yes No
22. Lies 1 2 3 4 5 6 7 Yes No
23. Teases or provokes other children 1 2 3 4 5 6 7 Yes No
24. Verbally fights with friends his own age 1 2 3 4 5 6 7 Yes No
25. Verbally fights with brothers and sisters 1 2 3 4 5 6 7 Yes No
26. Physically fights with friends 1 2 3 4 5 6 7 Yes No
27. Physically fights with brothers and sisters 1 2 3 4 5 6 7 Yes No
28. Constantly seeks attention 1 2 3 4 5 6 7 Yes No
29. Interrupts 1 2 3 4 5 6 7 Yes No
30. Is easily distracted 1 2 3 4 5 6 7 Yes No
31. Has short attention span 1 2 3 4 5 6 7 Yes No
32. Fails to finish tasks or projects 1 2 3 4 5 6 7 Yes No

33. Has difficulty entertaining himself alone 1 2 3 4 5 6 7 Yes No

34. Has difficulty concentrating on one thing 1 2 3 4 5 6 7 Yes No

35. Is overactive or restless 1 2 3 4 5 6 7 Yes No

36. Wets the bed 1 2 3 4 5 6 7 Yes No