Psychotherapeutic Resources

CHILD'S UPDATE FORM

Name: _____ Today's Date_____

Grade: _____ School: _____ Race: _____

What are the goals you have for your child's therapy? For example: "I know therapy has been helpful when…." _____

_____

_____

Referral source _____

In an effort to coordinate care, we would like to obtain/give information from previous providers and/or your referral source. With your written authorization, we will be informing your physician (by letter) of your diagnosis and care here, communicating (as necessary) with your referring agent and requesting past mental health records.
Please check: **YES**, and provide us with the names and addresses needed to prepare the authorization form(s) or check **No** if not necessary at this time.

Primary Care: _____ **Yes ____ No____***

Referral Source: _____ **Yes ____ No____***

Past Mental Health: _____ **Yes____ No____***

Circle as indicated: Y = Yes N = No DK = Don't Know (fill in blanks as indicated)

- **Family constellation (e.g. births, deaths divorce, moves)?** Y N DK Explain:
  _____
  _____
  _____
- **Legal involvement (arrests, lawsuits).** Y N DK Explain:
  _____
  _____
  _____
- **Physical Health of child or significant family member.** Y N DK Explain:
  _____
  _____
  _____
- **Use of alcohol or non-prescription drugs.** Y N DK Explain:
  _____
  _____
- **Use of narcotics or caffeine.** Y N DK Explain:
  _____
  _____

Current Medical Care

Physician _____
Medical Diagnosis _____
Medications/Dosage _____

Mental Health: Since your last treatment here, please not if your child has seen another outpatient therapist, been evaluated by a professional or been in inpatient treatment.

Dates (Month/Year)	**Where**	**Primary Therapist**