ORTIZ PSYCHOLOGICAL SERVICES
SYLVIA ORTIZ, LCSW
714 726-2794

**CLIENT INFORMATION – CHILD**

Child's Name: ___________________________________ Date of birth: _______________________

Address: _______________________________________________________________________________

Telephone: _______________________________________ Cell: _________________________________

Child's Physician: _________________________________ Telephone: _________________________

School: _____________________________________________ Grade: ______________________________

Teacher's Name: ________________________________________________________________________

Names and date of birth of siblings: ____________________________________________________

Reason for seeking services (check all that apply):

| | | | |
|---|---|---|---|
| _____Alcohol/Drug use | _____Anger problems | _____Anxiety | _____Compulsive behaviors |
| _____Coping problems | _____Eating problems | _____Depression | _____ Defiance |
| _____Fears/phobias | _____Hyperactivity | _____ Inattention | _____ No friends |
| _____Poor grades | _____Mental Confusion | _____ Poor social skills | _____ Sleeping problems |
| _____Poor self-concept | ______Mood swings | _____ Sexual acting out | _____ Suicidal threats |

Other: _________________________________________________________________________________

Previous therapist: ____________________________________Dates: ___________________________

Is child on any medication? Medication/Dosage: ________________________________________

Is there a family history of mental disorders/depression/autism, etc? Explain: ______

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Who referred you to our office?
_______________________________________________________________________________________