Assessment

Client information is confidential **except for:** Information which can be shared with the paying insurance or processor; information which suggests possible child abuse or endangerment; information which suggests that the client is a danger to self or others; information which indicates behavior which is a serious risk to a minor; information which may be required by a court order, or as prescribed by law; and information that client or guardian requests to be released.

I have read and understand the above.

Client signature____Date________

Signature of parent or guardian___________________________________Date________

(Print)
Client Name ________________________________Date__________________________

Age__________Date of Birth____________________Gender: M____ F____

Education____

School and year/grade (if in school)____

Employment/type of work____

Military Veteran? Yes____ No____

Who referred you to Dr. Lipin?____

ALLERGIC TO:

☐ Penicillin ☐ Sulfa
☐ Codeine ☐ Latex
☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________
☐ No Known Allergies

Current Medical Conditions: Treated? (circle)

1.____ Yes No

2.____ Yes No

3.____ Yes No

4.____ Yes No

Current Medications:

Medication	Dosage	How often	Reason	Date begun	Doctor
1.					
2.					
3.					
4.					
5.					
6.					

Previous Psychiatric/Psychological/Counseling Treatment:

Date	Place	Doctor/Clinician	Reason
1.			
2.			
3.			
4.			
5.			
6.			

Were there any prenatal, birth or developmental issues? Yes____ NO____