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____

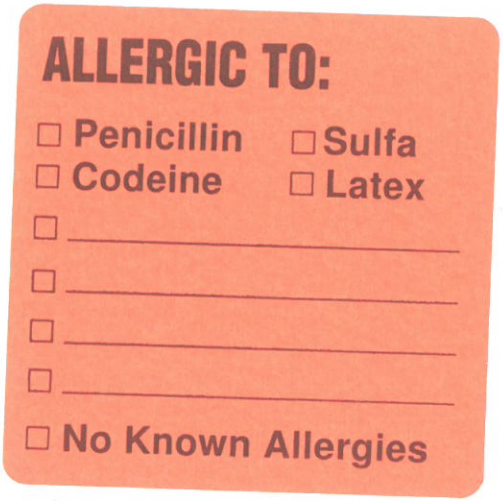
Education_____

School and year/grade (if in school)_____

Employment/type of work_____

Military Veteran? Yes____ No____

Who referred you to Dr. Lipin?_____



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____