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NEW PATIENT INFORMATION (Child/Teen)

Name: ______________________________________ Today's Date: ____________________

Date of Birth: ______________________ Age:_______________ Grade in School: _________

Name Prefers to be Called By: _____________________ Gender: _________________________

Home Address: ____

City, State, Zip:____

Parent/Guardian 1 :

Name: __________________________________ Date of Birth: _________________________

Occupation: ____________________________ Phone(s): _______________________________

Address (if different): ____

E-mail address (ONLY if I have permission to contact you here): _____________________________

Parent/Guardian 2 :

Name: __________________________________ Date of Birth: _________________________

Occupation: ____________________________ Phone(s): _______________________________

Address (if different): ____

E-mail address (ONLY if I have permission to contact you here): _____________________________

Are Parents/Guardians Married/Divorced/Other? ______________________________________

***(*PLEASE NOTE: If parents are divorced and share joint **legal** custody, I must have signed consent for treatment from BOTH PARENTS before I can treat the child. In most cases, even if one parent has full physical custody, **both** parents will have **legal** custody.)*

With whom does child live?: ____

Is Child Biological/Adopted/Other?_______ ________________________

Siblings:

Name Grade in School Age Live in the Home (Y/N)?

____

____

____

____

Who Else Lives in the Home?:

Name Age Relationship

____

____

Is someone other than parent(s) involved with significant care of child? If so, who:

____

Who referred you? ____

Why are you seeking treatment at this time?: ____________________________

____

____

____

Have you sought treatment for this in the past? If so, were you happy with the child's progress?____

____

Who is the child's pediatrician? ____

Address/Phone of pediatrician: ____

Approximate date of last physical: ____

Is the child currently taking any medications (prescribed or over-the-counter)? If yes, please list:

Medication Dosage Reason

____

____

____

Who prescribes the medications? ____

____

____

Developmental History:

Pregnancy:

Were there any complications with the pregnancy or birth? _________________________

____

Was the child healthy at birth and in infancy? _________________________________

Developmental milestones:

Did child walk, talk and meet other milestones within generally accepted limits? _________

____

Social Development:

Did child make friends easily or with difficulty? (Please describe): ____________________

____

Does child have at least one or two friends? _______________________________

Academic History:

When did child begin school (preschool? Kindergarten? Age?) ____________________

How did child adjust to the academic environment?: ___________________________

____

Please list all schools child has attended with ***most recent school first***: :

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

How does the child perform in school, academically?: __________________________

____

____

How is the child's behavior at school?: ______________________________________

____

____

Emotional Health History:

Are any of the following present(or were they present in the past) in the **child** or **family** members (including aunts, uncles, and grandparents on both sides of the family)?

	Please Specify Who
___ Alcohol Use/Abuse	______________________________
___ Anxiety	______________________________
___ Autism/Asperger's	______________________________
___ Bipolar Disorder	______________________________
___ Cutting/Self Harm	______________________________
___ Depression	______________________________
___ Drug Use/Abuse *	______________________________
___ Fire Setting	______________________________
___ Hair Pulling	______________________________
___ Homicide	______________________________
___ Hospitalization (Mental)	______________________________
___ Obsessive-compulsive Disorder	______________________________
___ Panic Attacks	______________________________
___ Undiagnosed Mental Health Issues	______________________________
___ Schizophrenia	______________________________
___ Skin Picking	______________________________
___ Suicide Attempts/Completions	______________________________
___ Other Emotional Issues	______________________________

* (including prescription and over-the-counter medications)