CHILD/ADOLESCENT NEW PATIENT INFORMATION FORM

This information is considered confidential and will not be released without your permission.

Child Information

Date form filled out: _____ Name of person completing form: _____
Relationship to the child: _____
Child's Name:_____ Age:_____
Sex: ___ Male ___ Female Religion:_____

Current Primary Care Physician (PCP): _____
PCP Phone: _____ Fax: _____

Current Psychiatrist (if applicable):_____
Phone:_____ Fax: _____
Reason for seeing this doctor: _____

Other health care provider currently involved with this child:
Name:_____
Phone:_____ Fax: _____
Reason child seen by this provider: _____

Present Family Information

Biological Father's Name: _____ Highest Education Level: _____
Occupation:_____ Living in the home? ___ Yes ___ No

Biological Mother's Name: _____ Highest Education Level: _____
Occupation: _____ Living in the home? ___ Yes ___ No

Relationship between biological parents: ___ Friendly ___ Neutral ___ Strained ___ Stressful with arguments
Child's biological parents: __ Never Married __ Married __ Divorced (when? _____) __ Separated when?(_____)
Is this child adopted? __ no __ yes (How old at time of adoption? _____)

Step-mother: Name: _____ Since Date/Year: _____
Step-father: Name: _____ Since Date/Year: _____

List all of this child's siblings:

Name	Full, ½, or step?	Age	Grade	Living in the home?	Behavior Problems?	Emotional Problems?	Learning Problems?

Why are you seeking help for this child?
1. _____
_____
2. _____
_____
3. _____
_____

Developmental History of this child:

Any complications with pregnancy: ___ no ___ yes: explain:_____
Fetal exposure to substances (check all that apply): ___ Nicotine___ Alcohol ___ Drugs ___ Toxins ___ other: _____
Any complications with labor: ___ no ___ yes: explain: _____
Medical complications at birth requiring medical care: ___ no ___ yes: explain:_____
Birth: ___ full term ___ early (born at how many weeks: _____) ___ late (born at how many weeks:_____)
Birth weight:_____ Delivery: ___ vaginal ___ C-Section

Mother's health after delivery: ___ normal ___ problems: _____
Mother experience any significant post-delivery sadness/mood change: ___ no ___ yes

Child's developmental milestones (e.g., crawling, sitting, walking, talking): ___ on time ___ early ___ late
If late, please check which milestones were delayed: ____ motor (crawling, sitting, walking)
___ language (talking, putting words together) ____ social (attachments, playing, relationships)

Early temperament: ___ pleasant, even keel, flexible ___ irritable, inflexible, easily upset
___ unresponsive, aloof, withdrawn ___ hard to please, cried often, difficult to comfort
___ other: _____

Has this child ever been the victim of: Physical abuse? ___ no ___ yes Sexual abuse? ___ no ___ yes
Verbal abuse ___ no ___ yes Neglect ___ no ___ yes

Has this child ever witnessed violence: In the home? ___ no ___ yes In the neighborhood? ___ no ___ yes

Medical History of this child:
Is this child currently being treated for any major medical conditions? ____ no ____ yes: (Please list condition, date diagnosed, treating physician): _____
_____
_____
Prior hospitalizations (Please list place, date, reason, outcome): _____

Sleep Difficulties falling asleep _____ Difficulties staying asleep _____ Hours of sleep _____ Wake up rested___

Does your child currently take any medications? ___ no ___ yes (if yes, please complete below)

Current Medications	*For what?*	*Dosage*	*Frequency*	*Date started*	*Prescribing physician*	*Comments*

Child taking any over the counter medications/for what? _____
_____

Past medications taken by this child/for what? _____
_____

Doe your child have any allergies? ____ no ____ yes: please list _____
_____

Family History Please *check* if anyone in this child's family (including extended family) has had a history of:

	No	Yes	Mother's family	Father's family
Learning Disability				
Attention Deficit Hyperactivity Disorder (ADHD or ADD)				
Mental Retardation				
Tic Disorder or Tourette's Disorder				
Autism or Developmental Disability				
Anxiety (e.g. Panic Attacks, Generalized Anxiety)				
Obsessive Compulsive Disorder				
Major Depression				
Bipolar Depression				
Suicide (attempts and/or completions)				
Schizophrenia				
Psychiatric Hospitalization				
Severe behavior problems or criminal activities				
Chronic medical illness (please list) Examples: asthma, migraines, fibromyalgia, IBD				
Thyroid disease				
Seizures				
Cancer				
Heart Disease				
Autoimmune Disorders				
Alcohol or chemical dependency				
Other:				
Other:				

Please check medical issues your child has had either past or current:

PAST	CURRENT	CONDITION	DATE	PAST	CURRENT	CONDITION	DATE
_____	_____	Head Trauma/Injury		_____	_____	High Fevers	
_____	_____	Loss of consciousness		_____	_____	Fainting Spells	
_____	_____	Spaciness/confusion		_____	_____	Seizures	
_____	_____	Motor Tics/Tourette's		_____	_____	Allergies	
_____	_____	Encephalitis/meningitis		_____	_____	Immune System Disease	
_____	_____	Drug use		_____	_____	Alcohol use	
_____	_____	Respiratory Disease *(chronic cough, asthma)*		_____	_____	Cardiovascular Disease *(heart murmur, dizziness)*	
_____	_____	Gastrointestinal Problems *(frequent vomiting, diarrhea)*		_____	_____	Genitourinary problems *(painful urination, wets the bed)*	
_____	_____	Musculoskeletal problems *(muscle pain, joint pain)*		_____	_____	Skin problems *(rashes, severe acne, bruises)*	
_____	_____	Hearing problems		_____	_____	Vision problems	
_____	_____	Other: _____		_____	_____	Other: _____	

Please check any that are significant concerns you have about your child at this time:

__ Pain management	__ Low energy/fatigue	__ Behavior problems
__ Headaches/Stomach aches	__ Depressed mood	__ Problems making/keeping friends
__ Issues with the law	__ High risk behaviors	__ Bullying/being teased
__ Sibling relationships	__ Homework time	__ Morning time/Bed time
__ Aggression	__ Cruelty to animals	__ Sexuality issues
__ Sleep problems	__ Anxiety/nervousness	__ Cutting self/Self-harm
__ Eating problems	__ Hyperactive	__ Impulsive (acts/speaks without thinking)
__ Toileting problems	__ Unusual Behaviors	__ Distractible/Short Attention Span
__ Lacks self-control	__ Over-reacts/extreme feelings	__ Poor problem solving
__ Overly shy	__ Irritable	__ School problems
__ Not affectionate	__ Hides feelings	__ Over-reliant on parents/others
__ Fearful	__ other: _____	__ other: _____

This child generally is: ___ compliant ___ not compliant. This child is compliant about _____% of the time.
When not compliant, it is usually because my child: ___ has strong will/stubborn ___ doesn't understand/gets confused ___ gets distracted/forgets ___ likes to push my buttons ___ isn't able to comply ___ knows I won't follow-through
Usual discipline technique(s): _____
_____
Parents agree on discipline? ___ yes ___ no (explain: _____)

Please check any areas that may be stressful for your child now or within the last 6 months:

__ School	__ Friendships	__ Sibling relationships
__ Living situation	__ Dating relationships	__ Family relationships
__ Financial difficulty	__ Family medical illnesses	__ Mental health issues of family member
__ Relocation/family move	__ Death of loved one	__ Divorce
__ Other _____	__ Other _____	__ Other _____

How does your child usually cope with stress, worry, or other negative feelings? _____
_____

_____

What is your child's typical mood, on average: ___ ecstatic ___ happy ___ content ___ sad ___ irritable ___ aloof
Your child typically is: ___ easygoing, flexible ___ rigid, inflexible ___ somewhere in-between

Has your child seen a therapist, counselor, or psychologist before? __ no __ yes
Provider Name:_____ Type of service: _____
Phone:_____ Fax: _____ Date of services: from _____ to _____
Reason child saw this provider: _____

Please list some overall strengths of your child (i.e., what you enjoy the most about this child): _____
_____
_____

What is most difficult about raising this child _____
_____

Education Information:

Current School:_____ Grade: _____ Primary Teacher:_____
School address: _____ City:_____ State: _____ Zip: _____
School phone number: _____ School fax number: _____
Child ever been retained in school? ___ no ___ yes: what grade:_____ how many times: _____
Child ever skipped a grade in school? ___ no ___ yes: what grade: _____
Child ever been expelled? ___ no ___ yes Suspended: ___ no ___ yes
Special Education Services? __ no __ yes-for what: _____
Has your child had a school evaluation for special education? __ no __ yes-date of last evaluation: _____
Individual Education Plan (IEP) in place? __ no __ yes-since when?_____ Renewal date: _____
Classroom accommodations under 504 Plan in place? __ no __ yes: Since when?: _____
Typical grades now:_____ in the past: _____
Any concerns about progress academically? __ no __ yes-explain: _____
_____
Any concerns about relationships with teachers? __ no __ yes, explain: _____
_____

Has your child missed school in the past year?(please circle)
1-10 days 11-25 days 26-50days 50+ days

Spiritual Orientation

Please list your family's spiritual orientation or religion:_____

How active are these beliefs in your life?
Very active **Somewhat active** **Not very active**

Additional comments or concerns:
_____
_____

Share some of your thoughts on your spiritual practice/religion (i.e. what are your beliefs, how have these beliefs impacted your child's health and well being).