0 8 5 2

Date _____/_____/_____

PATIENT INFORMATION

Child's Name _____

DOB _____

Birthplace _____

Primary Language _____

PERSON COMPLETING THE FORM

Name _____

Relationship to Child _____

REFERRAL INFORMATION

Who referred you to our service? _____

Why are you seeking services for your child? _____

_____

Are you concerned about any of the following (please check all that apply)?

☐ Academic Performance	☐ Depressed Mood	☐ Impulsivity	☐ Sleep Habits
☐ Adjustment to Illness	☐ Developmental Delays	☐ Low Self-Esteem	☐ Social Skills
☐ Aggressive Behaviors	☐ Hyperactivity	☐ Non-Compliance	☐ Self-Harm/Suicidality
☐ Attention Problems	☐ Drug Use	☐ Panic Attacks	☐ Tantrums
☐ Anxiety	☐ Eating Habits	☐ Peer Relationships	☐ Trauma/Abuse
☐ Bed Wetting	☐ Family Functioning	☐ Risky Behaviors	☐ Withdrawal

FAMILY INFORMATION

Marital Status: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced (child's age _____)

Custody: ☐ Joint ☐ Mother ☐ Father ☐ Foster Parent ☐ Grandparent ☐ Other _____

Mother's Name _____

Phone _____

Alt Phone _____

Email _____

Occupation _____

Primary Language _____

Father's Name _____

Phone _____

Alt Phone _____

Email _____

Occupation _____

Primary Language _____

If applicable:

Stepmother's Name _____

Stepmother's Phone _____

Stepfather's Name _____

Stepfather's Phone _____

Please list all the brothers and sisters, and any other children living with the family

Age	Sex	Relationship to Child	Living in the home?
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes

PROHIBITED ABBREVIATIONS - PLEASE WRITE COMPLETE WORD(S)	Abbreviations to avoid:
U - u - IU	microgram symbol µg
Q.D. - QD - q.d. - qd - Q.O.D. - QOD - q.o.d - qod	Greater than or Less than > or <
MS - MSO_4 $MgSO_4$	subcutaneous sc
5.0 mg (trailing zero) - .5mg (lack of leading zero)	

PSYCHOLOGY/PSYCHIATRY PATIENT INFORMATION

0 8 5 2

Date _____/_____/_____

FAMILY HISTORY

Have any family members had any of the following?

☐ Allergies
☐ Alzheimer's Disease
☐ Birth Defect
☐ Behavior disorder
☐ Blood Disorder
☐ Cancer
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Developmental Delay
☐ Diabetes
☐ Alcohol/Drug Use
☐ Genetic Disorder
☐ Heart Disease
☐ Learning Disability
☐ Muscular Dystrophy
☐ Neurological Disorder
☐ Physical Handicap
☐ Psychiatric Illness
☐ Stroke
☐ Tuberculosis
☐ Other _____

BIRTH AND DEVELOPMENTAL HISTORY

Length of Pregnancy _____ weeks Birth Weight _____ lb _____ oz
Complications at Birth ☐ Forceps Used ☐ Breeched ☐ Labor Induced ☐ Cesarean Delivery
☐ Other Complications _____

At what age did your child first do the following? Please indicate year/month of age.

_____ Walk Alone
_____ Speak First Words
_____ Speak in Sentences
_____ Toilet Trained

Is there a history of bedwetting or constipation? ☐ No ☐ Yes
Has your child received? ☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ None
If yes, when? _____ If yes, for how long? _____

EDUCATION

Name of School _____ Grade _____
School Phone _____
Has your child ever been retained? ☐ No ☐ Yes If yes, what grade? _____
Has your child ever qualified for:
☐ Emotional disability ☐ Gifted placement ☐ Learning Disability ☐ Self-contained classroom ☐ 504 Plan

MEDICAL HISTORY

Name of Pediatrician _____ Phone _____
Previous Hospitalizations _____
Previous Surgeries _____
Allergies _____
Current Medical Diagnoses and Problems _____
Other Treating Physicians: _____
Current Medications:

Name	Dose	Frequency

PSYCHOLOGY/PSYCHIATRY
PATIENT INFORMATION

0 8 5 2

Date _____/_____/_____

MENTAL HEALTH HISTORY

Has your child ever had a psychological or psychiatric evaluation? ☐ No ☐ Yes

Reasons for the evaluation and diagnosis and recommendations made _____

_____

Has your child ever participated in psychological counseling or therapy? ☐ No ☐ Yes

Reasons for therapy _____

_____

Duration of therapy _____

Name of psychologist/therapist _____

Has your child ever been prescribed psychotropic medication? ☐ No ☐ Yes

Name and dose of medication _____

Name of prescribing physician _____

Has your child ever made any suicidal attempts or gestures? ☐ No ☐ Yes _____

_____

Has your child ever been admitted to an inpatient crisis psychiatric unit? ☐ No ☐ Yes

Reason for admission _____

Duration of stay _____

Is there any history of involvement from the Department of Children and Families (DCF)? ☐ No ☐ Yes

Reasons for DCF involvement _____

_____

Is there a history of ☐ Physical Abuse ☐ Sexual Abuse ☐ Neglect

Is there any history of involvement from legal authorities? ☐ No ☐ Yes

Reasons for legal involvement _____

_____

Has your child ever engaged in ☐ Cruelty to Animals ☐ Fire Setting ☐ Theft ☐ Vandalism ☐ Truancy ☐ None

Physician's Name:_____ Signature:_____ Date:_____ Time:_____

PSYCHOLOGY/PSYCHIATRY
PATIENT INFORMATION