

**PATIENT REGISTRATION AND HISTORY: CHILD**

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Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

Are the requested services for: (please indicate request): ☐ Medical ☐ Litigation ☐ Due Process

Child's Name: (first) \_\_\_\_\_ (last) \_\_\_\_\_ (middle) \_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: ☐ M ☐ F ☐ Non-binary

Address: \_\_\_\_\_  
(Street) (City) (Zip)

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status (parents): \_\_\_\_\_ Ethnicity/Race: \_\_\_\_\_

Language(s) spoken: \_\_\_\_\_

School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_

Hand used for writing: ☐ Left or ☐ Right Glasses or hearing aids: \_\_\_\_\_

Medical/psychological diagnosis, physician, and date (if any): \_\_\_\_\_

Briefly describe the issues or symptoms and when they began: \_\_\_\_\_

What specific questions would you like answered? \_\_\_\_\_

Primary:

Health Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Secondary:

Health Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Responsible party for payment of services: \_\_\_\_\_

This form was completed by: Parents: ☐ Y or ☐ N Other: \_\_\_\_\_

If not completed by the parent, please provide the following information:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

## Family History

The following questions deal with the child's BIOLOGICAL family members:

### Mother

What is the mother's name (including maiden name): \_\_\_\_\_

Is she alive? ☐ Yes ☐ No If not, list cause of death: \_\_\_\_\_

Mother's occupation: \_\_\_\_\_

Mother's level of education obtained: \_\_\_\_\_

Mother's hobbies: \_\_\_\_\_

Does the mother have a known/suspected learning disability? ☐ Yes ☐ No

Briefly describe the mother's health history: \_\_\_\_\_

\_\_\_\_\_

### Father

What is the father's name: \_\_\_\_\_

Is he alive? ☐ Yes ☐ No If not, list cause of death: \_\_\_\_\_

Father's occupation: \_\_\_\_\_

Father's level of education obtained: \_\_\_\_\_

Father's hobbies: \_\_\_\_\_

Does the father have a known/suspected learning disability? ☐ Yes ☐ No

Briefly describe the father's health history: \_\_\_\_\_

\_\_\_\_\_

Please check which one: ☐ Step-parent ☐ Adopted parent ☐ Foster parent

Name: \_\_\_\_\_

Are they alive? ☐ Yes ☐ No If not, list cause of death: \_\_\_\_\_

Occupation: \_\_\_\_\_

Highest level of education obtained: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Do they have a known/suspected learning disability? ☐ Yes ☐ No

Briefly describe health history: \_\_\_\_\_

\_\_\_\_\_

When the child was born, what was the mother's age? \_\_\_\_ Father's age? \_\_\_\_

How many brothers are there? \_\_\_\_ How many sisters are there? \_\_\_\_

Where is child in the birth order? \_\_\_\_\_

Are there unusual issues associated with any of the siblings? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_

## Family Life

Was the child adopted or fostered (circle one)? ☐ Yes ☐ No At what age? \_\_\_\_

## Early History

Was child born: ☐ On time ☐ Late ☐ Prematurely (# of weeks \_\_\_\_ )

Weight at birth: \_\_\_\_ lbs \_\_\_\_ ozs Mother's weight gain during pregnancy: \_\_\_\_ lbs

Where was child born: \_\_\_\_\_

Was mother induced with Pitocin? ☐ Yes ☐ No

Was birth by Cesarean? ☐ Yes ☐ No ☐ Planned ☐ Emergency

*Check all that applied to the mother while she was pregnant:*

- ☐ Accident ☐ Alcohol use ☐ Gestational Diabetes ☐ Poor nutrition  
☐ Cigarette smoking ☐ Drug use ☐ Psychological problems ☐ Illness

Other issues: \_\_\_\_\_

List all the medications (prescription or over the counter) the mother took while pregnant:

During her pregnancy, did the mother live near a polluted area (toxic waste dump) or hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)? ☐ Yes ☐ No

If yes, describe: \_\_\_\_\_

Were there any issues associated with child's birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period immediately following the birth (e.g. need for oxygen, special equipment used, convulsions, illness, etc.)? ☐ Yes ☐ No

Describe: \_\_\_\_\_

Age child began:

Walking: \_\_\_\_\_

Language: \_\_\_\_\_

Toilet Training: \_\_\_\_\_

Overall development: \_\_\_ delayed \_\_\_ average \_\_\_ advanced

### Medical History of Child

Any major medical conditions: \_\_\_\_\_

Does the child have epilepsy or a seizure disorder? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_

Describe all hospitalizations (Include purpose, length of stay, and location):

Do or have any of the following conditions exist? (Check all that apply)

- ☐ Attention problems ☐ Head injury ☐ Speech delay ☐ Hearing problems  
☐ Hyperactivity ☐ Clumsiness ☐ Vision problems ☐ Frequent ear infections  
☐ Learning delay ☐ Development delay ☐ Muscle tightness or weakness

Other issues: \_\_\_\_\_

Known allergies: \_\_\_\_\_

List any medications the child currently takes (prescription or over the counter):

| Medication | Dosage | Frequency Taken | Date began Taking | Prescribed by | Prescribed for |
|------------|--------|-----------------|-------------------|---------------|----------------|
|            |        |                 |                   |               |                |
|            |        |                 |                   |               |                |
|            |        |                 |                   |               |                |
|            |        |                 |                   |               |                |

## Medical Information

Primary care physician information:

Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Up to date with immunizations and examinations: ☐ Yes ☐ No

Is there a treating psychologist/psychiatrist?

Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Start date of therapy: \_\_\_\_\_ Frequency of therapy: \_\_\_\_\_

Reason for therapy: \_\_\_\_\_

Has the child had a previous psychological/neuropsychological evaluation?

If yes, please list the name and address of the psychologist and date administered:

\_\_\_\_\_  
\* Please provide a copy of the report at your intake appointment

## Medical Testing

Check all the medical tests completed recently (within the past year) and report any abnormal findings:

☐ Angiography ☐ Blood work ☐ CT scan ☐ EEG ☐ MRI/fMRI ☐ PET/SPECT

Other test(s) \_\_\_\_\_

Please check all that existed in close biological family members (parents, siblings, grandparents, aunts, uncles, etc.).

Note who it was and describe the issue where indicated:

☐ Epilepsy or seizures \_\_\_\_\_

☐ Learning disabilities \_\_\_\_\_

☐ Mental retardation \_\_\_\_\_

☐ Speech or language disorder(s) \_\_\_\_\_

## Neurological or Psychiatric Disorders

☐ Bipolar disorder \_\_\_\_\_

☐ Depression \_\_\_\_\_

☐ Personality disorder \_\_\_\_\_

☐ Other psychiatric disorders \_\_\_\_\_

At any time, was the child exposed to toxic, hazardous, noxious or other dangerous or unusual substances? (ex. lead, mercury, radiation, solvents, pesticides, chemicals, etc.)? ☐ Yes ☐ No If yes, list: \_\_\_\_\_

## Substance Use History of Child

### Drugs

Please check all drugs currently using or have used in the past:

|                                                     | <i>Presently using</i> | <i>Used in the past</i> |
|-----------------------------------------------------|------------------------|-------------------------|
| <input type="checkbox"/> Amphetamines               | _____                  | _____                   |
| <input type="checkbox"/> Barbiturates               | _____                  | _____                   |
| <input type="checkbox"/> Cocaine or crack           | _____                  | _____                   |
| <input type="checkbox"/> Hallucinogens              | _____                  | _____                   |
| <input type="checkbox"/> Marijuana                  | _____                  | _____                   |
| <input type="checkbox"/> Opiates/Narcotics (Heroin) | _____                  | _____                   |
| <input type="checkbox"/> PCP                        | _____                  | _____                   |

List any other drugs, including designer and “non-harmful” of “non-addictive” drugs:

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Do you consider the child dependent on any of the above drug(s)? ☐ Yes ☐ No

Do you think the child is dependent on any prescription drug(s)? ☐ Yes ☐ No

Check all that apply:

☐ Has the child been through drug withdrawal? ☐ Used IV drugs? ☐ Drug treatment?

## **Personal History**

### Education

Describe the child’s performance as a student: ☐ A & B’s ☐ B & C’s ☐ C & D’s ☐ D & F’s

Please provide any additional/helpful comments about academic performance: \_\_\_\_\_

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Best subject in school: \_\_\_\_\_ Weakest: \_\_\_\_\_

Has the child been held back a grade? ☐ Yes ☐ No If yes, which grade: \_\_\_\_\_

Is the child in special classes/received special education services? ☐ Yes ☐ No

Does the child have a current IEP? ☐ Yes ☐ No

*\*If yes, please bring a copy of current IEP to intake meeting.*

### Recreation

Briefly list the types of recreation the child enjoys: \_\_\_\_\_

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### Child’s Occupational History

Current job title: \_\_\_\_\_ How long at job? \_\_\_\_\_

Current job responsibilities: \_\_\_\_\_

Prior jobs and time spent at them: \_\_\_\_\_

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## SYMPTOM SURVEY

Please place a check on the line next to each applicable symptom. Check the side marked "NEW" if the symptom has been present for 6 months or less. Check the side marked "OLD" if the symptom has been present for more than 6 months.

### Problem Solving

- |                                                                                               |                                                                   |
|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Difficulty figuring out how to do new things                         | <input type="checkbox"/> Difficulty figuring out how to do things |
| <input type="checkbox"/> Difficulty planning ahead                                            | <input type="checkbox"/> Difficulty thinking as quickly as needed |
| <input type="checkbox"/> Difficulty doing things in the right order                           | <input type="checkbox"/> Changing a plan or activity              |
| <input type="checkbox"/> Figuring out problems most other people can do                       | <input type="checkbox"/> Difficulty doing more than one thing     |
| <input type="checkbox"/> Difficulty verbally describing the steps involved in doing something |                                                                   |
| <input type="checkbox"/> Difficulty completing an activity in a reasonable amount of time     |                                                                   |
| <input type="checkbox"/> Difficulty switching from one activity to another activity           |                                                                   |
| <input type="checkbox"/> Easily frustrated                                                    |                                                                   |

Other problem solving difficulties: \_\_\_\_\_

### Speech, Language and Math Skills

- |                                                                                          |                                                           |
|------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Difficulty finding the right words to say                       | <input type="checkbox"/> Odd or unusual speech sound      |
| <input type="checkbox"/> Difficulty understanding what others are saying                 | <input type="checkbox"/> Difficulty with math             |
| <input type="checkbox"/> Unable to speak                                                 | <input type="checkbox"/> Difficulty staying with one idea |
| <input type="checkbox"/> Slurred speech                                                  | <input type="checkbox"/> Difficulty spelling              |
| <input type="checkbox"/> Difficulty understanding what was read                          |                                                           |
| <input type="checkbox"/> Difficulty writing letters or words (not due to motor problems) |                                                           |

Other speech, language, or math problems: \_\_\_\_\_

### Nonverbal Skills

- |                                                                                                                                    |                                                       |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Difficulty telling right from left                                                                        | <input type="checkbox"/> Problems drawing or copying  |
| <input type="checkbox"/> Difficulty recognizing objects or people                                                                  | <input type="checkbox"/> Decline in musical abilities |
| <input type="checkbox"/> Slow reaction time                                                                                        | <input type="checkbox"/> Difficulty dressing          |
| <input type="checkbox"/> Difficulty doing things the child should automatically be able to do (e.g. brushing teeth, etc.)          |                                                       |
| <input type="checkbox"/> Problems finding way around places the child has been to before                                           |                                                       |
| <input type="checkbox"/> Unaware of things on one side of the body ( <input type="checkbox"/> right <input type="checkbox"/> left) |                                                       |

Other nonverbal issues: \_\_\_\_\_

### Concentration and Awareness

- |                                                                     |                                                                 |
|---------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Highly distractible                        | <input type="checkbox"/> Loses train of thought easily          |
| <input type="checkbox"/> Problems concentrating                     | <input type="checkbox"/> Becomes easily confused or disoriented |
| <input type="checkbox"/> Blackout spells (fainting)                 | <input type="checkbox"/> Mind goes blank                        |
| <input type="checkbox"/> Doesn't feel very alert or aware of things |                                                                 |

Other concentration or awareness issues: \_\_\_\_\_

### Memory

- |                                                                           |                                                                |
|---------------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Forgetting where things are left (books, etc.)   | <input type="checkbox"/> Forgetting names                      |
| <input type="checkbox"/> Forgetting what they should be doing             | <input type="checkbox"/> Forgetting where they are             |
| <input type="checkbox"/> Forgetting recent events (such as the last meal) | <input type="checkbox"/> Forgetting past events (months/years) |
| <input type="checkbox"/> Need hints to remember things                    | <input type="checkbox"/> Forgetting the order of things        |
| <input type="checkbox"/> Forgetting facts                                 | <input type="checkbox"/> Forgetting how to do things           |

Other memory issues: \_\_\_\_\_

### Motor Coordination

- |                                                                    |                                                                |
|--------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Fine motor control problems               | <input type="checkbox"/> Weakness on one side of body          |
| <input type="checkbox"/> Difficulty walking or bumping into things | <input type="checkbox"/> Tremor or weakness                    |
| <input type="checkbox"/> Muscle tics or strange movements          | <input type="checkbox"/> Writing is very small                 |
| <input type="checkbox"/> Writing is very large                     | <input type="checkbox"/> Walking more slowly than other people |
| <input type="checkbox"/> Feeling stiff                             | <input type="checkbox"/> Balance problems                      |
| <input type="checkbox"/> Difficulty starting to move               | <input type="checkbox"/> Muscles tire quickly                  |

Other motor or coordination issues: \_\_\_\_\_

## Sensory

- |                                                                                       |                                                          |
|---------------------------------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Loss of feeling or numbness                                  | <input type="checkbox"/> Double vision                   |
| <input type="checkbox"/> Tingling or strange skin sensations                          | <input type="checkbox"/> See "stars" or flashes of light |
| <input type="checkbox"/> Difficulty telling hot from cold                             | <input type="checkbox"/> Losing hearing                  |
| <input type="checkbox"/> Problems seeing on one side                                  | <input type="checkbox"/> Difficulty tasting food         |
| <input type="checkbox"/> Blurred vision                                               | <input type="checkbox"/> Difficulty smelling             |
| <input type="checkbox"/> Blank spots in vision                                        | <input type="checkbox"/> Smelling strange odors          |
| <input type="checkbox"/> Need to squint or move closer to see clearly                 | <input type="checkbox"/> Brief periods of blindness      |
| <input type="checkbox"/> Difficulty looking quickly from one object to another object |                                                          |
| <input type="checkbox"/> Ringing in my ears or hearing strange sounds                 |                                                          |

Other sensory issues: \_\_\_\_\_

## Physical

- |                                             |                                                |
|---------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Loss of bowel control |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Excessive tiredness   |
| <input type="checkbox"/> Nausea or vomiting |                                                |

Other physical issues: \_\_\_\_\_

## Behavior

Check all that apply to your child in the past 6 months:

- ☐ Sadness or depression
- ☐ Anxiety or nervousness
- ☐ Sleeping problem (Falling asleep: ☐ Staying asleep: ☐)
- ☐ Become angry more easily
- ☐ Euphoria (feeling on top of the world)
- ☐ Much more emotional (cry more easily)
- ☐ Feel as if I just don't care anymore
- ☐ Doing things automatically (without awareness)
- ☐ Less inhibited (do things I would not do before)
- ☐ Difficulty being spontaneous
- ☐ Change in eating habits

Other recent changes in behavior/personality: \_\_\_\_\_

*Check the answer that best fits:*

- |                                       |                                          |                                   |
|---------------------------------------|------------------------------------------|-----------------------------------|
| Overall, symptoms have developed:     | <input type="checkbox"/> Slowly          | <input type="checkbox"/> Quickly  |
| Symptoms occur:                       | <input type="checkbox"/> Occasionally    | <input type="checkbox"/> Often    |
| Over the past 6 months symptoms have: | <input type="checkbox"/> Stayed the same | <input type="checkbox"/> Worsened |