

PATIENT REGISTRATION AND HISTORY: CHILD

Date: _____

Referred by: _____

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

Child's Name: (first) _____ (last) _____

DOB: _____ Gender: ☐ M ☐ F ☐ Non-binary

Parent(s) Name(s): _____

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>
☐ Amphetamines	_____	_____
☐ Barbiturates	_____	_____
☐ Cocaine or crack	_____	_____
☐ Hallucinogens	_____	_____
☐ Marijuana	_____	_____
☐ Opiates/Narcotics (Heroin)	_____	_____

☐ PCP

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

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: _____

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: _____

Child’s Occupational History

Current job title: _____ How long at job? _____

Current job responsibilities: _____

Prior jobs and time spent at them: _____

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

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

Other problem solving difficulties: _____

Speech, Language and Math Skills

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

Other speech, language, or math problems: _____

Nonverbal Skills

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

Other nonverbal issues: _____

Concentration and Awareness

- | | |
|---|---|
| ☐ Highly distractible | ☐ Loses train of thought easily |
| ☐ Problems concentrating | ☐ Becomes easily confused or disoriented |
| ☐ Blackout spells (fainting) | ☐ Mind goes blank |
| ☐ Doesn't feel very alert or aware of things | |

Other concentration or awareness issues: _____

Memory

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

Other memory issues: _____

Motor Coordination

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

Other motor or coordination issues: _____

Sensory

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

Other sensory issues: _____

Physical

- | | |
|---|--|
| ☐ Headaches | ☐ Loss of bowel control |
| ☐ Dizziness | ☐ Excessive tiredness |
| ☐ 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: | ☐ Slowly | ☐ Quickly |
| Symptoms occur: | ☐ Occasionally | ☐ Often |
| Over the past 6 months symptoms have: | ☐ Stayed the same | ☐ Worsened |