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CHILD INFORMATION FORM

REFERRED BY:____

NAME OF CHILD:______________________DOB:_______________SEX:___________________

ADDRESS:____

CITY:______________________________STATE:_______________ZIP CODE:_______________

HOME NUMBER:____________________

SCHOOL AND CURRENT GRADE:____

PEDIATRICIAN:____

MOTHER'S NAME:___________________AGE:________________

ADDRESS:____

HOME NUMBER:____________________CELL:___________________WORK:_______________

OCCUPATION:____

FATHER'S NAME:___________________AGE:_________________

ADDRESS:____

HOME NUMBER:___________________CELL:__________________WORK:_________________

OCCUPATION:____

PARENTS MARITAL STATUS:____

Please list the names, ages, and dates-of-birth of the patient's siblings:____________________

____

____

____

CREDIT CARD TO BE USED FOR PAYMENTS: MC VISA AMEX CHECK

#:____

EXPIRATION DATE:____________________SECURITY CODE:___________________

REASON FOR REFERRAL:

Primary concern:

Other concerns:

PRENATAL HISTORY:

Were there any complications during pregnancy and/or delivery?

How old were you when your child was born?

Were any of the following taken during pregnancy: Beer, wine, or alcohol; coffee/caffeine; prescription medications; herbal products?

Were there complications related to your child's delivery?

Child's birth weight? Apgar score?

Were there any health complications following birth?

INFANCY:

Were there any feeding, sleeping, responsiveness (alertness), or health problems during infancy?

How active was your child as an infant?

DEVELOPMENTAL MILESTONES:

Please complete the following:

Age he/she sat up?_______Age he/she crawl?_________Age he/she walked?________

Age he/she spoke single works other than mama/dada?___________Age he/she strung two or more words together?_________Age he/she toilet trained?_______

MEDICAL HISTORY:

Please check and describe any problems with the following:

Hearing_____________Vision_____________Gross motor coordination________________

Fine motor coordination_________________Speech, articulation, language processing________________

Has your child had any chronic health problems?

Has your child had any of the following: Head injury, convulsions, coma, persistent high fevers?

Is there any history of physical, sexual, or emotional abuse?

Does your child have difficulty sleeping at night?

Does your child have any difficulties with eating or with his/her appetite?

EDUCATIONAL AND LEARNING CONCERNS:

How is your child performing at school currently with regard to reading, math, and other academic skills?

At what grade level is your child functioning in reading and math?

Any difficulty completing assignments in school or at home?

Has your child ever had to repeat a grade?

Is he/she receiving any educational support services either in or outside of school?

Has your child's teachers expressed concerns about him/her?

Please briefly describe your child's experiences in:

Preschool:

Grade School:

Middle School:

High School:

PEER RELATIONSHIPS:

How does your child get along with his/her siblings?

Does your child seek friendships with peers?

Do peers seek friendships with your child?

Briefly describe any concerns regarding peer-related problems.

PSYCHIATRIC HISTORY:

Has your child ever shown difficulties in any of the following areas: mood (depression, elation, manic symptoms), anxiety, phobias, impulsivity, hyperactivity, aggression, judgment?

Has your child ever been evaluated by a mental health professional? Please describe below.

Has medication ever been prescribed for psychiatric, behavioral, attentional, or learning purposes?

Is there any family history of psychiatric, neurological, and/or learning disabilities in your extended family?

OTHER CONCERNS/ISSUES:

Please describe below: