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PATIENT REGISTRATION AND HISTORY: *CHILD*

Date: _____ Referred by: _____

Are the requested services for: (please indicate request):

	Medical
	Litigation
	Due Process

Child's Name: _____ Parent(s) Name(s): _____

DOB: _____ Gender: □ M or □ F

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 problems 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: _____

SSN: _____

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: _____

Rate your child's development progress:

Walking: _____

Language: _____

Toilet Training: _____

Overall development: _____

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 problems: _____

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 on a job, 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

Alcohol

Has the child used alcohol? □ Yes □ No

Drugs

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

	Presently using	*Used in the past*
□ 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 in the box for each applicable symptom.

Problem Solving

- □ Difficulty figuring out how to do new things
- □ Difficulty planning ahead
- □ Difficulty doing things in the right order
- □ Figuring out problems most other people can do
- □ 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
- □ Difficulty figuring out how to do things
- □ Difficulty thinking as quickly as needed
- □ Changing a plan or activity
- □ Difficulty doing more than one thing

Other problem solving difficulties: _____

Speech, Language and Math Skills

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

Other speech, language, or math problems: _____

Nonverbal Skills

- □ Difficulty telling right from left
- □ Difficulty recognizing objects or people
- □ Slow reaction time
- □ 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)
- □ Problems drawing or copying
- □ Decline in musical abilities
- □ Difficulty dressing

Other nonverbal issues: _____

Concentration and Awareness

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

Other concentration or awareness issues: _____

Memory

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

Other memory issues: _____

Motor Coordination

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

Other motor or coordination issues: _____

Sensory

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

Other sensory issues: _____

Physical

- □ Headaches
- □ Dizziness
- □ Nausea or vomiting
- □ Loss of bowel control
- □ Excessive tiredness

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