

Patient Information Sheet– Children (to be completed by parent)¹

NAME OF CHILD _____ **Date of Birth** _____

NAME OF PARENT’S OR LEGAL GUARDIANS _____

LEGAL STATUS OF PARENTS

NEVER MARRIED MARRIED SEPARATED DIVORCED

COURT ORDER OF CUSTODY

NO YES, SOLE LEGAL CUSTODY YES, JOINT LEGAL CUSTODY

IF Joint legal custody, has the consent of all parties or a court order been obtained?

YES NO²

ADDRESS OF PATIENT _____

Home Phone: (_____) _____ **May we leave a msg?** **YES** **NO**

Cell/Other phone: (_____) _____ **May we leave a msg?** **YES** **NO**

Emergency Contact: NAME _____ **Phone** _____

List the people currently living in primary or secondary residence

Name	Age	Relationship to You	Occupation

¹ The bold print represents questions that fulfill topics required by NCQA or another insurer.

² “Yes” must be answered for all children under the age of 14.

Who Referred The Patient? _____

Briefly describe your goals for your child’s therapy:

Mental Health Background

List any psychotropic medications (medications for nerves) that your child is taking.

Medication	Dose/Frequency	When Started	For What Symptom(s)?

List any previous mental health or substance abuse treatment (include any inpatient or hospital treatment for a mental health or substance abuse disorder) that your child has had.

Date of Treatment (approximate)	Name of Treatment Provider or Agency	What Was Your Problem at the Time?	Were Your Treatment Goals Met?

Was anything in the previous treatment particularly helpful? Not helpful? _____

At this time does your child ever have thoughts of self-harm? YES _____ NO _____

Have your child ever attempted suicide? YES _____ NO _____

At this time does your child ever think of harming others? YES _____ NO _____

Developmental History³

Prenatal/perinatal

Did the mother experience any potentially serious health problems during pregnancy such as high blood pressure, toxemia, RH incompatibility, measles, etc?

YES

NO

If so, what were they?

Was your child born prematurely?

YES

NO

If yes, how many weeks premature? _____

What was the baby's weight at birth? _____ pounds _____ ounces

Did your child experience any difficulties at birth such as breathing problems, oxygen deprivation, use of incubator, etc.

YES

NO

³ For children and adolescents, prenatal and perinatal events must be documented. The developmental history must cover physical, psychological, social, intellectual, and academic topics. Psychologists may add or delete questions to this section on developmental history as they believe is clinically indicated. Of course the psychologist can expand upon any of these topics in the clinical interview.

If yes, what were the problems?

Was your child substantially late in learning to

sit up _____ crawl _____ walk _____ talk _____

other developmental steps? _____

Education

Education (please circle highest grade in school)

K 1 2 3 4 5 6 7 8 9 10 11 12

Current School _____

Would you describe your child as a:

good student	average student	poor student
likes school	okay with school	dislikes school
very well-behaved in school	well-behaved in school	behaves poorly in school

Other Questions

Describe your child's religious or spiritual orientation? _____

If you have a religion, how often does your child attend religious services? (Circle one)

At least weekly monthly several times a year once a year or less

Which of the following statements best describe your child (check all that apply)

- Has a lot of friends to confide in or count on
- Has close family members to confide in or count on
- Has a few close friends to confide in or count on
- Has a few close family members to confide in or count on
- Has a lot of friends, but can't confide in them or count on them
- Has few friends and none to confide in or count on

Would you say that your child is lonely?

- frequently occasionally sometimes rarely

Does your family have a history of mental illness or substance abuse? If so, please explain the nature of the problem, treatment they received and indicate if any particular medication was helpful.

Legal History

Has your child ever been arrested or involved in litigation?

YES NO

If yes, please explain. _____

Medical Information

Name of primary care physician or provider _____

Do I have your permission to send basic information (presenting problem, summary of treatment, relevant health information, etc.) to your child's pediatrician or primary care provider?

YES _____ **NO** _____

If yes, you will need to sign a specific "authorization" or "release of information form" in order for me to contact your primary care provider.

How would you describe your child's current physical health?

___ excellent ___ good ___ average ___ poor ___ very poor

List any medical conditions that your child has.

Medical condition or symptoms	Treatment (s)

List any prescription medications that your child takes.

Drug	Dose/Frequency	When Started	For What Symptom(s)?

List any non prescription (over-the-counter) medications that your child takes?

Drug	Dose/Frequency	When Started	For What Symptom(s)?

Does your child have any allergies or sensitivities to drugs, foods, or other substances?

YES _____ NO _____

If yes, please indicate the substances that your child is allergic to or has sensitivities to:

Do your child smoke or use other tobacco products, drink alcohol, or use recreational drugs (such as marijuana, cocaine, or other drugs)?

YES _____ NO _____

If yes, please give more details such as nature of use and frequency.

Is there any other information that would be useful to know about your child?
