Child /Adolescent New Patient Form

Child's Name First Middle Last

Date of Birth _____ Referred by_____

Today's Date_____ Age _____ Child's SSN_____

Sex: Male Female Grade _____School_____

Mother's name: _____DOB: _____Home phone: _____

Address:_____

City, State, Zip Code:_____ Email: _____

Currently employed: ❑ No ❑ Yes, as: _____ Cell:_____

Father's name: _____ DOB: _____Home phone:_____

Address, if different from mother's:_____

City, State, Zip Code:_____ Email: _____

Currently employed: ❑No ❑Yes, as: _____ Cell:_____

Parents are presently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other_____

Child's custodian/guardian: _____

If applicable, Stepparent's name: _____ Phone:_____

Family's Ethnicity/Race:_____ Religion: _____

Insurance Company Name:_____

Plan ID: _____ Group ID: _____

Policy Holder's Name: _____ Employer Name: _____

Please list siblings and any other individuals living in the house

Name	Age	Relationship to Patient

Please list your child's strengths and what you enjoy most about your child.

_____

_____

_____

Please fill in any information you have on the developmental areas listed below.
Prenatal medical illnesses and health care:_____

_____

_____

Was your child premature? ❑ No ❑ Yes Weight at birth: _____ pounds

Any birth complications or problems?_____

_____

_____

Was there a history of postpartum depression, maternal or paternal depression during your child's early development? **Y or N** If yes, please elaborate.

_____

_____

Were there any difficulties with your child's attachment to either his/her mother or father? **Y or N** If yes, please elaborate. _____

_____

Please describe your child's sleep patterns or problems during his/her first few months of life:

_____

_____

Please describe your child's personality in his/her first few months of life:

_____

_____

Milestones: Approximately at what age did your child do each of the following?

Sat without support: _____ Crawled:_____

Walked: _____ Stayed dry all day: _____

Did not soil his/her pants: _____ Stayed dry all night:_____

Age when child said first word:_____ Age when child said first sentence:_____

Any speech, hearing, or language difficulties? **Y or N** If yes, please elaborate.

_____

_____

Please list any residential or out of home placements.

_____

_____

_____

Please list any educational concerns, learning disabilities, or educational strengths.

_____

_____

_____

Please list any special skills or talents your child has, including hobbies, recreational activities.

_____

_____

_____

List your child's major physical illness, hospitalizations, accidents and age of occurrence.

_____

_____

_____

Previous therapy experience, including name of prior provider and year of treatment:

_____

_____

_____

Has your child had past psychiatric hospitalizations? **Y or N** If yes, list where & reason for hospitalization._____

_____

_____

_____

Family history of mental illness and psychiatric hospitalizations:

_____

_____

_____

_____

Please list your child's prescribed medications and dosage:

_____

_____

_____

Please list the name of your child's pediatrician, psychiatrist and neurologist, if applicable.

_____

_____

State your main reason for seeking treatment or testing for your child. How long has this issue persisted?

_____

_____

_____

_____

_____

Please check any past or present issues that apply to your child and family.

	Child	*Mother*	*Father*	*Sibling*	*Grandparent*
Alcohol /Drug Abuse					
Psychiatric Hospitalization					
Anxiety					
Depression					
Bipolar Disorder					
Psychosis					
Serious Physical Illness					
Weight/eating problems					
Anorexia/Bulimia					
Insomnia					
Attempted Suicide					
Epilepsy					
Physical Abuse					
Sexual Abuse					
Death					
Legal Problems					

APPOINTMENT REMINDER CONSENT

Appointment reminders can be sent via text, phone or email. Please note that voicemails, email and text messages are never fully secure or confidential. Thus, if you prefer to opt out of appointment reminders due to privacy concerns, or for any other reason, please leave this form blank.

MINOR PATIENT'S NAME:_____

Please check the method/s you prefer your appointment reminder:

❑ **Email** Preferred Email Address:_____

❑ **Text Message** Mobile Number: _____

❑ **Phone Call** Preferred Number for Reminder: _____

IN SIGNING THIS FORM YOU ARE AGREEING TO RECEIVE APPOINTMENT REMINDERS VIA EMAIL, PHONE OR TEXT FOR YOUR MINOR CHILD.

_____

Guardian Signature Date