

Person to be billed for fees

| | | |
|-------------------------------|--------------------|-------------|
| Name: | | |
| Relationship to Child: | | |
| Address: | | |
| City: | State: | Zip: |
| Home Phone: | Cell Phone: | |

Child's Health History

| |
|--|
| Pediatrician's Name: |
| Date of Last Appt: |
| Phone: |
| Address: |
| City: State: Zip: |
| Please list any serious illnesses, surgeries, and medical problems that your child has ever had: |
| |
| Has your child ever experienced a severe blow to the head or loss of consciousness? Yes No If yes, please explain: |
| |

Medication

| | | |
|--|---------------|---------------|
| Please list any medications (prescribed and over-the-counter) that your child is <i>currently</i> taking: | | |
| Medication Name | Dosage | Reason |
| | | |
| | | |
| | | |

Development

| | | | |
|--|------|------------------------|------|
| Describe at what age your child reached the following developmental milestones: | | | |
| Crawling | Age: | Talking | Age: |
| Walking | Age: | Toilet Training | Age: |

| |
|---|
| Additional information regarding your child's development: |
| |

| | | | |
|-------------------|---------------------------------------|--------------------------------------|---------------------------------------|
| Is your child...? | <input type="checkbox"/> Right Handed | <input type="checkbox"/> Left Handed | <input type="checkbox"/> Ambidextrous |
|-------------------|---------------------------------------|--------------------------------------|---------------------------------------|

Child's Psychological History

| | |
|---|--|
| Has your child ever seen a therapist? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dates: | |
| If yes, for what concerns, and what was helpful or not helpful about this treatment? | |
| Has your child ever seen a psychiatrist? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dates: | |
| If yes, for what concerns, and what was helpful or not helpful about this treatment? | |

Child's School Information

| | |
|--|--|
| Name of the school that your child is attending: | |
| Current Grade Level: | Average Performance: |
| Has your child ever been given an IEP (Independent Educational Plan) or any other type of Special learning service? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please explain: | |
| Has your child ever had disciplinary action at school or have concerns been expressed by teachers? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please explain: | |

Child's Social Information

| | |
|--|--|
| Is your child involved in extracurricular activities? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, what type and how often? | |

Is your child involved in athletics? Yes No
If yes, please describe:

Describe your child's social interactions, both in and out of school (Play dates, close friendships, school friends):

Describe your child's favorite toy, television program or activity:

How often does your child engage in this activity?

Current Concerns

Briefly explain why your child is seeking psychological services at this time:

List any major changes or life events that have occurred for your child in the last two years:

Is there any additional information that would be important to know about your child?

Guardian Information

Employment status:

Full-Time Part-Time Retired
 Student Unemployed Home maker

Occupation:

| | | | |
|---|--|---------------------------------------|----------------------------------|
| Spouse/Partner Employment status: | | | |
| <input type="checkbox"/> Full-Time | <input type="checkbox"/> Part-Time | Retired | |
| <input type="checkbox"/> Student | <input type="checkbox"/> Unemployed | Home maker | |
| Spouse/Partner Occupation: | | | |
| Active Duty Military: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Branch: | |
| | | Rank: | |
| Ethnicity (check all that apply): | | | |
| African-American | | Asian | |
| American/Alaskan Indian | | Caucasian | |
| Hawaiian/Pacific Islander | | Latino/a | |
| Other: | | | |
| Sexual Orientation: | | | |
| <input type="checkbox"/> Heterosexual | | <input type="checkbox"/> Lesbian/Gay | |
| <input type="checkbox"/> Bisexual | | <input type="checkbox"/> Uncertain | |
| <input type="checkbox"/> Other: | | | |
| Religion: | | | |
| <input type="checkbox"/> Catholic | <input type="checkbox"/> Protestant | <input type="checkbox"/> Jewish | <input type="checkbox"/> Islamic |
| <input type="checkbox"/> Buddhist | <input type="checkbox"/> Hindu | <input type="checkbox"/> Christian | Other: |
| Highest Level of Education Completed: | | | |
| <input type="checkbox"/> Some High School | <input type="checkbox"/> High School Diploma/GED | <input type="checkbox"/> Some College | |
| <input type="checkbox"/> Technical/Apprentice Cert. | AA Degree | BA/BS Degree | |
| MA/MS Degree | MD/JD/Doctoral Degree | | |

Emergency Contact

| |
|-------------------------------|
| Name: |
| Relationship to child: |
| Address: |
| Phone: |

Thank you for your time, and I look forward to meeting you soon!