JONATHAN D. ROBBINS, Psy.D.

7241 SW 63rd Avenue Street Suite 102A • South Miami, FL 33143

Phone 305-609-4251 • jonathanrobbinspsyd@hotmail.com

Date: _____ Patient Name: _____ Age: _____

Patient Date of Birth: _____ SS#: _____

Parent(s)/ Name(s): _____

Name of person(s) with legal custody of child: _____

Name of legal guardian(s) of child: _____

Client Address: _____

Phone for Appointment Reminders: _____ ☐ Okay to leave messages @ this number

Alternate Number: _____ ☐ Okay to leave messages @ this number

Is it okay if I leave a message at these numbers? ☐ Yes ☐ No

Emergency Contact's name & phone #: _____

Primary Physician: _____ Phone: _____

Parents' Marital Status: ☐ Married ☐ Divorced ☐ Separated

Information Father:

Date of Birth: _____ Occupation: _____ Place of Employment: _____

Father's Home Phone: _____ Work: _____Cell _____

Father's Business/Occupation:_____ Work: _____Cell _____

Number of Marriages: _____ Number of Divorces: _____ email: _____

Information Mother:

Date of Birth: _____ Occupation: _____ Place of Employment: _____

Mother's Home Phone: _____ Work: _____Cell _____

Mother's Business/Occupation:_____ Work: _____ Cell _____

Number of Marriages: _____ Number of Divorces: _____ email: _____

Living Arrangements:

Please list name of those currently living in the home with patient:

Name	Gender	Age/Grade	Birth Date	Occupation / School
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

Your assistance by providing the following background information about your child/family in advanced is greatly appreciated. This will help me to efficiently address your concerns. This portion of the form will be part of your confidential clinical file. I will review this information with you during the intake; however, if you have specific questions about completing this form, please ask me.

Please briefly describe why you are here today:

Your child's developmental history:

Pregnancy / Delivery:

Healthy Pregnancy? ☐ **Yes** ☐ **No** **Full-Term Delivery?** ☐ **Yes** ☐ **No**

Healthy at Birth? ☐ **Yes** ☐ **No** **Extended Hospital Stay required?** ☐ **Yes** ☐ **No**

Birth weight: _____ lbs. _____ oz.

Briefly describe any concerns/difficulties regarding the conception, pregnancy, labor or delivery of your child:

Please describe your child as an infant/toddler:

Healthy, happy baby? ☐ **Yes** ☐ **No** **Easy to soothe?** ☐ **Yes** ☐ **No**

Colicky? ☐ **Yes** ☐ **No** **Excessive tantrums?** ☐ **Yes** ☐ **No**

Toileting concerns? ☐ **Yes** ☐ **No** **Age completed:**

Developmental milestones met "on time?" ☐ **Yes** ☐ **No**

Age child began walking: _____ **Age began talking: _____**

History of ear infections? ☐ **Yes** ☐ **No** **History of seizures/convulsions?** ☐ **Yes** ☐ **No**

History of brain injury? ☐ **Yes** ☐ **No** **Problems with self-regulation/self-control?** ☐ **Yes** ☐ **No**

Problems with authority? ☐ **Yes** ☐ **No** **Problems with behavioral compliance?** ☐ **Yes** ☐ **No**

Additional Information (as needed):

Please provide information regarding your family health and emotional history by marking the appropriate column where those problems were present for a particular family member.

Problem Area	Child / Teen	Mom	Dad	Sibling	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative (specify)
Depression									
Anxiety									
Panic Attacks									
Obsessions/ Compulsions									
Manic Depression/ Bipolar Disorder									
Psychotic Disorder: Hallucinations/Delusions									
Alcoholism									
Drug Abuse									
Suicide Attempt									
Learning Problems: Reading, Math, Writing									
AD/HD (Attention Deficit/Hyperactivity Disorder)									
Autism/Asperger's Syndrome									
Physical, Emotional, or Sexual Abuse									
Eating Disorder									
Thyroid Disorder									
Migraine Headaches									
Serious /chronic health concerns or illness- Specify:									
Other:									

Family History:
City/State where child was born: _____

Child's relationship with family/siblings: ☐ Good ☐ Distant ☐ Poor ☐ Excessive arguing/fighting

Briefly describe as needed: _____

Parental Relationship:

Parents' Current Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Remarried ☐ Other

Divorce/Custody/Visitation Concerns: _____

Is there parental/marital conflict? ☐ Yes ☐ No Does the child witness arguing/fighting? ☐ Yes ☐ No

Is the child indirectly aware of arguing/fighting? ☐ Yes ☐ No (If yes, please specify) _____

Is there domestic violence in the home? ☐ Yes ☐ No

If yes: For how long? _____ How Recently? _____

Child's Mental Health Treatment History: (Include inpatient & outpatient) ☐ No prior treatment

Provider	Dates of treatment	Reason for Treatment	Problem/Concern Resolved?

Has your child ever attempted suicide or talked of wanting to harm/kill him/herself? ☐ Yes ☐ No

If yes, please specify and describe the current status: _____

Child's Medical History: ☐ In good health ☐ Medical/Health related concerns

Current physician(s): _____

Current or prior health problems: _____

Hospitalizations? ☐ Yes ☐ No If yes, relevant history? _____

Current Medication: ☐ Yes ☐ No

Medication	Dosage	Frequency	Purpose

Past Medication ☐ **N / A**

Medication	Dosage	Frequency	Purpose

Sleep: ☐ No Concerns ☐ Concerns (check all that apply):

☐ Trouble falling asleep ☐ Trouble staying awake ☐ Early waking ☐ Nightmares

☐ Unusual sleep behavior – Describe: _____

Weight/Eating/Appetite Concerns: ☐ No Concerns ☐ Concerns (check all that apply):

☐ Eating too much ☐ Not eating enough ☐ Concerned about a possible eating disorder

Academic History:

Current school: _____ Grade level: _____

Most recent academic grades: Are these grades typical for your child? ☐ Yes ☐ No

Has your child ever repeated a grade? ☐ Yes ☐ No If yes, which grade(s)?

Are you concerned about your child's academics? ☐ Yes ☐ No

Are you concerned about your child's behavior at school? ☐ Yes ☐ No

Does your child have an Individual Education Plan (IEP) or any accommodations at school? ☐ Yes ☐ No

Social History/Peer Relationships:

How do you best describe your child's current friendship network?

☐ Many good friends ☐ A few close friends ☐ Almost no friends ☐ Several friends, but poor quality

☐ Makes friends, but has difficulty keeping them

Briefly describe concerns as needed: _____

_____

Traumatic experiences: ☐ Yes ☐ No (If yes, specify): _____

☐ Physical abuse ☐ Verbal/Emotional Abuse ☐ Sexual Abuse ☐ Neglect ☐ A death/other significant loss

At what age? _____ Lasting how long? _____

Moves/Relocations (When and Where): _____

_____

Occupational/Educational Background:
Has your child ever held a job? ☐ Yes ☐ No ☐ Too young

Job/Occupational History: _____

_____

_____

Legal History:
Has your child ever been in trouble with the law? ☐ Yes ☐ No

If Yes, Relevant History: _____

_____

_____

_____

Child's Substance Use History:
☐ No substance use ☐ Tobacco use ☐ Cocaine ☐ Social Drinking ☐ Caffeine ☐ Other

☐ Current alcohol/drug use ☐ Prior substance use, but discontinued ☐ Marijuana

☐ Current/Prior substance treatment ☐ Specify: _____

Other Concerns: ☐ None

☐ Running away ☐ Promiscuous/Unprotected sex ☐ Unplanned pregnancy ☐ Abortion

☐ Gambling ☐ Victim of unusually harsh discipline ☐ Self-harm/cutting ☐ Abusive/controlling relationship

Explain as needed: _____

_____

_____

Please describe what you would like your child/family to accomplish in treatment with me:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____