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| CHILD REGISTRATION AND HISTORY |
| Date: Provider: |
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| --- | --- |
| Child’s Name: | M  F  DOB: Age: |
| Address: | School District: |
| City: State: Zip: | School:  |
| Cell Phone: ( ) | Teacher: |
| Email: | School Phone: |

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| --- | --- |
| Parent/Guardian 1 | Name: |
| Address:  | Relationship to Child: |
| City: State: Zip: | Employer: |
| Home Phone: ( ) | Work Phone: ( ) |
| Cell Phone: ( ) | Email: |

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| --- | --- |
| Parent/Guardian 2 | Name: |
| Address:  | Relationship to Child: |
| City: State: Zip: | Employer: |
| Home Phone: ( ) | Work Phone: ( ) |
| Cell Phone: ( ) | Email: |
| **Person Responsible for Payment:** |  |

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| Insurance Information |
| Primary Insurance: | Secondary Insurance: |
| Subscriber: | Subscriber: |
| Subscriber's DOB: | Subscriber's DOB: |
| Ins. ID#: | Ins. ID#: |
| Ins. Group #: | Ins. Group #: |
| Deductible $\_\_\_\_\_\_\_\_\_ Co-Pay $\_\_\_\_\_\_\_\_\_\_ | Deductible $\_\_\_\_\_\_\_\_\_ Co-Pay $\_\_\_\_\_\_\_\_\_\_ |

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| Primary Physician: | Phone: |

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| PLEASE LIST CURRENT THERAPIES YOUR CHILD IS RECEIVING:

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| --- | --- | --- | --- |
| Provider | Type of Therapy | Phone | Date Begun |
|  |  |  |  |
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**Birth and Developmental History:**

Information requested pertains to the biological mother of the child:

1. Did the mother receive prenatal care? Yes\_\_\_ No\_\_\_
2. Did the mother take any medications during pregnancy?

Name of medication Reason taken Trimester

1. Did the mother smoke cigarettes, drink alcohol, or use drugs during pregnancy?

Substance Amount used per week Trimester

1. Did the mother experience any medical problems during pregnancy? Please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Length of pregnancy: \_\_\_\_\_ weeks Age of mother: \_\_\_\_\_\_

6. Were there any problems with the delivery? Please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery was: Vaginal\_\_\_ C-section\_\_\_

1. Birth weight:\_\_\_\_\_\_\_
2. Duration of mother’s hospital stay: \_\_\_\_\_\_\_\_ Baby’s hospital stay:\_\_\_\_\_\_\_\_\_
3. Were there any problems noted by anyone while the baby was still in the hospital? (for example, prolonged jaundice, need for incubator/oxygen, feeding problems, colic) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Did your child have any medical problems during infancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feeding difficulties? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“Colic”? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep difficulties? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How would you describe your child’s temperament as an infant? Was he/she an “easy” baby? Was he/she cuddly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. At what age did your child complete the following developmental milestones?

Milestone Age

Smiled \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walked \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First words (other than “mama” and “dada”) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2-3 word sentences \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toilet trained during day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

1. Does your child have any chronic health issues (e.g. asthma, genetic syndromes, diabetes)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does your child have any **Allergies** (food, environmental, etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Has your child had any surgeries or hospitalizations? If yes, please describe

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your child ever had a seizure? Y N Please describe dates of seizures, any diagnostic testing performed, and any medications given. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has your child ever had a head injury? Y N Please describe dates and circumstances. Did your child lose consciousness? Was a CT scan or MRI performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child taking any type of medication currently?

Name of medication Dosage Reason Date begun

1. Has your child ever taken any psychiatric medications in the past?

Name of medication Dosage Reason Dates

1. Has your child ever had a vision screen?

Date of screen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your child ever had a hearing screen?

Date of screen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any evaluations for your child (neurology, developmental pediatrics, psychologist). Please bring copies of these evaluations to your first appointment.

Type By whom Year Diagnostic Impression

**General Information:**

1. Please list information regarding child’s legal parent(s):

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion/Spirituality \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are parents currently living together? Y N If not, describe custody arrangement and which parent(s) have medical decision making:

3. Please list sibling(s):

Name \_ Age full/half/adoptive/step? Living in your home?

1. If your child is on a special diet, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list the goals you have for our work together: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History:**

Do any of your child’s biological relatives have the following conditions? Please check all that apply, past or present.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Mother’sFamily | Father’sFamily | Child’sSiblings |
| Attention Problems |  |  |  |  |  |
| Social Awkwardness |  |  |  |  |  |
| Learning problems |  |  |  |  |  |
| Language Delay |  |  |  |  |  |
| Autism Spectrum |  |  |  |  |  |
| Hyperactivity |  |  |  |  |  |
| Problems w/ Anger |  |  |  |  |  |
| Drug/Alcohol Abuse |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Suicide Attempt(s) |  |  |  |  |  |
| Problems w/ Anxiety |  |  |  |  |  |
| Bipolar Disorder |  |  |  |  |  |
| Schizophrenia |  |  |  |  |  |
| Psychosis |  |  |  |  |  |
| Criminal history |  |  |  |  |  |