**CHILD OR ADOLESCENT PATIENT INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date: Account No.: Dx:** | | | | | |
| **Child or Teen Patient Information** | | | | | |
| Last Name: | | First Name: | | Nickname: | |
| Birthdate: / / | | Age: | | Gender: | |
| Is child/teen adopted? Y or N | | Yes, age at adoption: | | Languages spoken at home: | |
| Street Address: | | City: | | State: Zip Code: | |
| Home Phone: | | Child’s cell phone: | | Best number to leave messages: | |
| Has your child/teen or a family member been seen by Dr. Pender before? Y or N | | | | | |
| Who has physical custody of this child/teen? | | | | | |
| Who has legal custody of this child/teen? | | | | | |
| **Referral Information** | | | | | |
| Referred by: | How did you learn about this practice: □ Doctor □ Lawyer □ Friend □ School  □ Co-worker □ Internet search □ Presentation/Talk □ Marketing □ Other | | | | |
| **School Information** | | | | | |
| Current School: □ Public □ Private | | | | □ Year Round □ Traditional □ Other | |
| Teacher’s Name: Grade: | | | | Retained: Y or N If yes, which grades: | |
| Special Education: □ IEP □ 504 | AIG: □ Reading □ Math | | | Tutoring: Y or N | |
| **Parent Information** | | | | | |
|  | | **Mother** | | | **Father** |
| Name | |  | | |  |
| Age | |  | | |  |
| Highest Education Level | |  | | |  |
| Occupation | |  | | |  |
| Employer | |  | | |  |
| Cell Phone | |  | | |  |
| Work Phone | |  | | |  |
| Home Phone (if different from child) | |  | | |  |
| Email Address | |  | | |  |
| Address (if different from child) | |  | | |  |
|  | | **Stepmother** | | | **Stepfather** |
| Name | |  | | |  |
| Age | |  | | |  |
| Highest Education Level | |  | | |  |
| Occupation | |  | | |  |
| Employer | |  | | |  |
| Cell Phone | |  | | |  |
| Work Phone | |  | | |  |
| Home Phone (if different from child) | |  | | |  |
| Email Address | |  | | |  |
| Address (if different from child) | |  | | |  |
| **Siblings** | | | | | |
| Names: 1- | Gender : Age: | | □ Full Sibling □ Half □ Step □ Adopted | | |
| 2- | Gender : Age: | | □ Full Sibling □ Half □ Step □ Adopted | | |
| 3- | Gender : Age: | | □ Full Sibling □ Half □ Step □ Adopted | | |
| 4- | Gender : Age: | | □ Full Sibling □ Half □ Step □ Adopted | | |
| **Medical Information** |  | |  | | |
| Child’s doctor: Name of Practice: Phone: Fax: | | | | | |
| Street Address: | City: | | | State: Zip Code: | |
| Medical Problems (list): | | | | | |
| Allergies: | | | | | |
| Hospitalizations/Surgeries: | | | | | |
| Medication Name: Dosage: X per day: Reason: | | | | | |
| Medication Name: Dosage: X per day: Reason: | | | | | |
| Medication Name: Dosage: X per day: Reason: | | | | | |
| **Birth and Developmental History** | | | | | |
| Length of Pregnancy: | Birth weight: | | | Complications: | |
| Used During Pregnancy: □ Alcohol □ Tobacco □ Illicit Drugs □ Prescription Medication | | | | | |
| Medical Problems at Birth: | | | | | |
| **Milestones** (Please list age child met each milestone) | | | | | |
| Motor Sat: Crawled: Walked: Current Difficulties: Y or N | | | | | |
| Language Single word: 3 words: Full sentences: Current Difficulties: Y or N | | | | | |
| Toileting Trained for day: Trained for Night: History of Accidents: Y or N | | | | | |
| Sleep Issues: □ Trouble Falling Asleep □Trouble waking up □ Sleepwalks □Night Terrors □ Nap issues | | | | | |
| **Mental Health History** | | | | | |
| Mental Health Diagnoses: | | | | | |
| Previous Professionals Seen: Name(s): Date(s): | | | | | |
| Previous Evaluations: □ Psychological □ Educational □ Speech and Language □ Occupational Therapy  □ Neuropsychological □ Emotional □ Behavioral | | | | | |
| **Family Stressors** | | | | | |
| □ Abuse □ Deaths □ Job Change □ Relocation □ Stepchildren □ Trauma  □ Births □ Divorce □ Marriage □ School □ Substance Use □ Other(s):  □ Bullying □ Finances □ Medical □ Separation □ Substance Abuse | | | | | |
| **Family Strengths** | | | | | |
| Please Describe: | | | | | |
| **Reason For Seeking Help At This Time:** | | | | | |
| Please Describe: | | | | | |
| Signature: Date: | | | | | |
| Relationship to Child/Teen: | | | | | |