**CHILD OR ADOLESCENT PATIENT INFORMATION**

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| **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:  |
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| **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:  |