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Patient and Billing Information

Today's Date: _____

Patient Name: (First)_____ **(Middle Initial)**_____ **(Last)**_____

D.O.B.: _____ **Age:** _____ **School:**_____**Grade:**_____

Parent(s) or Guardian(s) patient lives with: _____**Relationship:**_____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____ ***Permission to contact*** **() Yes () No**

Address: _____ **City:** _____

State:_____**Zip;**_____**SS#:**_____**Driver's License:** _____

Work Status: () FT Employed () PT Employed () FT Student () PT Student () Homemaker () Retired () Other

Employer's Name / Address: _____

Occupation/Job Title: _____ **Work/Shift Hours:** _____

Other Parent if not living with patient:_____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Address: _____ **City:** _____

State:_____**Zip;**_____**SS#:**_____**Driver's License:** _____

Work Status: () FT Employed () PT Employed () FT Student () PT Student () Homemaker () Retired () Other

Employer's Name / Address: _____

Occupation/Job Title: _____ **Work/Shift Hours:** _____

Other people living in the child's home:

Name_____**Age**_____**Relationship**_____

Name_____**Age**_____**Relationship**_____

Name_____**Age**_____**Relationship**_____

In case of an emergency you have my permission to contact: _____

Address/Phone #: _____ ***Your Initials:*** _____

Referred By: _____ **Phone:** _____

Address: _____

May I contact them to thank them for your referral? : () Yes () No

Primary Insurance Company: _____ **Policy #:** _____ **Group#:** _____

Insured Name:_____ **D.O.B.:** _____ **SS#:**_____

Patient relationship to Insured: _____

Employer Name/Address: _____

Secondary Insurance: _____ **Policy#:** _____ **Group#:** _____

Insured Name: _____ **D.O.B.:** _____ **SS#:** _____

Health History

Please list any current or recurring health problems: _____

Is the patient presently taking *any* medications? () Yes () No If yes, please list *name*, *use*, and *dosage:* _____

_____

Has the patient had previous mental health treatment? () Yes () No If yes, with whom _____

Is patient in current mental health treatment? () Yes () No If yes, with whom _____

Has the patient had any psychiatric hospitalizations? () Yes () No If yes, where and dates _____

_____

Significant Events in Patient's Life

Normal pregnancy: () Yes () No Explain _____

Normal delivery: () Yes () No Explain _____

Normal infancy: () Yes () No Explain _____

Colic: () Yes () No Explain _____

Illness: () Yes () No Explain _____

Hospitalizations: () Yes () No Explain _____

Injury: () Yes () No Explain _____

Parents divorced/separated: () Yes () No Explain _____

Parent ill/hospitalized: () Yes () No Explain _____

Number of homes in child's lifetime _____

Illness/injury/death of significant person: () Yes () No Explain _____

_____

Drug/alcohol history: Patient () Yes () No; Parent(s) () Yes () No; Family History () Yes () No

Explain _____

School Behavior

Age started school: _____ **Preschool: () Yes () No Significant events:** _____

_____

Rate your child's school experience related to academic learning:

	Good	Average	Poor
Preschool	_____	_____	_____
Kindergarten	_____	_____	_____
Current Grade	_____	_____	_____

To the best of your knowledge, at what grade level is your child functioning:

Reading _____ **Spelling** _____ **Arithmetic** _____

Has your child ever had to repeat a grade level? () Yes () No If so, when _____

Describe briefly any academic school problems _____

_____

Special Services received at school: _____

Present Class Placement: () Regular class () Other _____

Comprehension and Understanding

Do you consider your child to understand directions and situations as well as other children his/her age: () Yes () No

If not, why not_____

How would you rate your child's overall level of intelligence compared to other children:

Below average_____ **Average**_____ **Above Average**_____

Interests and Accomplishments

What are your child's main hobbies and interests? _____

_____

What are your child's areas of greatest accomplishment? _____

_____

What does your child enjoy doing most? _____

_____

What does your child dislike doing most? _____

_____

Is there anything else you would like to describe? _____

_____

_____

Please state briefly why you are seeking assistance now and what you would like to achieve: _____

_____

_____

_____

_____