NEW CHILD/ADOLESCENT PATIENT INFORMATION

PATIENT INFORMATION

PATIENT'S FULL LEGAL NAME (LAST, FIRST, MIDDLE)			PREFERRED NAME
SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PARENT EMAIL ADDRESS

PARENT/GUARDIAN INFORMATION

PRIMARY PARENT / GUARDIAN'S NAME (LAST, FIRST, MIDDLE)		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
MAILING ADDRESS			CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER		
SECONDARY PARENT / GUARDIAN'S NAME (LAST, FIRST, MIDDLE)		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
MAILING ADDRESS			CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER		

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	POLICY EFFECTIVE DATE	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT	EMPLOYER		
SECONDARY INSURANCE COMPANY NAME	POLICY EFFECTIVE DATE	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT	EMPLOYER		
PRIMARY CARE PROVIDER			

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR INFORMATION RELEASE

I hereby assign, transfer, and set over to Central Louisiana Medical Psychology Clinic all of my rights, titles, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information to determine these benefits. This authorization shall remain valid until written notice is given by me revoking this authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____

Patient Signature Date

CHILD HISTORY FORM

Patient's Name _____DOB _____Age_____

Person Completing Form _____Relationship to Patient _____

Why have you sought treatment for your child? What difficulties is your child experiencing? _____

_____

_____

Current marital status of mother:_____

Current marital status of father:_____

Who has custody of the child?:_____

A. CHILD'S MEDICAL AND DEVELOPMENTAL HISTORY

Did the baby's mother receive prenatal healthcare? _____

My baby was delivered at _____ weeks of pregnancy.

My baby weighed _____ pounds _____ounces at birth.

My child said his/her first words at _____ months/years old.

My child said 2-3 word sentences (e.g., "want milk" or "go bye-bye") at _____ months/years old.

My child walked at _____ months/years old.

My child was potty trained at _____ years old.

History of occupational therapy? _____

History of speech therapy? _____

History of physical therapy? _____

My child's pediatrician is _____

Approximate date of last pediatrician appointment _____

Did your child…	Please give details, including dates and time frames
Have any trouble at birth? (e.g. breathing problems, jaundice, infection, stayed in the hospital)	
Have any problems with language? (e.g. did not talk on time, did not speak clearly, gestured instead of talking, did not seem to understand simple directions)	
Have any problems with sleeping or eating?	
Have any problems with toilet training?	
Have any problems with temperament? (e.g. fussy, cried a lot, tantrums, difficult to soothe, did not smile, showed little emotion)	
Have any problems relating to other people? (e.g. avoided eye contact, did not like to be held, did not respond to when name was called, did not imitate others)	
Have any problems with self-care skills? (e.g. trouble learning to feed self, dress self, or bathe self)	
Have any hospitalizations for physical health reasons?	
Have any serious injuries? (if yes, indicate whether treatment was received and what kind)	
Have any head injuries? (if yes, indicate whether he/she lost consciousness, for how long, and whether treatment was received and what kind)	
Have any major physical health problems? (if yes, indicate whether treatment was received and what kind)	
Have any surgeries?	
Past or present prescription or over-the-counter medication for physical health reasons? (if yes, indicate what kind and for how long)	
Have any drug allergies? (if yes, indicate specific allergies)	

B. CHILD'S SCHOOL HISTORY

Child's current grade _____ Current school _____

Current academic problems _____

Current behavioral problems _____

Has your child ever repeated a grade and if so, which one(s):_____

Has your child ever been suspended or expelled? If so, what grade (s)? _____

Has your child ever received services in school for mental retardation/intellectual disabilities?_____

Has your child ever received services in school for learning disabilities?_____

Has your child ever received services in school for emotional/behavioral problems?_____

Has your child ever received services in school for social interaction problems?_____

Has your child ever received services in school for speech/language problems?_____

Has your child ever received services in school for motor skill

problems (occupational therapy, adapted physical education?_____

Has your child ever received testing for learning disabilities or for special education ?_____

CHILD'S MENTAL HEALTH EVALUATION AND TREATMENT HISTORY

Please list all mental health services your child has received (including psychological evaluations, educational evaluations, therapy, and inpatient hospitalizations)

Name of Provider or Facility	City and State	Reason for Treatment/evaluation	Dates of Service	Diagnoses

D. CHILD'S SOCIAL HISTORY

My child lives with _____

Problems getting along with peers? If so, please describe _____

_____

Any family stressors? If so, please describe _____

_____

Please save this completed form and email to: NewPatient@centrallamedpsych.com