Migranes No Yes ________________

Consent to treat a minor:

as a parent or legal guardian of ________________ I authorize his/her evaluation and treatment. I have the right to request information concerning the above minor's evaluation and treatment.

Parent/legal Guardian Signature: ____________________ Date: ____________

Acknowledgement of receipt-notice of privacy practices:____________________

Results of previous evaluations: Please bring copies of any reports

Occupational Therapy:____

Physical Therapy: ____

Speech Therapy: ____

Counseling: ____

Please circle any of the following that describe your relationship with your current spouse:

Stormy	Indifferent	Unrewarding	Disappointing	Harmonious
Impossible	Happy	Mistake	Understanding	Devoted
Hopeless	Wholesome	Insecure	Average	Secure

Other: ____

In general, would you say life in your present family is:

Excellent	Good	Fair	Poor	Bad

What are stresses affecting the stability of this child's family life? ______________________

What stressors have impacted or currently impacting your child? ______________________

Family History:

Does anyone in the child's **biological** family have:	No	Yes	Relationship to child
Attention problems/ADHD	No	Yes	________________
Behavior problems in youth	No	Yes	________________
Learning Disability	No	Yes	________________
Seizures	No	Yes	________________
Mental Retardation	No	Yes	________________
Tics/Tourette's Syndrome	No	Yes	________________
Autistic Spectrum Disorder	No	Yes	________________
Thyroid problems	No	Yes	________________
Depression	No	Yes	________________
Bipolar disorder	No	Yes	________________
Anxiety or Panic Attacks	No	Yes	________________
Obsessive Compulsive Disorder	No	Yes	________________
Schizophrenia	No	Yes	________________
Alcohol Problems	No	Yes	________________
Drug Problems	No	Yes	________________
Trouble with the law	No	Yes	________________
Diabetes	No	Yes	________________
Suicide (or attempts)	No	Yes	________________

Family History con't:

Psychiatric Hospitalizations	No	Yes	________________

Head injury? N Y Loss of consciousness: N Y Date & circumstances: ________________

List any major illnesses and/or surgeries of the child and the child's age at the time

A. ____
B. ____
C. ____
D. ____

Please list all medication child is taking; both prescribed and over the counter:

Medication	Purpose	Dose	Taken regularly?

Sleep Patterns:

Total hours of sleep per night: _________ Usual Schedule: _______ to __________

Does your child take naps during day? N Y If yes, how many hours each day? _____

Does your child have:

Difficulties falling asleep:	No	Yes
Frequent awakening:	No	Yes
Snoring:	No	Yes
Restlessness/Movements:	No	Yes
Nightmares:	No	Yes
Not Rested upon awaking:	No	Yes

Abuse History:

Is there any history of abuse or neglect? N Y

If yes, what was the nature of the abuse? Circle all that apply:

Physical	Emotional	Neglect
Accidents	Disasters	Sexual
Witnessing Violence		Other: ____________________________

Child Protective Services Report? ______________________________________

Any current Therapies?

Past	Present	Early Intervention	_____/week for ______ minute sessions
Past	Present	Occupational Therapy	_____/week for ______ minute sessions
Past	Present	Physical Therapy	_____/week for ______ minute sessions
Past	Present	Speech Therapy	_____/week for ______ minute sessions
Past	Present	Counseling	_____/week for ______ minute sessions
Past	Present	Psychiatric	_____/week for ______ minute sessions

At what age did your child:
Crawl________________________
Walk________________________
First sounds__________________
First words___________________
Using 2 word sentence__________
Day time bladder trained________
Nighttime bladder trained_______

Presenting Problem:
Briefly describe your child's current difficulties and the reason you are seeking services?____
____
How long has this been a problem?____
What seems to help?____
What seems to make problem worse?____
What have you tried to help with these difficulties?_________________________________
What are your goals/expectations for your child's treatment?__________________________
____
Struggles/concerns: ____
____
____

Medical History:
Date of child's last physical: ___________________
Name of pediatrician/family physician: ______________________________________
Address: ____
Phone:__________________________ Fax: ________________________________
Date of Hearing exam:______________ Date of Eye exam: ________________

Allergies (drug, food, seasonal, environmental etc.)? N Y If yes, please name and describe:_____
____

Ear infections? N Y If yes, please name and describe:_____________________________________
____

Reflux? N Y If yes, please name and describe:____
____

Seizures? N Y If yes, please name and describe:____
____

Headaches? N Y If yes, please name and describe:_______________________________________

Dad's Cell phone:__________
Occupation: __________ Employer: ___________
Education:___________ DOB:_______________
Home phone:_________ Work phone:_________
Cell phone:___________ Email:______________
Please indicate if a message can be left at: Home:____ Work:__ Cell:__ Text:___ Email:____

Medical/Developmental History:

Birth History:

Type of Delivery: Vaginal/C-Section Complications during labor or delivery?____________________

____

Was the child premature? No Yes If yes, by how many weeks?________________

During pregnancy, was the mother on medication? No Yes If yes, what kind? ________________

____

During pregnancy, did the mother smoke, drink alcohol or use drugs? No Yes If yes, please explain how much: ____

Did the mother have any difficulties with the pregnancy, labor, or delivery of this child?
No Don't Know , please explain Yes, please specify________________________

____

____

____

Did the child have any problems at birth?
No Don't Know , please explain Yes, please specify

____

____

____

Infancy/Childhood: Describe your child as an infant/toddler:________________________________

Problems with feeding:	N	Y
Severe Colic or excessive crying	N	Y
Irritable	N	Y
Overactive	N	Y
Easily overstimulated	N	Y
Withdrawn	N	Y
Didn't like to be held	N	Y
Difficult to Soothe	N	Y

Playful Connections Therapy Center PLLC
New patient Information

Date: _______ Referred by: ______________________
Person completing form:_____________________________
Relationship to child: ______________________________

Personal information:

Child's name:____________________ Child's Date of Birth:__________________
Address:________________________ City/State/Zip:_______________________
How long at this address: __________
Home phone:____________________
Child's School: ___________________ Grade: ______________

Mom's name:____________________ Dad's name:__________________
Step dad's name:_________________ Step mom's name:_____________

List all people living in child's household:

Name	Relationship to child	Age

If any brothers or sisters living outside the home, list their names and ages**:**

____

If parents are separated/divorced, how old was child when this separation occurred? ___________
Who has custody of child? ________________________

Mom's:

Occupation: __________ Employer: ___________
Education:___________ DOB:_______________
Home phone:_________ Work phone:_________
Cell phone:___________ Email:______________
Please indicate if a message can be left at: Home:____ Work:__ Cell:__ Text:___ Email:____