# Child Patient Registration

## I. Patient Information:

Date: ______________________

### A. **Basic Demographic Information**:

Name: ________________________________________________________________
Last First Middle

Identified Gender: _________ Age: ______ Date of Birth: ____/_____/______ Social Security #:_____-____-______

Address: ________________________________ Home Phone: ________________________________

________________________________ Cell Phone: ________________________________

E-mail: ________________________________ Work Phone: ________________________________

Occupation: ________________________________ Employer: ________________________________

Emergency Contact: ________________________ Relationship: ________________________________

Address: ________________________________ Phone: ________________________________

### B. **Family Life**:

| | |
|---|---|
| 1. Name of Parent/Guardian: | Relationship to Child: |
| Home address: | Date of Birth: |
| | Home Phone: |
| Occupation: | Cell Phone: |
| Employer: | Work Phone: |
| 2. Name of Parent/Guardian: | Relationship to Child: |
| Home address: | Date of Birth: |
| | Home Phone: |
| Occupation: | Cell Phone: |
| Employer: | Work Phone: |
| 3. What is the parents' relationship status? | |
| With whom does the child live? | |
| Who has legal custody of the child? | |
| Who is responsible for payment of the bill? | |
| Social Security # of Guarantor/Payer - - | |

4. Please list all members of the child's immediate family and/or people living in his/her home.

| Name | Age | Relationship | Occupation |
|---|---|---|---|
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## II. Financial Information:

### A. What method of payment will be used to pay for services provided? (Initial as indicated.)

____I am paying completely out-of-pocket.
____I am using my health insurance benefits.

Health Insurance Company: ______________________________________

Name of Policy Holder: __________________________________________ Date of Birth: _____/______/______

Relationship to patient: __________________________________________

Insurance ID#: __________________________________________________ Group#: _______________________

Employed by: ___________________________________________________

### B. Assignment and Release:

___ If choosing to self-pay:
I understand I am financially responsible for all services, charges and fees.

___ If using health insurance:

I hereby authorize my insurance benefits to be paid directly to *Poehailos, Dupont & Associates, PLC* for services rendered. I authorize the release of any information as required by my insurance company or other reimbursing agency. I understand I am financially responsible for the charges not covered by my insurance company.

C. **Contract for Payment:**

________ I authorize my credit card to be billed for all copays, ancillary charges, fees and services rendered that are not covered by my health insurance benefits at Poehailos, Dupont & Associates, PLC.

Signature of Guardian/Guarantor: Date:

**Parent Questionnaire for Child/Adolescent Intake**

Today's Date: _________________________

Child's name: _________________________________ Nickname: __________________________________

Date of Birth: _____/________/___________ Identified Gender: ___________________________________

Name of person completing questionnaire: ______________________________________________________

Relationship to child: _______________________________________________________________________

## I. Initial Thoughts:

A. Briefly describe your reason for seeking services.

B. Who referred you to us?

C. What are your goals/hopes for treatment?

## II. Previous Mental Health Treatment:

A. Does your child have any history of mental health concerns (e.g., depression, anxiety)? If so, please describe.

B. Has your child ever received counseling, psychological or psychiatric treatment? If so, please include names of clinicians, dates of treatment and nature of the problem(s).

C. Has your child ever been in a hospital for mental health/emotional problems? If so, when and where?

D. Is your child receiving services at any other local agencies (e.g., tutoring, speech therapy)? If so, please list the agency

E. Has your child ever been on medication for emotional/behavioral problems? If so, please complete:

| Date | Medication | Dosage |
|---|---|---|

F. Has your child ever completed a psychological evaluation or educational assessment? If so, please complete: ***Please include copies of any reports obtained as a result of prior assessment.**

| Date | Clinician/Specialist | Diagnosis/Intervention |
|---|---|---|

## III. Medical History:

**A.** Who is the child's current primary care physician?
Name: ____________________________________________
Address: ____________________________________

Phone Number: ______________________________

B. What are any current (or significant past) medical problems for which the child has been treated?

C. What medications (prescription or non-prescription) is the child currently on?

| Date | Medication | Dosage |
|---|---|---|

Any medication allergies?

Any other allergies?

D. Has your child ever had to undergo surgery? Sustained any significant injuries (e.g. head injury, broken bones)? Lost consciousness? Had a seizure? If so, describe.

E. Were there any problems during pregnancy or delivery? Were developmental milestones met on time?

F. Does your child smoke? Do you know of/ suspect drug or alcohol use?

G. Is there a family history of medical or mental health problems? Please describe.

H. Is there any other medical information you feel is important?

## IV. Educational History:

A. What is the child's current school: ______________________________ Grade: __________

B. Who is the child's primary teacher? ______________________________

C. Who is the child's guidance counselor? ______________________________

D. What schools has the child previously attended?

| Date | School | Grade(s) |
|---|---|---|

E. Does your child receive special education services? Have a 504 Plan or an IEP*? Has s/he had to repeat any grades? If so, describe. ***Please include copies of any IEP or 504 Plan, past and present.**

F. Is there a family history of learning or school problems? If so, describe.

## V. Psychosocial Information:

A. Please list any significant individuals, who do not live in the home, who are involved in the child's life. Include step-parents, older siblings, step- or half-siblings, grandparents, etc.

| Name | Age | Relationship |
|---|---|---|

**B. Spiritual Life:**

How important is Spirituality/religion in the child's life? ____ Very _____ Somewhat ____Not at All

a. If s/he/they belong to a religious organization, what is your denomination?______________________

b. What facility/church do s/he/they attend? ______________________________

c. Who is the child's spiritual leader/pastor? Youth leader? ______________________________

C. Has the child ever been involved with the law? If so, describe.

D. What do you consider to be the most significant stressors the child has had to face in his/her life? Has s/he had to face abuse, death of a loved one, peer ridicule, separation/divorce?

E. Do you have any concerns about the child's friendships or relationships with peers? If so, describe.

F. Do you have any concerns about the child's relationships with family members? If so, describe.

G. Do you have any concerns about the child's behavior at school or home? If so, describe.

H. Please list some of the child's special interests or hobbies.

I. Please list some of the child's strengths and positive qualities.

**VI. <u>Suggestions and Comments</u>:**

A. How did you hear about us?

B. Do you have any suggestions/comments regarding this form and/or the registration process?

*Thank you for the time and attention you have devoted to this form. It will help us to better serve you.*