DISCOVERY PLAY

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New PATIENT INFORMATION FORM (CHILD)

Child's Full Name _____ Age: _____ Today's

Date _____/_____/_____What is the primary reason for today's visit?

_____

Child's Home Address:

_____

City: _____ State: _____Zip: ----------

How long has the child lived at this address? _____

Child's gender: M / F Child's - Date of Birth: _____/_____/_____

Person completing this form: _____Relationship to child_____

Mother's Full Name: _____Mother's Age: _____ Education:

Mother's Employer: _____Mother's type of Work: _____

Mother's Work Phone: _____Mother's Home phone_____

Mother's Mobile Phone: _____ Mother's Email: _____

Father's Full Name: _____Father's Age: _____ Education: Father's

Employer: _____Father's Type of Work:

Father's Work Phone: _____Father's Home Phone: _____

Father's Mobile Phone: _____ Father's Email:_____

How was your child referred to our office?
_____

Phone Number of the Referral Reference: _____
Who is the child's Pediatrician/Primary Care Provider?
_____

Phone Number: _____

Address: _____

Demographics
Child's primary residence: Both Parents ___ Mother ___ Father ___Other ___

If OTHER, then please describe: _____
Marital status of the child's parents:

Married? _____Divorced? _____Separated? _____

If other than above, please explain:
_____

In the case of divorce/separation, what are the custody arrangements?

Siblings:
Name _____Age _____ Name _____ Age _____
Name _____Age _____ Name _____ Age _____
Name _____Age _____ Name _____ Age _____

Other relatives or persons living in the home:

Name_____Age _____Relationship to child: _____

Name _____ Age _____Relationship to child _____

Name _____ Age _____Relationship to child _____

Name _____ Age _____Relationship to child _____

Is the child adopted? Yes _____ No _____

If yes, please describe the circumstances:
_____

Spirituality
Which religion is practiced in the home?
_____
Which religion does the child practice?
_____

Does your family attend church? _____No _____Yes

If yes, please provide the church's name
_____

What denomination is your church?
_____

School Information

Name of School: _____ Phone:_____

Teacher's Name _____ Grade: _____

Type of School: Public _____ Private _____ Special _____ Alternative _____

Grades repeated: _____ Grades skipped: _____

How many detentions has the child received in totality? _____

How many detentions has the child received this school year? _____

If one or more detentions were reported, then please explain the circumstances:

Has the child ever been expelled? No _____ Yes _____

If yes, then please indicate the number of times _____

Has the child ever had any trouble with law enforcement? No ___ Yes ___

If yes, please explain
_____

Has the child ever spent time in juvenile detention? No ___ Yes ___
If yes, please explain:
_____

Are there any known Learning Disabilities? No ____Yes ____
If yes, please explain:
_____
Does the child have an IEP (Individualized Education Plan) at school? No___ Yes___

Does the child have a 504 Plan at school? No___ Yes___

If the child **does** have an IEP or a 504 Plan, then please describe the circumstances below:

_____

If needed, may we have permission to contact the school? No ____Yes ____

If yes, then please sign your name below:

Signature _____Date _____/_____/_____

***This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney.**

Is the child in any Special Programs (speech, reading, etc.)? No ____ Yes ____

If yes, explain: _____

How does the school describe the child's academic/social performance? _____

What does the child do best in at school? _____

Which of the following problems, if any, does the child have in school?
_____Does not do homework _____Poor Spelling _____Poor Reading Skills
_____Does not remain seated _____Oppositional in class _____Makes careless errors
_____Does not finish homework _____Messy and Disorganized _____Forgets Assignments
_____Incomplete class work _____Talks out inappropriately _____Poor Handwriting
_____Distracted _____Poor Attention _____Test Anxiety
_____ Poor Math _____Excessive time to complete assignments

Peer Interactions:
No friends ___
Few friends ___
Many friends ___
Loses friends ___
Trouble making new friends ___
Has the child ever been bullied? No___ Yes ___

If yes, please explain: _____

Has the child ever been called a bully? No ___ Yes ___

If yes, please explain: _____

Further comments on homework, academic functions, peer relations: _____

Family Medical History
Do medical illnesses run in the family (seizures, thyroid problems, allergies, etc.)? No___ Yes__

If yes, please explain: _____

Is there a history of cardiac (heart) problems in the family? No ___ Yes ___

If yes, please explain: _____

_
Family Psychiatric History
(Please note: Depression, Bipolar Disorder, Attention Deficit, Obsessive-Compulsive Disorder, Tic, Disorder, Anxiety Disorders, Schizophrenia or other Psychotic Disorders, Substance Abuse, Suicide, Attempts, Hospitalizations, and other Psychiatric problems)

Has the child's mother or maternal relatives had similar or other psychiatric problems?

Has the child's father or paternal relatives had similar or other psychiatric problems?

Does the child's brother(s) or sister(s) have any psychiatric problems?

Birth History
While pregnant with this child, was the mother under a doctor's care? No ___ Yes ___
Was the mother given medication? No ____ Yes ____
Was the mother under anesthesia during childbirth? No ____ Yes ____ I do not know ____
If yes: Local _____ Epidural _____ General _____
How many hours from first contraction to delivery? _____ Birth Weight: ____lbs. ___oz.
Check any that apply to this pregnancy:
_____ Anemia ____Elevated blood pressure ____Toxemia
____ Measles ____ Swollen ankles ____ Bleeding
____German Measles ____Influenza _____ Kidney disease
_____ Strep throat ____ Other viruses ____Other illness
_____ Emotional problems ____Threatened miscarriage ____Smoking
_____ Alcohol use ____Gestational Diabetes _____ Use of illicit drugs

Developmental History
Motor development (sitting, crawling, walking): Average ___ Fast ___ Slow___
Speech and Language: Average ___ Fast ___ Slow ___
Bladder Trained: Average ___ Fast ___ Slow ___
Bowel Trained: Average ___ Fast ___ Slow ___
Handedness: Right ___ Left ___ Both ____

Medical History
Has the child had any of the following?
____ Measles ____ Chicken Pox _____ Strep Throat _____ Hay Fever

____ Asthma ____ Hearing deficits _____ German Measles _____ Whooping Cough
_____ Meningitis _____ Abscessed ears _____ Seizures/Convulsions
_____Vision Problems _____ Mumps _____ Diphtheria _____ Encephalitis
_____ Tubes in ears _____ Head Trauma _____ other illnesses

Has the child had any prior surgeries?

Does the child currently take any medications for medical problems?

Does the child have any allergies to medicines?

When was the child's last physical exam?

_____

Was lab work done? No _____ Yes _____

Was an EKG done? No _____ Yes _____

If yes to the above, what were the results?

_____

Overall how would you rate the child's physical health?

_____

Is there anything else you would like us to know about the child's physical health before we meet together?

_____

Prior Treatment History

Please check all of the following that apply to/have ever applied to the child:

Afraid to go to school ___ Ran away from home ___Cruel to animals ___ Sets fires ___
Often lies to family and others ___Oppositional to authority ___Frequent falls ___
Disrespects/destructs the property of others ___ Wet the bed after age 5 ___Tics ___
Frequent transitions (family moved a lot, changed schools a lot, etc) ___ Nightmares ___
Exposed to incest ___Promiscuous ___Difficulty with reading, writing, mathematics___
Truant from school ___ Failed or repeated a grade ___ Disturbed sleep ___Fear of the dark ___
Awkward at games or other social activities ___ Trouble with eyesight ___ Left-handed ___
Mispronounces words, has a lisp, stutters/stammers ___ None of these apply ___

Psychiatric Medication History
Has the child ever been prescribed psychiatric medications? No _____ Yes _____
If yes, please list medication names, their responses, and indicate which one was most effective:

Medication Name:
Dose:
Response:

Has the child ever received mental health therapy or counseling? No _____ Yes _____

Has the child ever been hospitalized for psychiatric reasons? No ____ Yes ____

If yes, please list names and dates:

_____

Has the child ever been a (known or suspected) victim of verbal/emotional abuse? No / Yes
If yes, please explain:

Has the child ever been a (known or suspected) victim of physical abuse? No / Yes
If yes, please explain: _____

Has the child ever been a (known or suspected) victim of sexual abuse? No / Yes

If yes, please explain: _____

Is there anything else you want us to know about your child's mental health before we meet Together?

GUARANTOR / GUARDIAN INFORMATION:
Relationship to Patient: _____
Full Name:

_____
(First) (MI) (Last)

Address:

_____

City: _____State: _____Zip: _____

Date of Birth: ___/___/___ Gender: M / F - SSN: _____/____/_____Phone Number:

Employer's Name & Address:

_____

Employer's Phone Number: _____

I, the undersigned, agree that I am financially responsible for all services provided by DISCOVERY PLAY. I am aware that office policy requires payment at the time of service. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% of the outstanding balance. I understand if I don't pay, the providers from DISCOVERY PLAY have the rights to terminate the treatment.

I understand that outstanding balances over 90 days may be referred to a collection agency.

Parent / Guardian/Guarantor: _____ Date: _____