CHILD OR ADOLESCENT PATIENT INFORMATION

DATE:	ACCOUNT NO.:	DX:
CHILD OR TEEN PATIENT INFORMATION		
Last Name:	First Name:	Nickname:
Birthdate: / /	Age:	Gender:
Is child/teen adopted? Y or N	Yes, age at adoption:	Languages spoken at home:
Street Address:	City:	State: Zip Code:
Home Phone:	Child's cell phone:	Best number to leave messages:
Has your child/teen or a family member been seen by Meredith Furr, LCMHC-A before? Y or N		
Who has physical custody of this child/teen?		
Who has legal custody of this child/teen?		
REFERRAL INFORMATION		
Referred by:	How did you learn about this practice: □ Doctor □ Lawyer □ Friend □ School □ Co-worker □ Internet search □ Presentation/Talk □ Marketing □ Other	
SCHOOL INFORMATION		
Current School: □ Public □ Private		□ Year Round □ Traditional □ Other
Teacher's Name:	Grade:	Retained: Y or N If yes, which grades:
Special Education: □ IEP □ 504	AIG: □ Reading □ Math	Tutoring: Y or N

PARENT INFORMATION		
	MOTHER	**FATHER**
Name		
Age		
Highest Education Level		
Occupation		
Employer		
Cell Phone		
Work Phone		
Home Phone (if different from child)		
Email Address		
Address (if different from child)		
	STEPMOTHER	**STEPFATHER**
Name		
Age		
Highest Education Level		
Occupation		
Employer		
Cell Phone		
Work Phone		
Home Phone (if different from child)		
Email Address		
Address (if different from child)		

SIBLINGS

Names: 1-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
2-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
3-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
4-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted

MEDICAL INFORMATION

Child's doctor:	Name of Practice:	Phone:	Fax:
Street Address:	City:	State:	Zip Code:

Medical Problems (list):

Allergies:

Hospitalizations/Surgeries:

Medication Name:	Dosage:	X per day:	Reason:
Medication Name:	Dosage:	X per day:	Reason:
Medication Name:	Dosage:	X per day:	Reason:

BIRTH AND DEVELOPMENTAL HISTORY

Length of Pregnancy:	Birth weight:	Complications:

Used During Pregnancy: □ Alcohol □ Tobacco □ Illicit Drugs □ Prescription Medication

Medical Problems at Birth:

MILESTONES (Please list age child met each milestone)

Motor	Sat:	Crawled:	Walked:	Current Difficulties: Y or N
Language	Single word:	3 words:	Full sentences:	Current Difficulties: Y or N
Toileting	Trained for day:	Trained for Night:		History of Accidents: Y or N

Sleep Issues: □ Trouble Falling Asleep □Trouble waking up □ Sleepwalks □Night Terrors □ Nap issues

MENTAL HEALTH HISTORY

Mental Health Diagnoses:

Previous Professionals Seen: Name(s): Date(s):

Previous Evaluations: □ Psychological □ Educational □ Speech and Language □ Occupational Therapy
□ Neuropsychological □ Emotional □ Behavioral

FAMILY STRESSORS

□ Abuse	□ Deaths	□ Job Change	□ Relocation	□ Stepchildren	□ Trauma
□ Births	□ Divorce	□ Marriage	□ School	□ Substance Use	□ Other(s):
□ Bullying	□ Finances	□ Medical	□ Separation	□ Substance Abuse	

FAMILY STRENGTHS

Please Describe:

REASON FOR SEEKING HELP AT THIS TIME:

Please Describe:

Signature: Date:

Relationship to Child/Teen: