Child Registration and History

PATIENT DEMOGRAPHICS

First Name (Legal) Last Name

Preferred Name/Nickname

Date of Birth Current Age

Guardian's Name

Self
Biological Parent(s)
Adoptive Parent(s)
Foster Guardian(s)
Other

Gender Male Female

Address
City, State, Zip

Phone

Phone

E-mail Address

Additional Contact Information

Referral Source

Referral Contact Information

CUSTODY AND LIVING ARRANGEMENTS

Patient Lives With
(Name and Roles)

Additional Family
(Name and Roles)

Parents' Marital Status — Married | Divorced | Separated | Never Married | Widowed

Parents' Custody Agreement — Legally Documented | NA | Informal

Father's Custody — Full | Shared | Physical
Visitation, Frequency/Duration of Visits:

Mother's Custody — Full | Shared | Physical
Visitation, Frequency/Duration of Visits:

INSURANCE INFORMATION

Provider

Primary Person Covered

Relationship to Patient

Address

Phone

Employer

Primary Person's SS#

Patient's Member #

Group Number

It is highly recommended that you contact your insurance company prior to the first visit to ensure you are aware of your coverage and any limitations. You may contact the department's Financial Counselor, Sarah Cooper, at (919) 966-0089 for additional assistance with this.

Please bring the patient's insurance card to the first appointment!

HISTORY OF PROVIDERS

Any previous mental health services (therapy, medication, testing, etc.)? Yes No

Previous Provider

Phone

Previous Provider

Phone

Previous Provider

Phone

Previous/Current Psychiatric Diagnosis

Current Psychiatric Medications

Current Prescribing Physician

Address

Phone

Past Psychiatric Hospitalizations (with dates and reasons)

Past Medical Diagnosis and Current Concerns

Current Pediatrician

Address

Phone

Current Medical Medications

Date of last check-up

Hearing test

Vision test

Past Medical Hospitalizations
(with dates and reasons)

Frequent headaches?	Yes No	Frequent stomachaches?	Yes No

Allergies

SCHOOL

Patient's Current School

Current Grade

Special Accommodations	IEP	504 Plan	Informal	None

Teacher(s), counselor(s), and other involved school staff

REASONS FOR SEEKING EVALUATION/TREATMENT

Current Concerns

Current suicidal thoughts and/or gestures?	No	Yes	Unknown

Past history of suicide attempts and/or gestures?	No	Yes

If yes, please explain.

History of involvement with juvenile court/probation officer?	No	Yes

If yes, please explain.

History of involvement with Child Protective Services?	No	Yes

If yes, please explain.

PROBLEM CHECKLIST

1= Never
2= Sometimes
3=Often
4= Always
NA= Unknown or not applicable

Sad or Depressed Mood	1	2	3	4	NA
Lack of interest/motivation in previously enjoyed activities	1	2	3	4	NA
Boredom	1	2	3	4	NA
Withdrawal from friends	1	2	3	4	NA
Multiple unfounded medical complaints	1	2	3	4	NA
Decreased self-esteem	1	2	3	4	NA
Excessive self-blame and guilt	1	2	3	4	NA
Suicidal behaviors or thoughts	1	2	3	4	NA
Increased tearfulness	1	2	3	4	NA
Rapid changes in mood	1	2	3	4	NA
Difficulty making friends	1	2	3	4	NA
Difficulty keeping friends	1	2	3	4	NA
Increased irritability, difficult to please	1	2	3	4	NA
Overly sensitive to others	1	2	3	4	NA
Rages that last an hour or more	1	2	3	4	NA
Rapid and continuous speech	1	2	3	4	NA
Inflated beliefs about self and abilities	1	2	3	4	NA
Decreased need for sleep	1	2	3	4	NA
Overactive	1	2	3	4	NA
Fidgets	1	2	3	4	NA

Easily distracted or inattentive	1	2	3	4	NA
Impulsive	1	2	3	4	NA
Difficulty following through with directions	1	2	3	4	NA
Fails to finish tasks	1	2	3	4	NA
Loses things easily	1	2	3	4	NA
Changes the topic often and unprompted when speaking with others	1	2	3	4	NA
Has difficulty waiting turns	1	2	3	4	NA
Often blames others for his/her mistakes or misbehaviors	1	2	3	4	NA
Constantly refuses to comply with reasonable rules	1	2	3	4	NA
Defiant toward authority	1	2	3	4	NA
Looses his/her temper often	1	2	3	4	NA
Runs away from home, school truancy	1	2	3	4	NA
Has set fire(s)	1	2	3	4	NA
Involvement in physical fights	1	2	3	4	NA
Has homicidal behaviors and/or plans	1	2	3	4	NA
Dangerous behaviors and/or plans	1	2	3	4	NA
Deliberate cruelty to animals or people	1	2	3	4	NA
Sexual abuse of others	1	2	3	4	NA
Changes in sleep (explain below)	1	2	3	4	NA
Changes in toileting (explain below)	1	2	3	4	NA
Daytime soiling or wetting	1	2	3	4	NA
Nighttime bed-wetting	1	2	3	4	NA

If changes, was patient previously fully potty trained					
Changes in weight (explain below)	1	2	3	4	NA
Changes in appetite (explain below)	1	2	3	4	NA
Binge eating	1	2	3	4	NA
Over use of laxatives, diuretics, or diet pills	1	2	3	4	NA
Fasting or strict dieting not prescribed by a physician	1	2	3	4	NA
Persistent concern with body shape/weight	1	2	3	4	NA
Excessive exercise or preoccupation with exercise	1	2	3	4	NA
Fearful of being separated from caregiver (at school, at night, being left with a baby-sitter, etc.)	1	2	3	4	NA
Excessively shy when with unfamiliar people	1	2	3	4	NA
Startles easily	1	2	3	4	NA
Seems on edge	1	2	3	4	NA
Stuck on a traumatic event	1	2	3	4	NA
Nightmares about past events	1	2	3	4	NA
	Frequency				
Preoccupation for cleanliness, excessive hand-washing or peculiar orderliness	1	2	3	4	NA
Habits or rituals that he/she does not appear able to help	1	2	3	4	NA
Has unpleasant thoughts or unnecessary worries	1	2	3	4	NA
Doesn't talk outside the home, limits who he/she will talk to	1	2	3	4	NA
Abnormal movements, jerks or tics of the head, shoulders, mouth, upper or lower body	1	2	3	4	NA

History of frequent coughing, throat clearing, stuttering, or unusual noises	1	2	3	4	NA
Difficulty understanding spoken directions with many steps or long sentences	1	2	3	4	NA
Needs someone to "interpret" what someone else has said	1	2	3	4	NA
Difficulty expressing ideas or feelings, fully answering questions	1	2	3	4	NA
Difficulty following television programs	1	2	3	4	NA
Doesn't understand gestures or facial expressions of others	1	2	3	4	NA
Doesn't make good eye contact	1	2	3	4	NA
Restricted or repetitive patterns of behavior, interests, activities or routines.	1	2	3	4	NA
Difficulty following social rules (when/how to interrupt, taking turns, personal space)	1	2	3	4	NA
Does not play well or interact with children; prefers to play alone.	1	2	3	4	NA
Unusual fascination with objects (not toys)	1	2	3	4	NA
Has abnormally strange ideas	1	2	3	4	NA
Displays bizarre behaviors	1	2	3	4	NA
Has unusual worries or thoughts	1	2	3	4	NA
Speech does not make sense to others (loosely connected ideas, rambling, etc.)	1	2	3	4	NA
Sees or hears things that others do not	1	2	3	4	NA
Fights for control over everything and/or is bossy with other children	1	2	3	4	NA
Hoards food or objects	1	2	3	4	NA

Is destructive of his/her or others' things	1	2	3	4	NA
Is clingy to others	1	2	3	4	NA
Displays indiscriminate affection with strangers	1	2	3	4	NA

Explanation for items above:

Does patient have any current or history of alcohol/drug use? Yes No

If yes, please answer questions below.

Current substance(s) used:

Frequency of Use? Amount

Past substance(s) used:

Frequency of Use? Amount

History of blackouts, overdoses, withdrawal symptoms, or other physical symptoms due to alcohol or drug use?

Yes No

Periods of sobriety (if any):

DEVELOPMENTAL HISTORY

PREGNANCY

Full-term (=40 weeks) Yes No If not, how many weeks?

Any complications? (pregnancy or delivery)

INFANCY AND EARLY CHILDHOOD

Who were the primary caregivers?

Did mother experience
postpartum depression?

Bonding problems?

Sleeping problems?

Feeding problems?

How would you describe patient's early temperament? (happy, tense, easy-going, etc.)

In general, did your child meet developmental milestones:

- Earlier than normal
- Within normal limits
- Somewhat later than normal

Approximate age patient walked Spoke Toilet trained

FAMILY HISTORY

Have any of patient's family members been diagnosed with any medical conditions? If yes, please explain.

Have any of patient's family members been diagnosed with any mental health conditions? If yes, please explain.

Family stressors (check all that apply)

- Marital conflict
- Frequent moves
- Domestic violence
- Multiple caretakers
- Physical illness/medical problems
- Parent/child conflicts
- Sexual/physical abuse

Recent or significant deaths in the family?

HISTORY OF TRAUMA

Please describe any history of trauma (i.e. child abuse, exposure to violence, witnessing a crime, etc.)

Please list any significant losses in the child's life. (Death of family members, pets, friends, etc.)

STRENGTHS AND SUPPORTS

What are patient's strengths?

What are parents' and family's strengths?

What supports are available to patient? (i.e. community group, church, family friends, etc.)

What are some activities and things of interest to patient? (i.e. favorite toys, games, activities, etc.)

Is patient involved in any activities within the community? If yes, what are they and how often does he/she attend? (i.e. soccer, piano lessons, art classes, etc.)

Any additional information that will assist in further assessing and treating patient?

Person Completing Form

Date Completed

Upon completion of this form, please return it to therapist at your next appointment or by mail, email, or fax. Please be aware that any information sent via email or fax is not guaranteed to be completely safe and may be at risk. If responding to an encrypted email sent by therapist, information and messages may be safer than without encryption, but are still not 100% protected.

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