Marni L. Jacob, Ph.D.
New Child Patient Information Form

Patient's Name: ____ Date: _________________________

Person completing this form (name & relationship): ____

Child Age: __________ Child DOB: ______/______/______ Child Sex: ____________Child Race: ___________________

Address: ____ Phone (H): _________________________________

____ Phone (C): _________________________________

____

Who referred you for this evaluation: ____

Briefly describe the reason for your visit: ____

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What are your goals for treatment: ____

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Are there any topics that you would prefer not discussed in front of the child? For example, family history, particular concerns? ____

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Mother's Name: ____

Father's Name: ____

Name/Relationship of other caregivers in the home: ____

Child's Living Situation: ☐

1 = Lives with both biological parents (same residence)
2 = Lives with both biological parents (different residences – shared custody)
3 = Lives with single parent: Mother
4 = Lives with single parent: Father
5 = Lives with Mother and Stepfather
6 = Lives with Father and Stepmother
7 = Lives with Grandparents
8 = Other (specify):________________

Revised 5.5.15

Mother's highest education received ☐ Father's highest education received ☐

1 = Some high school
2 = High school graduate
3 = Obtained GED
4 = Some college
5 = University/College Graduate
6 = Graduate School (MA/MS/PhD/MD/etc)

Mother's Current Occupation: ____

Father's Current Occupation: ____

Names and Ages of Siblings (including adopted/step/half-siblings): ____________________________

____

Number of siblings living with child ☐ Number of siblings living outside of child's home ☐

How well does your child get along with:

siblings	☐ excellent	☐ well	☐ fair	☐ poor	☐ terrible	☐ n/a
parents	☐ excellent	☐ well	☐ fair	☐ poor	☐ terrible	☐ n/a
relatives	☐ excellent	☐ well	☐ fair	☐ poor	☐ terrible	☐ n/a

CHILD DEVELOPMENTAL HISTORY

Was your child born ☐ AT TERM ☐ EARLY ☐ LATE How many weeks/months at birth: ______________

How much did the baby weigh at birth? ___________LBS ________ OZS.

Were there any problems with the pregnancy? ☐ NO ☐ YES

If YES, (specify): ____

Were there any problems/complications during delivery? ☐ NO ☐ YES

If YES, (specify): ____

Were there any problems with the baby after she/he was born? ☐ NO ☐ YES

If YES, (specify): ____

Do you feel that the child's developmental milestones were: ☐ EARLY ☐ LATE ☐ ON TIME

When did the baby start to walk? ____

When did the baby start to talk? ____

Did the child have trouble learning to speak? ☐ NO ☐ YES

Is the child toilet trained? ☐ NO ☐ YES If yes, how old when trained? ____________

Does your child have a history of any significant medical illnesses, surgeries, or hospitalizations? ☐ NO ☐ YES

If YES, (specify): ____

____

Does your child currently have problems with sleep? ☐ NO ☐ YES

If YES, (specify): ____

____

Does your child currently have problems with appetite or exhibited significant recent weight changes? ☐ NO ☐ YES

If YES, (specify): ____

____

Has your child previously participated in therapy for an emotional/psychiatric/behavioral problem? ☐ NO ☐ YES

If YES, please complete the following:

Diagnosis/Purpose of Treatment	Therapist Name, Location	Dates of Treatment	Child Response to Therapy/ Reason for Stopping

Has your child ever been hospitalized for an emotional/psychiatric/behavioral problem? ☐ NO ☐ YES

If YES, please specify: ____

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Has your child previously taken psychiatric medication for an emotional/psychiatric/behavioral problem? ☐ NO ☐ YES

If YES, please complete the following:

Medication and dose	Diagnosis/Reason Prescribed	Prescribing Physician, Location	Dates on Medication	Response / Any side effects?

Does your child have a history of physical, sexual, or emotional abuse, or any significant trauma? ☐ NO ☐ YES

If YES, please specify: ____

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Has anyone in the child's family had a mental, emotional or behavioral problem? ☐ NO ☐ YES

If YES, please fill in the chart below.

Relationship to Child	Father's Side	Mother's Side	Diagnosis

Is your child currently taking any <u>other</u> medications (besides those for psychiatric purposes)? ☐ NO ☐ YES

If YES, please complete the following:

Medication and dose	Diagnosis/Reason Prescribed	Prescribing Physician, Location	Dates on Medication	Response / Any side effects?

SCHOOL INFORMATION

This child attends ☐ PUBLIC school ☐ PRIVATE school ☐ HOME schooled

Current Grade: ________________________ If summer, indicate last grade completed: ______________________

School Name:____

What type of classes does this child attend? ☐ REGULAR ☐ GIFTED ☐ ESE

What marks/grades does he/she earn? ____

Does your child have an IEP? ☐ NO ☐ YES (reason:____)

Does your child have a 504 Plan? ☐ NO ☐ YES (reason:____)

Has your child been held back or skipped a grade? ☐ NO ☐ YES (specify:____________________________________)

Has your child been suspended/expelled from school? ☐ NO ☐ YES (specify:________________________________)

Does your child currently exhibit behavior problems at school? ☐ NO ☐ YES (specify:__________________________)

SOCIAL FUNCTIONING

How many **close** friends does your child have? ☐ None ☐ 1-2 close friends ☐ Several close friends

How well does your child get along with his/her peer group?

☐ excellent ☐ well ☐ fair ☐ poor ☐ terrible ☐ n/a

Do you have concerns about your child's social relationships? ☐ NO ☐ YES

If YES, please specify: ____

____

How often does your child spend time with peers/friends outside of school? ____________________________

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Does your child currently participate in any extracurricular activities/clubs? ☐ NO ☐ YES

If YES, please specify: ____

____

Is your child currently involved in any legal matters? ☐ NO ☐ YES

If YES, (specify): ____

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Is there anything else in particular that is important for me to know? If so, please specify: __________________

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