Solutions
Psychiatric Associates
A MEDICAL CORPORATION

16450 Los Gatos Blvd #112
Los Gatos, CA 95032
PH: 408-402-0450 FAX: 408-402-0950

Child Registration Form

Patient Information

Today's Date: _____

Patient Last Name: _____ **Patient First Name:** _____ **MI:** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____ **Social Security No.** _____-_____-_____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Contact Number: _____ **Email:** _____

School Attended: _____ **Grade:** _____

Referred by: _____

*****ALLERGIES*** **to Medications** (please list all): _____

_____

Parent/Legal Guardian Contact Information

Name of Parents/Legal Guardian: _____

Address of Parent/Legal Guardian: _____

Home phone number of Parents/Legal Guardian: _____

Work number #1: _____ **Cell number #1:** _____

Work number #2: _____ **Cell number #2:** _____

Medical Contact Information

Pediatrician Name: _____

Pediatrician Address: _____

Pediatrician Phone Number: _____
Permission to contact pediatrician (please check one): ____yes ____no

Primary Therapist Name: _____

Therapist Address: _____

Therapist Phone Number: _____
Permission to contact primary therapist (please check one): ____yes ____no

Emergency Contact Information

Emergency Contact Name: _____ **Phone Number:** _____
Relation to patient: _____

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Family Demographics

_____ _____
Name of person completing form Relationship to patient

Parents:

_____ _____
Mother's Name Mother's Occupation

Age: _____ Highest level of education complete: _____

*Any learning problems, attention problems, or behavior problems:
_____

*Any medical problems:
_____

_____ _____
Father's Name Father's Occupation

Age: _____ Highest level of education complete: _____

*Any learning problems, attention problems, or behavior problems:
_____

*Any medical problems:
_____

Please describe current living arrangements. Be sure to include blended family members, whom the child lives with, custody arrangements, etc. If this is a blended family, please provide stepparent demographics.
_____
_____
_____
_____

Siblings:

	Name	Age	Living at home? If not, where?	Medical, social, school problems
1.				
2.				
3.				
4.				

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Developmental History

1. How was your health during pregnancy? _____

2. How old were you when your child was born? _____ 3. Was (s)he born on schedule? _____

4. Do you recall using any of the following substances or medications during your pregnancy?

Substance	Never	1-2 times	3-9 times	10-19 times	20-40 times	40+ times
Beer or Wine						
Hard Liquor						
Coffee/Cokes/Caffeine						
Cigarettes						
Street Drugs (If yes, list)						

5. During pregnancy, did you ingest Valium, tranquilizers, antiseizure medications, antibiotics, sleeping pills, or other prescription medications? ☐ Yes ☐ No *If yes, please list below:

List: _____

6. Did you have toxemia or eclampsia? ☐ Yes ☐ No

7. Was there Rh factor incompatibility? ☐ Yes ☐ No

8. Were there indications of fetal distress during labor or birth? ☐ Yes ☐ No

9. What was the duration of labor? _____

10. What was the child's birth weight? _____

11. Were there health complications following birth? ☐ Yes ☐ No Explain: _____

12. Were there early infancy feeding problems? ☐ Yes ☐ No

13. Was the child colicky? ☐ Yes ☐ No

14. Were there early infancy sleep pattern difficulties? ☐ Yes ☐ No

15. Problems with being alert? ☐ Yes ☐ No

16. Did the child have any congenital problems? ☐ Yes ☐ No

17. Was the child an easy baby? ☐ Yes ☐ No

18. Did the child enjoy cuddling? ☐ Yes ☐ No

19. When (s)he wanted something, how insistent was (s)he? _____

20. How would you rate the activity level of the child as a toddler?

☐ Very active ☐ Active ☐ Average ☐ Less active ☐ Not active

21. Developmental Milestones. Please note the age ranges for each of the following behaviors:

BEHAVIOR	3-6mos	7-12mos	13-18mos	19-24mos	25-36mos	37-48mos
Sit up						
Crawl						
Walk						
Speak single words						
Speak in sentences						
Toilet trained for bladder						
Toilet trained for bowel						

22. Approximately how much time did toilet training take from onset to completion? _____

23. How well did you child deal with transition and change?

_____

_____

Medical History

Please rate each of the medical conditions below:

CONDITION:	Very Good	Good	Fair	Poor	Very Poor
Health					
Hearing					
Vision					
Gross Motor Coordination					
Fine Motor Coordination					
Speech Articulation					

*If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

1. Has (s)he had any chronic health problems (i.e. asthma, diabetes, heart condition)?

_____

_____

2. Operations: _____
3. Hospitalization for illness:

_____

_____

4. Head injuries: _____
5. Convulsions with or without fever: _____
6. Coma: _____ 7. Poisoning: _____
8. Persistent high fevers: _____
9. Loss of consciousness: _____
10. Is there any suspicion of alcohol or drug use? _____
11. Is there a history of physical or sexual abuse? _____
12. Sleep:
    A. Does your child settle down to sleep? _____
    B. Sleep through the night without disruption? _____
    C. Experience nightmares, night terrors, sleep walking, sleep talking? _____
    D. Is your child a very restless sleeper? _____
13. Does your child have bladder control problems? _____
14. Does your child have bowel control problems? _____
15. Does your child have appetite control problems? _____
16. When was your child's last physical examination? _____
17. List all medications your child has taken and/or is taking for non-psychological problems:

_____

_____

Social History

Siblings:

1. How does your child get along with his brothers and sisters? _____

_____

Peers:

2. Does your child seek friendships with peers? _____
3. Is your child sought by peers for friendship? _____
4. Does your child play primarily with children their own age? Younger? Older? _____

_____

5. Describe any problems your child may have with peers: _____

_____

_____

Parents:

6. Check any of the following strategies that have been successful in addressing behavior:

☐ Verbal reprimands ☐ Time Out ☐ Removal of privileges ☐ Rewards

☐ Acquiescence to child ☐ Avoidance of child

7. On the average, what percentage of the time does your child comply with initial commands:

☐ 0-20% ☐ 20-40% ☐ 40-60% ☐60-80% ☐80-100%

8. On the average, what percentage of the time does your child eventually comply with commands:

☐ 0-20% ☐ 20-40% ☐ 40-60% ☐60-80% ☐80-100%

9. To what extent are you and your spouse consistent with respect to disciplinary strategies?

☐ Most of the time ☐ Some of the time ☐ None of the time

Self:

10. What are your child's main interests and hobbies? _____

_____

11. What are some of your child's greatest accomplishments? _____

_____

_____

12. What do you like about your child? _____

_____

_____

_____

School History

1. Please summarize your child's progress (academic, social, testing) within each of the grade levels below:

Preschool: _____

_____

Kindergarten: _____

_____

Grades 1-3: _____

_____

_____

Grades 4-6: _____

_____

_____

Grades 7-9: _____

_____

_____

Grades 10-12: _____

_____

_____

2. Has your child ever been in any type of special educational program? Explain. _____

_____

3. Has your child ever been suspended or expelled from school for reasons of behavior? _____

_____

4. Does your child like school? _____

5. Do teachers like your child or have any problems concerning your child? _____

_____

Treatment History

1. Has your child ever has any of the following forms of treatment?

Type of Treatment	Dates	Duration	Key Personnel
Individual Psychotherapy			
Group Psychotherapy			
Family Therapy			
Hospitalization			
Residential Treatment Ctr.			
Therapeutic Board School			

2. Has your child ever been prescribed any of the following?

Medication	Dates	Duration	Key Personnel
Ritalin			
Cylert			
Dexedrine			
Prozac / Zoloft			
Other antidepressants			
Anticonvulsants			
Antipsychotics			

3. List the names of any and all mental health professionals who have provided treatment. Please include pediatrician or primary care physician.

Name: _____ Degree: _____
Address: _____
Telephone: _____ Type of Practice: _____

Name: _____ Degree: _____
Address: _____
Telephone: _____ Type of Practice: _____

Name: _____ Degree: _____
Address: _____
Telephone: _____ Type of Practice: _____

Behavior Check Lists

1. Problems with concentration (check all that apply)

☐ Fidgets ☐ Difficulty remaining seated ☐ Easily distracted
☐ Difficulty waiting his/her turn ☐ Often blurts our answers to questions ☐ Difficulty playing quietly
☐ Difficulty following instructions ☐ Difficulty sustaining attention from one activity to another
☐ Often talks too much or interrupts ☐ Often does not listen
☐ Often engages in physically dangerous activities.

*At what age did these problems begin? _____

2. Problems with authority (check all that apply)

☐ Often loses temper ☐ Often argues with adults ☐ Is often angry or resentful
☐ Often actively defies or refuses adult requests or rules ☐ Is often spiteful or vindictive
☐ Often deliberately does things that annoy other people ☐ Often blames others for his own mistakes
☐ Is often touchy or easily annoyed by others ☐ Often swears or uses obscene language

*At what age did these problems begin? _____

3. Problems with rules (check all that apply)

☐ Stolen something without confronting anyone ☐ Run away from home, at least twice
☐ Lies often ☐ Has deliberately set fires ☐ Often truant ☐ Has engaged in breaking and entering
☐ Forced someone into sexual activity ☐ Used a weapon in a fight ☐ Often initiates physical fights
☐ Stolen something when it involved confrontation ☐ Physically cruel to people

*At what age did these problems begin? _____

4. Problems being alone (check all that apply)

☐ Shows unrealistic and persistent worry about possible harm to parental figures
☐ Shows unrealistic and persistent worry that a terrible event will separate him/her from his/her parental figures
☐ Persistent refusal to go to school ☐ Persistent refusal to sleep alone
☐ Persistent avoidance to being alone ☐ Repeated nightmares about being separated
☐ Frequent complaints of feeling sick ☐ Excessive distress in anticipation of being separated from parental figures
☐ Excessive distress when separated from home or parent figures

*At what age did these problems begin? _____

5. Problems with anxiety (check all that apply)

☐ Unrealistic worry about future events ☐ Unrealistic concern about competence
☐ Unrealistic concern about appropriateness of past behavior ☐ Marked self-consciousness
☐ Marked inability to relax ☐ Excessive need for reassurance ☐ Frequent complaints of feeling sick

*At what age did these problems begin? _____

6. Problems with depression (check all that apply)

☐ Depressed mood most of the time ☐ Irritable most of the time ☐ Loss of pleasure in normal activities

☐ Decrease/increase in appetite ☐ Weight loss ☐ Sleeps most of the time

☐ Trouble sleeping ☐ Fatigue or loss of energy ☐ Acts either groggy or agitated

☐ Feelings of worthlessness or excessive guilt ☐ Diminished ability to concentrate

☐ Suicidal thoughts or attempts

*At what age did these problems begin? _____

7. Additional problems (check all that apply)

☐ Cuts or burns oneself ☐ Reckless sexual activity ☐ Overreact to being touched

☐ Compulsive rituals ☐ Interested in the occult or Satan ☐ Panic attacks

☐ Explosive temper out of all proportion to triggering event ☐ Unusual fears ☐ Pattern of reckless driving

☐ Pattern of intense and unstable relationships ☐ Extremely dependent or needy

☐ Pattern of reckless spending ☐ Gambles

Family History

Please use the space below and on the last page to document any family history (blood relatives) of mental illnesses, depression, school problems, substance abuse and alcohol problems, psychiatric treatment, suicides, or behavior problems. Please include at least one generation removed.

_____

_____

_____

_____

_____

During the past four weeks, how often has your child:

	Never	Rarely	Occasionally	Frequently	Very Frequently
Had trouble concentrating	0	1	2	3	4
Hurt or torture animals	0	1	2	3	4
Been taken advantage of by others	0	1	2	3	4
Set or threaten to set a fire	0	1	2	3	4
Pulled out his/her hair	0	1	2	3	4
Had hallucinations (report hearing, seeing, etc., things that were not there)	0	1	2	3	4
Gotten startled or acted jumpy	0	1	2	3	4

Failed to complete activities or assignments	0	1	2	3	4
Gotten overly upset if he/she made a mistake	0	1	2	3	4

1. Please state as clearly as possible the problems, which concern you, regarding your child:

2. Additional comments and notes: