

Dear Parent,

Thank you for your interest in bringing your child to see our mental health clinician. In order to get the most out of our initial meeting, we have found it useful to gather some information prior to the appointment.

- Please complete the enclosed form, entitled “Patient and Family History,” and bring it **completed** to the appointment. If it is not completed when you arrive the appointment may have to be rescheduled.
- The initial appointment will last approximately one hour.
- If the child is seeing a therapist and is under the age of 8 years old they **do not** come to the initial visit.
- The child must be accompanied by his/her **legal** guardian.
- If both parents share in raising the child, it is best to have both parents present at the first appointment. If you must bring the child’s sibling(s) to the appointment, please bring an adult to care for these children in the waiting room while you and your child are with the provider.
- Please bring contact information (name, address, telephone number) for your child’s primary care doctor and any other professionals (medical specialists, therapists, counselors, etc.) your child sees regularly. In addition, please bring contact information for your child’s school and the name of his/her primary teacher. Please bring a copy of any pertinent information, including evaluations, from your child’s school.

If it becomes necessary to cancel your initial appointment, please call us as soon as possible. Failure to cancel an initial appointment within 24 hours prior to the appointment may result in dismissal from the clinic.

We accept credit cards (MasterCard, Visa, American Express and Discover Card).

Please call us if you have any further questions prior to the appointment. We look forward to providing mental health care for your child.

Sincerely,

Greensquare Developmental Specialists  
Children’s Medical Group

# Patient and Family History

## Greensquare Developmental Specialists

Please bring completed form to intake. Failure to do so will result in rescheduling.

### I. Patient Information

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Child's Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone: ( ) \_\_\_\_\_ **Child's Social Security Number:** \_\_\_\_\_

Gender Identity: male female transgender male transgender female gender queer

Additional \_\_\_\_\_ patient refused

What sex was assigned at birth \_\_\_\_\_?

Preferred pronouns: She/her/hers He/him/his They/them/theirs Other \_\_\_\_\_

#### Parent Information:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

(Social Security Numbers needed for insurance purposes)

#### Parent Information:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address:  same as above, or:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone: ( ) \_\_\_\_\_

Mobile Telephone: ( ) \_\_\_\_\_

Work Telephone: ( ) \_\_\_\_\_

May we contact at work? no yes

Stepparent's name (if applicable): \_\_\_\_\_

Address:  same as above, or:

Street \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone: ( ) \_\_\_\_\_

Mobile Telephone: ( ) \_\_\_\_\_

Work Telephone: ( ) \_\_\_\_\_

May we contact at work? no yes

Stepparent's name (if applicable): \_\_\_\_\_

Marital status: married single

cohabitation divorced separated

widowed

Number of Marriages: \_\_\_\_\_

Marital status: married single

cohabitation divorced separated

widowed

Number of marriages: \_\_\_\_\_

Name of insurance: \_\_\_\_\_

Insurance address from back of card: \_\_\_\_\_

Provider/Customer service phone number from card: \_\_\_\_\_

Policy/Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Who holds the insurance: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

Your Email Address: \_\_\_\_\_

Ethnicity: Hispanic or Latino \_\_\_\_\_ Not Hispanic or Latino \_\_\_\_\_ Patient refused \_\_\_\_\_ Unknown \_\_\_\_\_  
 Race: American Indian or Alaska native \_\_\_\_\_ Asian \_\_\_\_\_ Black or African American \_\_\_\_\_  
 Native Hawaiian or Pacific Islander \_\_\_\_\_ White \_\_\_\_\_ Other \_\_\_\_\_ Patient refused \_\_\_\_\_  
 Unknown \_\_\_\_\_

Who currently has legal custody of the child? \_\_\_\_\_

Is child in foster care? no yes, list Bureau of Milwaukee Child Welfare case worker name and telephone: \_\_\_\_\_

Is child adopted: no yes, at what age? \_\_\_\_\_

Child's Place of Birth: \_\_\_\_\_ Primary Language Spoken: \_\_\_\_\_

Siblings (please list)

Name	Gender	Age	Current living situation

## II. Developmental History

Did mother experience any illnesses during pregnancy? no yes, explain \_\_\_\_\_

Did mother smoke cigarettes during pregnancy? no yes, amount \_\_\_\_\_

Did mother use alcohol during pregnancy? no yes, amount \_\_\_\_\_

Was the child premature? no yes, age at delivery \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Were there any problems during delivery? no yes: explain \_\_\_\_\_

Please describe the child's early:

Sleep patterns: \_\_\_\_\_

Personality: \_\_\_\_\_

Please give the approximate age at which the child first began to:

Roll over \_\_\_\_\_ Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_

Speak words \_\_\_\_\_ Toilet Train (day) \_\_\_\_\_ Toilet Train (night) \_\_\_\_\_

Difficulties with child's hearing: no yes, explain \_\_\_\_\_

Difficulty with child's vision: no yes, explain \_\_\_\_\_

## III. Mental Health History

Has the child received mental health care?  No (skip to section IV)  yes (please describe):

Current or previous psychiatrist? (Name, address, telephone, dates of treatment) \_\_\_\_\_

Current or previous therapist? (Name, address, telephone, dates of treatment) \_\_\_\_\_

Previous psychiatric hospitalizations? (Where, reason, dates of treatment) \_\_\_\_\_

Please list any *previous psychiatric* medications the child used:

Name	Dose	Frequency	Date started/stopped	Reason for taking	Reason stopped

## IV. Medical History

Child's Current Primary Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone :( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Please list all medications the child is currently taking: Including over the counter meds and nutritional supplements.

<i>Name</i>	<i>Dose</i>	<i>Frequency</i>	<i>Reason</i>	<i>Date started</i>

Please list any allergies the child has (including medications, food, environmental):

<i>Item allergic to</i>	<i>Typical reaction</i>	<i>Standard treatment</i>

Please list any ongoing health problems the child has (e.g., asthma, diabetes, etc.)

<i>Condition</i>	<i>Treatment</i>	<i>First Diagnosed</i>

Has the child ever experienced a seizure? no yes, type \_\_\_\_\_

Has the child ever experienced a head injury (from fall, car accident, sports, etc.) that resulted in loss of consciousness/blackout? no yes, explain \_\_\_\_\_

Has the child ever had surgery? no yes, explain (when, why) \_\_\_\_\_

Has the child ever been hospitalized overnight? no yes, explain (when, why, duration) \_\_\_\_\_

Please list any family member(s) with the following illnesses:

<i>Condition</i>	<i>Child</i>	<i>Mother</i>	<i>Father</i>	<i>Sibling</i>	<i>Grandparent</i>	<i>Other (who)</i>
Allergies						
Sexually Transmitted Disease						
AIDS or HIV						
Neurological Disorders						
Alcohol or Drug Abuse History						
Physical and/or Sexual Abuse History						
Head Injury						
Seizures						
Migraines						
Alzheimer's Disease						
Depression						
Bipolar (Manic-Depression)						
Schizophrenia						
ADHD or ADD						
Obsessive-Compulsive						
Anxiety						
Autism Spectrum Disorder						
Suicide (including attempts)						
Other medical:						

Are the child's immunizations up to date?  yes  no, explain \_\_\_\_\_

### V. Educational History

Child's current school: \_\_\_\_\_ Grade level: \_\_\_\_\_

School address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary teacher's name: \_\_\_\_\_

<i>Level of Schooling</i>	<i>Where, Dates</i>	<i>Any Concerns/Difficulties</i>
Early Education (0-3 services)		
Preschool		
Elementary School		
Middle School		
High School		

Has the child ever received any of the following services? If yes, please describe and give dates:

Tutoring:  no  yes, explain \_\_\_\_\_

Special Education:  no  yes, explain \_\_\_\_\_

Physical Therapy:  no  yes, explain \_\_\_\_\_

Occupational Therapy:  no  yes, explain \_\_\_\_\_

Speech Therapy:  no  yes, explain \_\_\_\_\_

Other: \_\_\_\_\_

Does the child have a history of?

Learning disabilities:  no  yes, explain \_\_\_\_\_

Reading problems:  no  yes, explain \_\_\_\_\_

Mathematics problems:  no  yes, explain \_\_\_\_\_

Speech problems:  no  yes, explain \_\_\_\_\_

Coordination problems:  no  yes, explain \_\_\_\_\_

Please report the parent's educational histories:

Mother's highest level of education: \_\_\_\_\_

Does mother have a history of educational difficulties?  no  yes, explain \_\_\_\_\_

Father's highest level of education: \_\_\_\_\_

Does father have a history of educational difficulties?  no  yes, explain \_\_\_\_\_

### VI. Social History

Is mother currently employed?  no  yes, job \_\_\_\_\_

Is father currently employed?  no  yes, job \_\_\_\_\_

Is stepmother currently employed?  n/a  no  yes, job \_\_\_\_\_

Is stepfather currently employed?  n/a  no  yes, job \_\_\_\_\_

Has child ever worked?  no  yes, job \_\_\_\_\_ hours per week? \_\_\_\_\_

Describe child's social activities: \_\_\_\_\_

How many close friends does child have? \_\_\_\_\_

How much time per week does child spend with friends? \_\_\_\_\_

Please describe child's special skills/hobbies/talents \_\_\_\_\_

What is your religious/spiritual preference, if any? \_\_\_\_\_

How important is your spiritual life for you and your family? \_\_\_\_\_

Please check all that describe your child:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Follows directions  | <input type="checkbox"/> Easy going                                   | <input type="checkbox"/> Has many interests                                       | <input type="checkbox"/> Healthy  |
| <input type="checkbox"/> Does chores   | <input type="checkbox"/> Talks about feelings                         | <input type="checkbox"/> Responsible  | <input type="checkbox"/> Plays Well                                       |
| <input type="checkbox"/> Polite  | <input type="checkbox"/> Cooperative                                  | <input type="checkbox"/> Trustworthy  | <input type="checkbox"/> Energetic  |
| <input type="checkbox"/> Tolerant  | <input type="checkbox"/> Patient                                      | <input type="checkbox"/> Truthful   | <input type="checkbox"/> Sleep Problems                                   |
| <input type="checkbox"/> Fidgets   | <input type="checkbox"/> Marked inability to relax                    | <input type="checkbox"/> Often argues with adults                                 | <input type="checkbox"/> Decrease or increase in appetite                 |
| <input type="checkbox"/> Often loses things  | <input type="checkbox"/> Low self esteem                              | <input type="checkbox"/> Often swears or uses obscene language                    | <input type="checkbox"/> Complaints about body (headaches, stomach aches) |
| <input type="checkbox"/> Often does not listen   | <input type="checkbox"/> Avoidance of being alone                     | <input type="checkbox"/> School refusal   |   |
| <input type="checkbox"/> Easily distracted   | <input type="checkbox"/> Repeated nightmares                          | <input type="checkbox"/> Cruel to animals   |   |
| <input type="checkbox"/> Often talks excessively   | <input type="checkbox"/> Suicidal thoughts or attempts                | <input type="checkbox"/> Outgoing   |   |
| <input type="checkbox"/> Difficulty playing quietly  | <input type="checkbox"/> Worries about future events                  | <input type="checkbox"/> Lies often   |   |
| <input type="checkbox"/> Difficulty following instructions                                     | <input type="checkbox"/> Worries about past behavior                  | <input type="checkbox"/> Runs away from home overnight                            |   |
| <input type="checkbox"/> Difficulty sustaining attention                                       | <input type="checkbox"/> Excessive need for reassurance               | <input type="checkbox"/> Often initiates physical fights                          |   |
| <input type="checkbox"/> Often blurts out answers to questions before they have been completed | <input type="checkbox"/> Is often touchy or easily annoyed by others  | <input type="checkbox"/> Often actively defies or refuses adult requests or rules |   |
| <input type="checkbox"/> Trouble concentrating   | <input type="checkbox"/> Feelings of worthlessness or excessive guilt | <input type="checkbox"/> Often engages in physically dangerous activities         |   |
| <input type="checkbox"/> Shifts from one activity to another                                   | <input type="checkbox"/> Marked self-consciousness                    | <input type="checkbox"/> Is often angry or resentful                              |   |
| <input type="checkbox"/> Often blames others for own mistakes                                  | <input type="checkbox"/> Often loses temper                           | <input type="checkbox"/> Physically cruel to people                               |   |
| <input type="checkbox"/> Poor concentration or difficulty making decisions                     | <input type="checkbox"/> Friendly                                     | <input type="checkbox"/> is often spiteful or vindictive                          |   |
| <input type="checkbox"/> Difficulty remaining seated   | <input type="checkbox"/> Worries about possible harm to others        | <input type="checkbox"/> Has stolen   |   |
| <input type="checkbox"/> Often interrupts or intrudes on others                                | <input type="checkbox"/> Worries about separation from parents        | <input type="checkbox"/> Deliberate fire setting                                  |   |
| <input type="checkbox"/> Often does things that annoy other people                             | <input type="checkbox"/> Interacts with family                        |   |   |

Please describe the nature of the problem(s) for which you and your child are seeking treatment:

What question(s) do you want answered:

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Form completed by: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

*Thank you for completing the form. The provider will review it with you at your initial appointment.*

***For office use only***

*I have reviewed the preceding information with the patient/family.*

*Signature* \_\_\_\_\_ *Date:* \_\_\_\_\_