

NEW MINOR PATIENT INTAKE FORM

Child's Address: Child's Age: Child's Date of Birth: Grade: Teacher Name in School: Form Being Completed By:			t ivallie		
Grade: Teacher Name in School:	Ge				
Form Being Completed By:		nder: □ Male □	Female Current	School:	
Parant Information		Primary	Phone:		Today's Date:
arent inionnation					
Parent 1 Name:		Age:	Primary Pho	one:	
Address (if different from child's):					
Relationship to Child: 🗆 Biological Parent 🗀	Adoptive Parent	☐ Step Parent	☐ Foster Parent	☐ Court Appoint	ed Legal Guardian
Education (last grade finished): Occupa	ation:				
Parent 2 Name:		Age:	Primary Pho	one:	
Address (if different from child's):					
Relationship to Child: 🗆 Biological Parent 🗀	Adoptive Parent	☐ Step Parent	☐ Foster Parent	☐ Court Appoint	ed Legal Guardian
Education (last grade finished): Occupa	ation:				
Marital Status of Child's Parents: ☐ Married (how ☐ Father Re-married (how long?) ☐ Mot☐ One Parent Deceased (how long?) ☐ f divorced, name of custodial parents:	ther Re-married (ho Other	ow long?)	Both Parents		-
Does child have visitation with non-custodial pare					
·	•				
varile and address of non-custodial parent.					
May we request his/her participation in the child's					
Caregiver Information					
	they have health, le	earning or behavio	or issues:		
Caregiver Information		earning or behavio	or issues: With Whom Are	They Living?	Problem (If Any)
Caregiver Information Please list any other children by name and note if	· ·		T	They Living?	Problem (If Any)
Caregiver Information Please list any other children by name and note if	· ·		T	They Living?	Problem (If Any)
Caregiver Information Please list any other children by name and note if	· ·		T	They Living?	Problem (If Any)
Caregiver Information Please list any other children by name and note if First and Last Name	Age Relation	onship to You	With Whom Are	They Living?	Problem (If Any)
Caregiver Information Please list any other children by name and note if First and Last Name Please list any other people living in the home (for	Age Relation	onship to You rent, uncle, fiance	With Whom Are	They Living?	
Caregiver Information Please list any other children by name and note if First and Last Name	Age Relation	onship to You	With Whom Are	They Living?	Problem (If Any) Male or Female
Name and address of non-custodial parent:					

Self-helpindependent xills	Please check your concerns:			
Describe behavior problems in the community: What type of help would you like us to give you and your child? Child's Medical Conditions: Surgery: Date: Serious Illiness: Date: By Whom? Head Injury Date: Beported? Chroic Ear Infections Characterists: Characterists: Characterists: Characterists: Date: By Whom? Chroic Ear Infections Characterists: Characterists	☐ Speech/language ☐ Ability to relate to peers/adults ☐ Does not follow rules ☐ Non-compliance ☐ Aggression/fighting ☐ Rigid/can't adapt to change in scholar Repetitive behaviors (hand flappin Learning (math, reading, writing) ☐ Disorganization ☐ Work completion	ig, rocking)	□ Anxious/worried □ Depressed/sad □ Substance abuse □ Self harm □ Sleep problems □ Eating problems □ Sensory (over or under sensitive) □ Getting along with siblings □ Sexual Activity Other:	Please explain items checked:
What type of help would you like us to give you and your child? Child's Medical Conditions: Serious Illness: Date: Berious Illness: Date: By Whom? Head Injury Number Type Outcome? Namber Head Injury Number Head Injury Head Injury Head Injury Hease explain items checked: Head Injury Head	Describe behavior at school:			
What type of help would you like us to give you and your child? Child's Medical Conditions:	Describe behavior problems in the co	ommunity:		
Child's Medical Conditions:	What has been done to attempt to so	olve these issue	es:	
Surgery:	What type of help would you like us t	o give you and	d your child?	
Serious Illness:	Child's Medical Conditions:			
Serious Illness:	☐ Surgery:	Date:	☐ Abuse	Please explain items checked:
Accident:				
□ Head Injury Date: Reported? Number Type Outcome? □ Chronic Ear Infections □ Abnormal Eating Behavior □ Hearing Difficulty □ Hearing Difficulty □ Eye/Nision Problems □ Eye/Nision Problems □ Eye/Sion Problems □ Eye/Sion Problems □ German measles □ Infectious disease □ High blood pressure/pre-eclampsia/toxemia □ Garette use □ German measles □ Swelling or edema □ Previous miscarriages □ Urine abnormality □ Prescription medication use, please list □ Previous still birth □ Gestational diabetes □ "Blue baby" Please explain items checked: □ Previous still birth Birth Weight: □ "Blue baby" Please explain items checked: □ Previous				
Number Type	☐ Head Injury	Date:	Reported?	
Hearing Difficulty	Number Type			
Eye/Vision Problems			☐ Abnormal Eating Behavior	
Allergies:FoodMedicines Nausea and vomiting _ Anemia _ Alcohol or drug use Infectious disease High blood pressure/pre-eclampsia/toxemia _ Cligarette use German measles Durine abnormality _ Prescription medication use, please list _ Previous miscarriages Urine abnormality _ Prescription medication use, please list _ Previous still birth Gestational diabetes	☐ Hearing Difficulty		☐ Kidney Infection	
Prenature Alachol or drug use Alcohol or drug use Cigarette use Ciga			☐ Eye/Vision Problems	
□ Nausea and vomiting □ Anemia □ Alcohol or drug use □ Infectious disease □ High blood pressure/pre-eclampsia/toxemia □ Cigarette use □ German measles □ Swelling or edema □ Previous miscarriages □ Urine abnormality □ Prescription medication use, please list □ Previous still birth □ Gestational diabetes □ Gestation use, please list □ Previous still birth □ Birth Conditions □ Birth Conditions □ Previous still birth □ Premature □ Jaundice □ Previous still birth □ Premature □ Jaundice □ Previous still birth □ Premature □ Jaundice □ Previous still birth □ Previous still birth	D		☐ Allergies:FoodMedicines	
German measles			T America	□ Alaskalandon o
□ German measles □ Swelling or edema □ Previous miscarriages □ Urine abnormality □ Prescription medication use, please list □ Previous still birth □ Gestational diabetes □ Birth Conditions Birth Conditions Birth Weight: □ "Blue baby" Please explain items checked: □ Gestation age in weeks □ Needed incubator □ Swallowing difficulty □ Baby had trouble breathing □ Home delivery □ Convulsions □ Other □ Developmental Milestones - at what age did your child do the following? Roll over □ Months Potty trained, day □ Months Speak first word □ Months Speak 2 to 3 word sentences □ Months First tooth □ Months Sit without help □ Months Dress him/herself ■ Months Ride a trike ■ Months			—	
□ Urine abnormality □ Prescription medication use, please list □ Previous still birth □ Gestational diabetes □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □				_
Gestational diabetes Birth Conditions			<u> </u>	_
Birth Conditions Birth Weight: "Blue baby" Please explain items checked: Premature Jaundice Gestation age in weeks Needed incubator Swallowing difficulty Gestations Other Other Developmental Milestones - at what age did your child do the following? Roll over Months Potty trained, day Months Please explain: Speak first word Months Speak 2 to 3 word sentences Months Months Sit without help Months Ride a trike Months Ride a trike Months	•		Prescription medication use, please list	Li Frevious still bil til
Birth Weight: "Blue baby" Please explain items checked: Premature Jaundice Jaundice Premature Jaundice Jaundice Jaundice Jaundice Jaundice Jaundice Ja				
□ Premature □ Jaundice _ Gestation age in weeks □ Needed incubator □ Long labor □ Swallowing difficulty □ Baby had trouble breathing □ Home delivery □ Convulsions □ Other			——————————————————————————————————————	Diagon applein Marcon de adead
Gestation age in weeks			*	Please explain items checked:
□ Long labor □ Swallowing difficulty □ Baby had trouble breathing □ Other □ Other □ Developmental Milestones - at what age did your child do the following? Roll over □ Months Potty trained, day □ Months Please explain: □ Other □ Months Potty trained, night □ Months First tooth □ Months Speak 2 to 3 word sentences □ Months Dress him/herself □ Months Ride a trike □ Months Ride a trike □ Months				
□ Baby had trouble breathing □ Home delivery □ Convulsions □ Other Developmental Milestones - at what age did your child do the following? Roll over Months Potty trained, day Months Speak first word Months Potty trained, night Months First tooth Months Speak 2 to 3 word sentences Months Dress him/herself Months Sit without help Months Ride a trike Months				
Developmental Milestones - at what age did your child do the following? Roll over Months	3			
Developmental Milestones - at what age did your child do the following? Roll over Months				
Roll over Months				
Speak first word Months		age did your cl	_	21
First tooth Months				Please explain:
Dress him/herself Months Sit without help Months				
Ride a trike Months				
	Diess nim/nerseii Months			
Patient Signature:			nide a tilke MOIItils	
Patient Signature: Date:				
Patient Signature: Date:				
Patient Signature: Date:				
Patient Signature: Date:				
Patient Signature: Date:				
Patient Signature: Date:				
	Patient Signature:			Date:

Name of DHS worker (if applicable) Name of Juvenile Court Officer (if applicable) Name of Guardian Ad-Litem (if applicable) Name of other Agency (if applicable) Therapist, Counselor or Physician (if applicable) Any other persons/agencies that may provide	Primary Care Physician Name of DHS worker (if applicable) Name of Guardian Ad-Litem (if applicable) Name of Guardian Ad-Litem (if applicable) Name of other Agency (if applicable) Threapist, Counselor or Physician (if applicable) Any other persona/agencies that may provide valuable information concerning the child	r (if applicable) ourt Officer (if applicable) d-Litem (if applicable) cy (if applicable) r or Physician gencies that may provide		Name	Address	Email	Phone
Name of Juvenile Court Officer (if applicable) Name of Guardian Ad-Litem (if applicable) Name of other Agency (if applicable) Therapist, Counselor or Physician (if applicable) Any other persons/agencies that may provide	Name of Juvenile Court Officer (if applicable) Name of Guardian Ad-Litem (if applicable) Name of other Agency (if applicable) Therapist, Counselor or Physician (if applicable) Any other persons/agencies that may provide	ourt Officer (if applicable) d-Litem (if applicable) cy (if applicable) r or Physician gencies that may provide	rimary Care Physician				
Name of Guardian Ad-Litem (if applicable) Name of other Agency (if applicable) Therapist, Counselor or Physician (if applicable) Any other persons/agencies that may provide	Name of Guardian Ad-Litem (if applicable) Name of other Agency (if applicable) Therapist, Counselor or Physician (if applicable) Any other persons/agencies that may provide	d-Litem (if applicable) cy (if applicable) r or Physician gencies that may provide	lame of DHS worker (if applicable)				
Name of other Agency (if applicable) Therapist, Counselor or Physician (if applicable) Any other persons/agencies that may provide	Name of other Agency (if applicable) Therapist, Counselor or Physician (if applicable) Any other persons/agencies that may provide	cy (if applicable) r or Physician gencies that may provide	Name of Juvenile Court Officer (if applicable)				
Therapist, Counselor or Physician if applicable) Any other persons/agencies that may provide	Therapist, Counselor or Physician if applicable) Any other persons/agencies that may provide	r or Physician gencies that may provide	lame of Guardian Ad-Litem (if applicable)				
if applicable) Any other persons/agencies that may provide	if applicable) Any other persons/agencies that may provide	gencies that may provide	lame of other Agency (if applicable)				
Any other persons/agencies that may provide	Any other persons/agencies that may provide	gencies that may provide in concerning the child	herapist, Counselor or Physician				
valuable information concerning the child	valuable information concerning the child	n concerning the child	Any other persons/agencies that may provide				
			aluable information concerning the child				