Upcounty Neuropsychology, LLC

NEW CHILD PATIENT PACKET

Patient's Name (incl. nickname)		Patient DOB	Today's Date
Patient's Age	Current Grade	Patient's Sex	Patient's Race
Address		Patient's SSN (required)	
Parent E-mail			

Mother/Legal Guardian Name	Father/Legal Guardian Name
Mobile Phone	Mobile Phone
Home Phone	Home Phone
Work Phone	Work Phone
Address (if different from patient)	Address (if different from patient)
Employer	Employer
DOB	DOB
Marital Status	Marital Status

Financially Responsible Parties (Guarantors)

Primary Guarantor	Relationship to Patient	SSN (required)
Secondary Guarantor	Relationship to Patient	SSN (required)

Insurance Information

Policy Holder's Name	
Primary Insurance	
Policy/Identification Number	
Group Number	Insurance Telephone Number

Reason for Seeking Mental Health Services (check all that apply):

_____ Behavioral Problems

_____ Attention or Hyperactivity Problems

_____ Anxiety

_____ Suicidal Thoughts

_____ Autism

_____ Neuro/psychological Testing

_____ Depression

_____ Other

Who Referred You:

_____ Pediatrician _____

_____ Hospital / Emergency Department _____

_____ Specialist _____

_____ School _____

_____ Other _____

History of Problems:

(1) What are the biggest problems that you and/or your child are experiencing?

(2) How long has your child had these problems?

(3) What do you hope to learn from the evaluation?

(4) Has your child ever received mental health, psychological, or psychiatric services before?

(5) Has your child ever received medication for a psychiatric, emotional, or behavioral condition? If yes, please list.

(6) Is your family under any unusual stress (such as illnesses, accidents, deaths, moves, conflict at home, separation, divorce, or finances) at this time?

Home

Please provide the names, ages, and relationships of all those persons who are living with you and the patient:

Name:	Age:	Relationship:
(1)		
(2)		
(3)		
(4)		
(5)		

Briefly describe childcare arrangements from birth to present:

School

(1) Name of current school: _____

(2) Does your child attend any special education classes or receive any special education services?

(3) Does your child have any problems in school? If yes, please describe.

(4) Has your child ever repeated a grade or been “held back” for any reason?

(5) Does your child make friends easily?

(6) Does your child have a best friend?

Medical Information

Child's Physician	Phone	Address
Child's Psychiatrist	Phone	Address

(1) Date of last physical examination _____

(2) Does your child take any medication (including vitamins and over-the-counter meds)?

Medication:	Dosage:	Frequency:	Date Began

(3) Current and past health problems:

(4) Has your child ever been hospitalized? If yes, for what reason? When and where?

(5) Is there any history of psychiatric, emotional, behavioral, learning, or alcohol/substance abuse problems in your family?

(6) Has your child ever had any of the following medical problems?

Accidents	Y or N	Birth Defects	Y or N
Anemia	Y or N	Poisoning	Y or N
Asthma	Y or N	Problems Eating	Y or N
Bowel Problems	Y or N	Problems Seeing/Hearing	Y or N
Convulsions	Y or N	Problems Speaking	Y or N
Chronic Illness	Y or N	Skin Problems	Y or N
Head Injury	Y or N	Headaches	Y or N
Other (please specify)	Y or N	_____	

_____

Pregnancy

(1) During the pregnancy with this child, did the mother experience any medical or mental health problems? If yes, please describe.

(2) How many weeks did the pregnancy last? _____

(3) Were there any complications during labor or delivery? If yes, please describe.

(4) Baby's weight: _____ pounds _____ounces

(5) Baby's length: _____ pounds _____ounces

(6) APGAR scores, if known: At Birth _____ At 5 minutes _____

(7) Number of days baby stayed in the hospital after birth: _____

Development

Child's approximate age when s/he began:

Walking _____ (months)

Talking (single words) _____ (months)

Talking (short sentences – 2+ words) _____ (years)

Toilet Training: Daytime _____ (years) Nighttime _____ (years)

Does your child have wetting accidents during the day? _____ At night? _____

Does your child have soiling accidents during the day? _____ At night? _____

Other

Is there any other information that might assist us in understanding your child?