

MIND MATTERS

Patient Information Registration

PATIENT:

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____

MAILING ADDRESS: _____ ZIP: _____

PLACE OF BIRTH: _____ SEX: _____ MARITAL STATUS _____

SS #: _____ DRIVERS LICENSE: _____

TELEPHONE: _____ CELL PHONE: _____

RESPONSIBLE GUARDIAN (IF CHILD): _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

GUARANTOR/SPOUSE/PARENT:

NAME: _____ RELATIONSHIP _____

ADDRESS: _____ CITY: _____ STATE: _____

MAILING ADDRESS (if different) _____ ZIP: _____

DOB: _____ SEX: _____ MARITAL STATUS: _____

SS#: _____ DRIVERS LICENSE#: _____

TELEPHONE: _____ CELL PHONE: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT: _____ PHONE: _____ CELL #: _____

INSURANCE INFORMATION:

CARRIER & ADDRESS: _____

PRIMARY INSURED: _____

GROUP NAME: _____ GROUP NUMBER: _____

POLICY/CERTIFICATE NUMBER: _____ PLAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SECONDARY COVERAGE: _____

PRIMARY INSURED: _____

GROUP NAME: _____ GROUP NUMBER: _____

POLICY/CERTIFICATE NUMBER: _____ PLAN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

REFERRED BY: _____ FAMILY PHYSICIAN: _____

SIGNATURE: _____ DATE: _____

MIND MATTERS

150 Big Trees Rd
Suite A
Murphys, CA 95247
(209) 728-2184

INTAKE EVALUATION QUESTIONNAIRE

Patient Identification

Name _____ First Appointment Date _____
Date of Birth _____ Age ____ Sex ____ Grade ____
Address _____ Social Security # _____
City _____ School _____
Home Phone _____ Current Teacher _____
Religion _____ Cell Phone _____
Email Address _____

Parent/Guardians:

Mother _____ Social Security # _____
Daytime phone _____ Cell _____
Father _____ Social Security # _____
Daytime phone _____ Cell _____

Emergency Contact _____ Phone _____
Relationship to patient _____

Referral Source

Referred/recommended by _____

Do we have permission to release information to the referring professional when appropriate? Yes ____ No ____

Do we have permission to contact the child's teacher to gather information?
Yes ____ No ____

If referred to another professional, may we share this information? Yes ____ No ____

Signature of Responsible Person _____ Date _____

Purpose Of Consultation

Please give a brief summary of your concerns:

Has the patient ever been evaluated and/or treated in the past for a similar condition or concern? If so, please provide details of treating professional, diagnosis and prior therapies.

MEDICAL HISTORY

Are there any current medical problems?

Current medications? _____

Any supplements or vitamins? _____

Any hospitalizations? _____ For what conditions? _____

Other doctors seen regularly? _____

Any allergies to medications? _____

Have any of the following occurred?

Head injuries _____ Seizures/convulsions _____

Thyroid disorders _____ Asthma/eczema _____

Ear infections _____ Hayfever _____

Pneumonia _____ Heart Disease _____

Liver problems _____ Kidney disease _____

Anemia _____ Growth Delays _____

Bowel Problems (constipation, diarrhea, abdominal pain, abnormal stools?) _____

Abnormalities on any blood tests, X-rays, EEG, brain scans, nutritional studies, etc.:

FAMILY HISTORY

Family Structure(who lives in the household with the child, please give relationships to the child) _____

Family Development (please include divorces, separations, deaths, traumatic events, etc.)

Is there significant marital stress or other family stresses present in the household?

Explain: _____

Natural Mother's History:

Age _____ Outside employment? _____

Highest grade completed _____

Any learning or reading difficulties? _____

Any behavioral problems as a child? _____

Marriages _____

Medical Problems? _____

Childhood atmosphere (nurturing, abuse, chronic illnesses, major stresses) _____

Has natural mother ever sought psychiatric treatment? _____

Natural mother's alcohol/drug use history: _____

Have any of the mother's family members or relatives had any of the following: alcohol or drug abuse, depression, ADHD, anxiety, autism spectrum disorders, obsessive compulsive disorder, nervous breakdowns, or dyslexia?

Natural Father's History:

Age _____ Outside employment? _____

Highest grade completed _____

Any learning or reading difficulties? _____

Any behavior problems as a child? _____

Marriages _____

Medical Problems? _____

Childhood atmosphere (nurturing, abuse, chronic illnesses, major stresses) _____

Has natural father ever sought psychiatric treatment? _____

Natural father's alcohol/drug abuse history _____

Have any of the family members or relatives had any of the following: alcohol or drug abuse, depression, ADHD, autism spectrum disorders, anxiety, obsessive compulsive disorder, nervous breakdowns or dyslexia? _____

Step or Adoptive Mother's History:

Age _____ Outside employment _____

Highest grade completed _____

Any learning difficulties? _____

Any behavior problems as a child? _____

Marriages _____

Medical Problems? _____

Childhood atmosphere (nurturing, abuse, chronic illnesses, major stresses) _____

Has adoptive/step mother ever sought psychiatric care? _____

Adoptive/step mother's alcohol or drug use history _____

Age of adoption or custody of the child _____

Step or Adoptive Father's History

Age _____ Outside employment _____

Highest grade completed _____

Marriages _____

Medical Problems _____

Childhood atmosphere (nurturing, abuse, chronic illnesses, major stresses) _____

Has the step/adoptive father ever sought psychiatric treatment? _____

Step/adoptive father's alcohol or drug use history _____

Age of adoption or custody of the child _____

Siblings

Names, ages, relationships, any significant problems or particular strengths:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Family Stresses

Please describe any family stresses that may have occurred or are occurring now: _____

Developmental History

Prenatal History:

Pregnancy planned or unplanned _____ Was there prenatal care? _____

Any significant prenatal problems such as:

1) Bleeding _____ 2) Excessive vomiting _____

3) Hospitalizations _____

4) Drug or alcohol use _____

5) Smoking _____ 6) Diabetes _____

7) Serious infections _____ 8) Anemia _____ 9) Trauma _____

Birth History:

Premature/on-time or late? _____ Type of delivery _____

Birth weight _____ Birth Length _____ APGAR Score _____

Jaundice _____ Breathing difficulties _____

Length of hospital stay _____ Any complications? _____

Any infections? _____

Primary caretaker(s) for first five years of life _____

Any significant separations from parents --age, durations, circumstances, etc. :

Sleep Behaviors:

Any of the following:

Sleep terrors _____ Frequent nightmares _____

Trouble falling or staying asleep _____

Difficulty getting up in the morning _____

Difficulty sleeping in their own bed _____

Bedtime rituals _____

Motor Development:

If known, please give the approximate age at which the child did the following:

Rolled over _____ Sat without support _____ Walked _____

Rode a bike _____ Threw a ball overhand _____

Compared to his/her peers:

Does he/she seem to be well coordinated? _____

Does he/she run/catch a ball well? _____

Does he/she do well in games or sports? _____

Does he/she do well in activities that require fine hand coordination? _____

How is his/her handwriting? (if applicable) _____

Are there sports or games in which he/she excels? _____

Any prior physical or occupational therapy evaluations? _____

Language Development:

When did he/she first say "dada/mama"? _____ Other words? _____

Sentences? _____

Is his/her speech generally clear? _____

Was speech ever thought to be delayed? _____

Was there ever a time when speech ability seemed to get worse? _____

Does he/she seem to have odd speech either in content or the way it is said? Give examples: _____

Does he/she seem to understand what is spoken? _____

Does he/she seem to retain what is said? _____

Any difficulties in conversing? _____

Any prior speech therapy evaluations? _____

Social Development:

Quality of attachment to: Mother _____ Father _____

Is he/she shy with strangers? _____ Is there good eye contact? _____

In early childhood, did he/she play well with others? _____

Does he/she make/keep friends easily? _____

Does he/she play well with others now? _____

Relationship with family members _____

Favorite activities or hobbies _____

Any peculiar or intense interests? _____

Any repetitive sounds or physical movements that seem odd? _____

Behavior and Discipline:

Is he/she compliant or non-compliant? _____

Defiant? _____ Talking back? _____

Knowingly breaks rules? _____ Lying? _____

Methods of discipline(time out, take away privileges, star chart, etc.) _____

Does he/she seem to respond to discipline well? _____

Any fears or phobias? _____

Any habits? _____

Is he/she able to express his/her feelings well? _____

How is his/her mood generally? _____

Has he/she ever been physically, sexually, or emotionally abused? _____

Any drug or alcohol use? (if applicable) _____

School History:

Current grade _____ School _____

Teacher _____

Average grades _____

Specific learning difficulties? _____

Has an IEP ever been done? When? Where? _____

Is homework a problem? _____

Learning strengths _____

Learning weaknesses _____

Has a classroom teacher expressed concerns? Be specific _____

Overall Strengths of Child:

Questions?

Do you have any specific questions answered that may not otherwise be addressed? _____

Additional Information:

In addition to the Intake Evaluation Questionnaire, please complete or obtain the following for the evaluation process if possible:

Any prior medical evaluation or consultation materials regarding this concern

A sample of the child's handwriting

Any IEP or Child Study Team testing and recommendations from the school

Any prior blood test, X-ray, or brain scan results

Copies of school report cards

Any prior speech therapy, occupational therapy or psychological evaluations