

# New Perspectives

PATIENT UNDER 18

A Counseling and Consultation Group

## REGISTRATION FORM

<b>CLIENT INFORMATION</b>									
Name					Referred to New Perspectives by:				
Street									
City				State			Zip		
Phone (H) ( )			(W) ( )			Other ( )			
Date of Birth			Gender (circle) M F		SSN				
Marital Status (Check box to right)		<b>Single</b>		<b>Married</b>		<b>Divorced</b>		<b>Other</b>	
Relationship to Policyholder		<b>Self</b>		<b>Spouse</b>		<b>Child</b>		<b>Other</b>	
Employment Status		<b>Full Time</b>		<b>Part Time</b>		<b>Unemployed</b>			
School Status		<b>Full Time</b>		<b>Part Time</b>		<b>Does not attend school</b>			
Is treatment related to		<b>Employment</b>		<b>Auto Accident</b>		<b>Other Accident</b>		<b>None of these</b>	
<b>POLICYHOLDER/INSURANCE INFORMATION</b>									
<i>If secondary coverage is available, please request additional insurance form</i>									
Name					Member ID No.			Grp. No.	
Street						SSN			
City				State			Zip		
Phone (H) ( )				(W) ( )			Other ( )		
Date of Birth			Gender (circle) M F		Authorization No.				
Insurance Company						Phone ( )			
Street				City			State		Zip
Employer									
<b>FOR OFFICE USE ONLY</b>									
Intake Date				Therapist		Referral		Code	
Client Amount/Copay 1st Visit				Primary Dx					
Client Amount/Copay 2nd Visit				Other Payment Information					
Benefits				Deductible		Amt. Met		Visits/Year	
Utilization Review						Max \$/Yr.		Verified	

AD = Advertising ATTY = Attorney EAP = Employee Assistance Program CL = Clergy GW = Good Work MC = Managed Care  
MD = Physician MISC = Miscellaneous OT = Other Therapist SCH = School

*In order for us to bill your insurance company we must have complete information about your insurance. If there is some information that you do not have available at this time, please call it in to the office as soon as possible. If we are lacking information, we are unable to bill your insurance company. You will be held financially responsible for all charges incurred.*

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(410)751-9205 / Fax: (410)751-6191

McDonogh Crossroads  
6 Park Center Court / Suite 103  
Owings Mills, Maryland / 21117

Hunter Professional Centre  
904-A Washington Road  
Westminster / Maryland / 21157



## Child History Questionnaire

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

Home Address \_\_\_\_\_

School \_\_\_\_\_ Phone \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

School Address \_\_\_\_\_

**Pediatrician** \_\_\_\_\_

Pediatrician's Address \_\_\_\_\_

Phone: \_\_\_\_\_ Fax Number \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mother's Address \_\_\_\_\_

Mother's Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

School level completed \_\_\_\_\_ Occupation \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Date of Birth \_\_\_\_\_

Father's Address \_\_\_\_\_

Father's Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

School level completed \_\_\_\_\_ Occupation \_\_\_\_\_

**Status of Parent's Marriage:**

Married     Separated     Divorced     Widowed     Single

How long married? \_\_\_\_\_ How long divorced? \_\_\_\_\_ Child's age at divorce \_\_\_\_\_

If parents are divorced, separated, or single who has legal custody of the child?

Mother     Father     Mother and Father     Other \_\_\_\_\_

I, \_\_\_\_\_ give my consent to have my child, \_\_\_\_\_  
*(Custodial Parent)* *(Name of Child)*

**seen for evaluation and/or treatment at New Perspectives.**

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Therapist \_\_\_\_\_ Date \_\_\_\_\_

Other Family Members	Relationship	Date of Birth

A. Please list the problems with which you want help for this child:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

B. What have you said to the child about this appointment? \_\_\_\_\_

C. Whose idea was it that this child have this appointment? \_\_\_\_\_

D. Has this child had any previous evaluations besides routine standardized school testing, such as a psychological evaluation, speech evaluation, occupational evaluation or psychiatric evaluation?

If so where and when? Please attach copies of any available reports. \_\_\_\_\_

E. Has this child received any special treatments (psychological counseling, psychiatric help, speech therapy, diets?) If so, please describe, including the approximate dates and the names of the therapists:

F. Medications currently being taken by child \_\_\_\_\_

G. Has this child been retained in a grade?  Yes  No If so, what grade? \_\_\_\_\_

H. Does this child receive any special education services and if so, what types of services? \_\_\_\_\_

I. Please circle all personality and behavior traits that currently apply to your child.

- |         |             |             |            |                |               |
|---------|-------------|-------------|------------|----------------|---------------|
| Sad     | Happy       | Leader      | Follower   | Moody          | Friendly      |
| Quiet   | Overactive  | Independent | Dependent  | Sensitive      | Affectionate  |
| Fearful | Cooperative | Tantrums    | Lethargic  | Sleep Problems | Oppositional  |
| Loner   | Social      | Anxious     | Compulsive | Forgetful      | Even Tempered |

Please feel free to elaborate on any of these traits, or any other characteristics that you are concerned about:

J. Please describe this child's strengths and interests: \_\_\_\_\_

K. Family History - Following is a list of problems that sometimes run in families. Please indicate if the child's mother, father, brother, sister, or other relative (aunt, uncle, grandparent, or cousin) has had any problems in these areas:

1. Hyperactive as child \_\_\_\_\_
2. Trouble learning to read \_\_\_\_\_
3. Trouble learning to write \_\_\_\_\_
4. Trouble in arithmetic \_\_\_\_\_
5. Behavior Problems in elementary school \_\_\_\_\_
6. Behavior problems as a teenager \_\_\_\_\_
7. Kept back in school \_\_\_\_\_
8. Legal problems \_\_\_\_\_
9. Drug/Alcohol problems \_\_\_\_\_

10. Mental health concerns \_\_\_\_\_
11. Hospitalizations due to mental health or substance abuse \_\_\_\_\_
12. Other (please describe) \_\_\_\_\_

**BIRTH AND DEVELOPMENTAL HISTORY**

**Pregnancy**

Length in months \_\_\_\_\_ Any illness/complications during pregnancy? \_\_\_\_\_

Medications taken by mother during pregnancy? \_\_\_\_\_

Substances used during pregnancy? \_\_\_\_\_

Cigarettes      How many? \_\_\_\_\_

Alcohol      How many drinks? \_\_\_\_\_

Drugs      Please describe type(s) of drug and frequency of use: \_\_\_\_\_

Was the father taking any medications or drugs at the time of conception? If so, what? \_\_\_\_\_

Did mother or baby stay in Special or Intensive Care?  Yes  No If yes, please explain \_\_\_\_\_

Was the birth of the child "normal" or were there any complications? \_\_\_\_\_

**Ages at Milestones**

Gross motor:	Crawled _____	Fine Motor:	Fed self with spoon _____
	Walked alone _____		Scribbled _____
	Ran Well _____		Tied shoes _____
	Sat by self _____		

Language:	Single words _____
	Used sentences (2 + words) _____
	Spoke clearly _____

Potty trained:	Urine during day _____	Urine during night _____
	Bowels during day _____	Bowels during night _____

Rate of development overall:       Slow     Normal     Fast

**Medical Issues**

Hospitalizations \_\_\_\_\_

Chronic Medical Conditions (i.e. asthma, ear infections) \_\_\_\_\_

Current Medical Concerns \_\_\_\_\_

**Signature of Person Completing Form** \_\_\_\_\_

Relationship to child \_\_\_\_\_ Date \_\_\_\_\_