HEALTH GROUP PSYCHOLOGICAL SERVICES, INC.
NEW PATIENT REGISTRATION FORM
CHILD/ADOLESCENT

Welcome to Health Group Psychological Services. We look forward to helping you reach your treatment goals. This form is specifically for those seeking care for a child or adolescent, and requests information about your family as it may be helpful to us in understanding your child's needs as well as providing information to you concerning how your care will be addressed. Please take a few moments to complete this form. These questions are designed to help us meet your treatment needs. Your child's medical history and physical health is important as some psychological or behavioral difficulties are linked to physical problems. Your provider will answer any questions.

Parents or guardians should complete this form.

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Home Phone :_____(ok to call? YES NO) Age: _____ Gender: ___Female ___Male

Parent Cell #:_____(ok to call? YES NO) Patients SSN# :_____

Address_____ City_____ State_____ Zip_____

School Currently Attending_____ Grade_____ Teacher_____

Full time student ? YES NO

If parents are divorced, is **legal** custody: ___ Joint ____ Sole If sole, whom? _____

Primary Care Physician_____ Phone # _____

Emergency Contact:_____ Phone # _____

Primary Insurance Information	Secondary Insurance Information
Medical Plan Name_____	Medical Plan Name_____
Insured Name_____	Insured Name_____
Insured Birth Date_____	Insured Birth Date_____
Insured SSN_____	Insured SSN_____
Member ID_____	Member ID_____
Group # _____	Group # _____
Employer_____	Employer_____
Payor / Health Plan_____	Payor / Health Plan_____
Insured relationship to patient ____parent _____step parent ____guardian	Insured relationship to patient ___parent ____step parent ___guardian

Please describe your reason for seeking treatment for your child at this time (include date/month/year the problem started):_____

_____

Was there an event which made these issues or problems surface? ___YES ___NO If yes, please describe:

_____

_____

What goals do you expect to achieve from treatment?

_____

_____

Please indicate and rate the severity (1-4) of the following issues you would like to address in your child's treatment

NONE 1	MILD 2	MODERATE 3	SEVERE 4
_____Depression	_____Lack of Friends	____Divorce/Separation Issues	
_____Anxiety	_____Loneliness	____Sexuality/Sexual Issues	
_____Controlling stress	_____Problems Coping	____Family/Stepfamily conflict	
_____Loss of a loved one	_____Abuse/Victimization	____Behavioral problems	
_____Problems at school	_____Financial problems	____Eliminating Drug/ Alcohol Problems	
_____Problem w/ friends	_____Legal matters	____Eliminating another habit (i.e. overeating,	
_____other_____	_____Lying	Stealing, ect.)	
		____Obsessive/compulsive symptoms	

Please indicate how the issue(s) for which you are seeking treatment affect the following areas of your child's life:

	No effect	Little effect	Some effect	Much effect	Significant effect	N/A
Family	1	2	3	4	5	N/A
School behavior	1	2	3	4	5	N/A
Home behavior	1	2	3	4	5	N/A
Grades	1	2	3	4	5	N/A
Friendship	1	2	3	4	5	N/A
Family finances	1	2	3	4	5	N/A
Physical health	1	2	3	4	5	N/A
Anxiety level/nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
Sleeping habits	1	2	3	4	5	N/A
Sexual issues	1	2	3	4	5	N/A
Concentration/attention	1	2	3	4	5	N/A
Anger management	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A

PERSONAL MEDICAL HISTORY

Does your child have any allergies to food/ medications? YES NO If yes, please describe

_____

Please list any prescription and over the counter medication your child currently or frequently uses: (include name and dosage)_____

Please list hospitalizations, medical/surgical illnesses (include hospital name, dates, illness/procedure)_____

_____

When was you child's last physical examination done? (include date, M.D. and findings)_____

_____

Is your child being treated for any medical condition? If yes, please list: _____

_____

Does your child complain of the following? (circle all that apply)

Double or poor vision	unusual excessive thirst	cessation of menses	bedwetting
Difficulty hearing	indigestion, gas, heartburn	irregular menses	soiling
Fainting	stomach pain	chest pain	nightmares
Blackouts	diarrhea or constipation	shortness of breath	night terrors
Convulsions	vomiting/ vomiting blood	palpitations/heart fluttering	pregnancy
Paralysis	blood in stool	swelling of hands/feet	
Dizziness	change in appetite or eating habits	joint pain	
Headaches	trouble sleeping	problem with memory/concentration	
Thyroid problem	pain of genitals	lumps on body:_____	
Coughing/wheezing	weight loss/gain # lbs_____		

For any of the above circled items, please describe: _____

_____

To your knowledge, has your child ever used drugs or alcohol? ____Yes ____No

Substance	Amount	Frequency	Last Taken

Does you child have a history of blackouts, seizures, or withdrawal symptoms? ____Yes ____No

If yes, please describe_____

Has your child ever received mental health or substance abuse treatment? _____Yes ____No

Inpatient/ outpatient	Provider Name	First seen	Last seen	Medication/ dosage

LIFESTYLE/ HABITS

	Amount currently using	Most ever used
Caffeinated soft drinks	_____	_____
Cigarettes (pack/day)	_____	_____
Alcohol (Drinks/day)	_____	_____

	Type(s)	Frequency
Exercise	_____	_____
Hobbies	_____	_____
Hrs/ week Spent at work	_____	_____
Hrs/ week Spent on school work	_____	_____

FAMILY MEDICAL HISTORY

A. Has anyone in your family had a serious medical illness?_____

B. Has any one in your family had a psychiatric (nervous or mental) illness?_____

C. If so, what type of treatment, if any, did they receive?_____

D. Has anyone in your family had a substance abuse problem?_____

E. Were there any maternal illness during pregnancy?_____

F. Medications taken during pregnancy?_____

G. Drugs or alcohol taken during pregnancy?_____

H. Was pregnancy full term?_____ Birth weight?_____

I. Did you child exhibit excessive colic during infancy?_____

J. Has a family member been diagnosed with Attention Deficit Disorder? _____

K. Date of most recent hearing test? _____Vision test _____Results _____

L. Death of family members or friends?_____

DEVELOPMENTAL AND SCHOOL HISTORY

A. At what approximate age did you child: Walk_____ Talk _____

B. Did your child exhibit behavioral or emotional problems at preschool ages? _____

C Does your child express any specific fears?_____

D. History of molestation or abuse?_____

E. How many schools has your child attended?_____

F. How many hours of sleep does your child typically get?_____ Usual bedtime_____ Usual rising tine_____

G. Do you consider you child's appetite normal?_____

H. Does you child have any unusual dietary habits?_____

I. Average grades in elementary school?_____ Avg. in middle school?_____ High school_____

J. # of absences from school for illness per month?_____ Tardies per month_____ Discipline referrals_____

K. Did your child exhibit problems moving from kindergarten to first grade?_____ elementary to Jr high?_____

L. Has your child been in special education classes? _____ Which grade?_____ Presently?_____

M. Is your child involved in after school activities?_____

N. How much time does you child spend on homework on an average night?_____

O. Have you noticed any major changes in the past two years in behavior or attitude?_____

P. Does you child have extreme (beyond normal) conflict with one or more siblings?_____

Q. Has your child ever been arrested?_____ Been on probation? _____Lived away from home?_____

R. Has you child shop lifted? _____ Destroyed property? _____ Hit/ Attacked others? _____

S. What is your child's usual feeling about school? Likes_____ Dislikes_____

FAMILY MEMBERS

Please list all members of your household, age and relationship to your child

_____

_____

_____