THE MINDSET CENTER

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New Patient Registration Form

(Minor Clients Under Age 18)

Name of Minor Client:________________________________

Nickname?___________________________

Address:				
Street:	**City**		**State**	**Zip**
Phone: (H)		**Ok to Leave Message?**	**YES**	**NO**
(C)		**Ok to Leave Message?**	**YES**	**NO**
(Other)		**Ok to Leave Message?**	**YES**	**NO**
School:			**School Phone**	
Teacher:			**Grade**	
Date of Birth:			**Gender**	**(circle) M F**
Insurance Provider	**Insurance Holder:**			
Insurance Policy Number	**Group Number:**			
Pediatrician:		**Phone:**		
Pediatrician Address:			**Referral Made By Physician? Y/ N**	

Mother/Parent A's Name________________________ Date of Birth______
Parent's
Address____
Parent's Home Phone_____________________________________
Work____
Cell Phone____
Email____
School level completed____________________________________
Occupation____

Father/Parent B's Name________________________ Date of Birth_______
Parent's
Address____
Parent's Home Phone_____________________________________
Work Phone____
Cell Phone____

Email Address_____________________________________
School level completed___________________________________
Occupation____

Marital Status of Parents:
☐ 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/Parent A ☐ Father/Parent B ☐ Mother/Parent A and Father/Parent B ☐ Other _______________________

What are your primary concerns about your child?
____
____
____
____
____

Is the child aware of this meeting? YES NO

If yes, what have you said to the child about this meeting/evaluation?
____
____
____

Is your child motivated for treatment? YES NO

Previous Evaluations (Psychiatric, Psychological, Therapy, Speech, Occupational or Otherwise):

Name of Provider	Type of Treatment	Dates of Services	Contact Information

Medical Issues
Hospitalizations____
____

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

Allergies____
____

Current Medical Concerns
____
____

Is your child on any medications *CURRENTLY*? **YES** **NO**

If yes, please list:

Name of Medication	Dosage

Family History of Medical/Psychological Issues (Please Check)

Condition	Mother	Father	Sister(s)	Brother(s)	Others
ADHD					
Anxiety					
Depression					
Behavior Problems					
Learning Disabilities					
Drugs/Alcohol					
Psychiatric Hospitalizations					

DEVELOPMENTAL HISTORY

BIRTH: _____________ WEEKS

BIRTH COMPLICATIONS?
____
____

PREGANCY NORMAL: YES NO

IF NO PLEASE
DESCRIBE:____
____
____

SUBSTANCE USE DURING PREGNANCY? YES NO
IF YES, PLEASE CHECK:

☐ Cigarettes How many? _____________
☐ Alcohol How many drinks?__________
☐ Drugs Please describe types of drug use and frequency_______________

Ages at Milestones

Gross motor:
Crawled _________
Walked alone _________
Sat by self _________
Ran well _________

Fine motor:
Fed self with spoon_____
Scribbled ________
Tied shoes ________
Spoke clearly __________

Language development:
Single words __________
Used sentences __________
(2+ words) __________

Potty trained: Urine for day__________________ Bowels for day________
Urine for night_________________ Bowels for night___________________

Rate of development overall: ☐ Slow ☐ Normal ☐ Fast

EDUCATIONAL HISTORY

HAS YOUR CHILD EVER BEEN RETAINED FROM A GRADE? YES NO
IF YES WHICH GRADE? ____________

DOES YOUR CHILD RECEIVE ANY SPECIAL EDUCATIONAL SERVICES?
YES NO
IF YES PLEASE DESCRIBE:
____
____
____

DOES YOUR CHILD HAVE AN I.E.P. OR 504 PLAN? YES NO

DOES YOUR CHILD RECEIVE ANY *PRIVATE TUTORIAL SERVICES*?
YES NO
IF YES, PLEASE LIST

NAME	TYPE OF TUTOR	CONTACT INFORMATION

PLEASE DESCRIBE YOUR CHILD'S PERSONAL STRENGTHS AND INTERESTS:

____
____
____
____

NAME OF PERSON COMPLETING THIS FORM:
____ DATE:____________________