ADVANCED BEHAVIORAL MEDICINE, PC

Child Intake Information

Name: _____ Date: _____

Address: _____ City: _____

Zip Code: _____ Phone Number: _____

Age: _____ M / F Birthdate: ___ / ___ / ___ School: _____ Grade: _____

Height: _____ Weight: _____

Who referred you here? _____ Primary Doctor: _____

Work hrs/wk: _____ TV / Video Games hrs/wk: _____ Internet hrs/wk: _____ Fun reading hrs/wk: _____

Major Interests (Activites, Hobbies, Religion): _____

Mother's birth date: _____ SS# _____ Phone Number: _____

Address: _____ Work Number: _____

Education: _____ Occupation: _____ Employer: _____ Religion: _____

Father's birth date: _____ SS# _____ Phone Number: _____

Address: _____ Work Number: _____

Education: _____ Occupation: _____ Employer: _____ Religion: _____

FAMILY STRUCTURE:

Name	Relationship	Age	If deceased, year	City of Residence
Primary Household				
Second Household				
Other Immediate Relatives				
	Maternal Grandmother			
	Maternal Grandfather			
	Paternal Grandmother			
	Paternal Grandfather			

Child Intake Information

How is your child doing in school? _____

What is the present difficulty? _____

History of Medical Illness, Operations, Traumas: _____

Medications: _____

Drug Allergies: _____

Do you suspect that your child is using alcohol or mood altering drugs? Explain: _____

Previous counseling, reason, outcome: _____

What stressful life events has this child experienced? _____

What else do you want us to know about your child? _____

If living away from home and >12 yoa:

Emancipated minor: Y / N If Y , then: Have proof? Y / N Married: Y / N Support self: Y / N In Military: Y / N