

Romi Mann, Psy.D.
Clinical Psychologist (PSY 25226)
415.508.7664

Today's Date: ___/___/___ Your Name: _____

Your relationship to the child: _____

How did you hear about my practice?

- Friend or acquaintance: _____
- Referring provider, if so, provider's name: _____
- Insurance panel directory
- Good Therapy
- Network Therapy
- Psychology Today
- Other therapy directory or website, if so, please list: _____
- Internet search (Google, Bing, Yahoo, etc.)
- Other, specify: _____

Child's Biographical Information

Child's First Name: _____ Last Name: _____ MI ___

Date of Birth: ___/___/___ Current Age: _____

Ethnic/Cultural Identity: _____

Gender Identity: _____

Who is the child's legal guardian(s)? _____

Who has physical custody of the child? _____

Is this child a ward of the court? No Yes If yes, since what date? _____

Was this child adopted? No Yes, If yes, at what age? _____

Child's School Information

School Name: _____ City: _____

Grade: _____ Classroom teacher: _____

Does this child have any learning disabilities? No Yes, If yes, specify _____

Does this child have an IEP (Individualized Education Plan)? No Yes

Special education teacher (if applicable): _____

Learning specialist (if applicable): _____

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Family Information

Please list all the people currently living in the same household with the child, including non-family members (add additional lines, if needed). If the child lives in two homes, both homes need to be described.

Name	Age	Relationship to the child

Second Home (if applicable). List all the people currently living in the child's second home:

Name	Age	Relationship to the child

List other significant people who do not live in the homes above:

	Name	Age	City and State
Parents not living in child's home			
Siblings not living in child's home			
Grandparents			
Babysitters			
Others			

Pre-Natal and Birth History

Was this child full-term? Yes No If no, number of weeks when born _____

Did mother experience any complications with any of the following and, if so, please describe:

- Pregnancy No Yes: _____
- Labor No Yes: _____
- Delivery No Yes: _____

Developmental Milestones

Did this child experience any delays with any of the following and, if so, please describe:

- Walking No Yes: _____
- Talking No Yes: _____
- Toileting No Yes: _____
- Muscle coordination No Yes: _____
- Social relationships No Yes: _____

Developmental Problems

Has this child had a history of any of the following and, if so, please describe

- Sleep problems No Yes: _____
- Temper tantrums No Yes: _____
- Eating problems No Yes: _____
- Unusual crying spells No Yes: _____
- Refusing to go to school No Yes: _____
- Aggressive behavior No Yes: _____
- Oppositional behavior No Yes: _____
- Special fears No Yes: _____
- Other problems No Yes: _____

Health and Social History

How would you describe this child's physical health? Excellent Good Fair Poor

	No	Yes	Details
Has this child had any significant medical problems, now or in the past?			
Does this child have any chronic or recurring medical conditions?			
Has this child ever been hospitalized for medical reasons?			
Has this child ever been hospitalized for psychiatric reasons?			
Has this child experienced any other significant medical issues (serious injuries, loss of consciousness, surgeries, etc)?			
Is this child currently taking any medication (including psychiatric medication)?			
Has this child taken psychiatric medications in the past?			
Has this child ever attempted suicide or tried to harm him/herself?			
Has this child had problems with substance use (alcohol, prescription medications, or recreational drugs)?			
Has this child ever been in a physical fight that resulted in injury to self or others?			
Has this child ever been injured or hurt by physical or sexual abuse?			

Physical and Mental Health Care

Health Insurance Company (even if not using for therapy) _____

Does this child have a primary care physician (or clinic)? No Yes

If yes (Name/Location/Phone Number):

Has this child ever participated in psychotherapy? No Yes

If yes, when and for how long?

Is this child currently under the care of a psychiatrist, psychologist, or therapist? No Yes

If yes (Name/Location/Phone Number):
