Dear Parent,

Thank you for your interest in bringing your child to see our mental health clinician. In order to get the most out of our initial meeting, we have found it useful to gather some information prior to the appointment.

- Please complete the enclosed form, entitled "Patient and Family History," and bring it **completed** to the appointment. If it is not completed when you arrive the appointment may have to be rescheduled.

- The initial appointment will last approximately one hour.

- If the child is seeing Dr Angela Baker-Franckowiak they **should** come to all appointments.

- If the child is seeing a therapist and is under the age of 8 years old they **do not** come to the initial visit.

- The child must be accompanied by his/her **legal** guardian.

- If both parents share in raising the child, it is best to have both parents present at the first appointment. If you must bring the child's sibling(s) to the appointment, please bring an adult to care for these children in the waiting room while you and your child are with the provider.

- Please bring all bottles of prescription medication your child is taking. Also, please bring contact information (name, address, telephone number) for your child's primary care doctor and any other professionals (medical specialists, therapists, counselors, etc.) your child sees regularly. In addition, please bring contact information for your child's school and the name of his/her primary teacher. Please bring a copy of any pertinent information, including evaluations, from your child's school.

If it becomes necessary to cancel your initial appointment, please call us as soon as possible. Failure to cancel an initial appointment within 24 hours prior to the appointment may result in dismissal from the clinic.

We accept cash, checks, and credit cards (MasterCard, Visa, American Express and Discover Card).

Please call us if you have any further questions prior to the appointment. We look forward to providing mental health care for your child.

Sincerely,

Greensquare Developmental Specialists
Children's Medical Group

Patient and Family History

Greensquare Developmental Specialists

Please bring completed form to intake. Failure to do so will result in rescheduling.

I. Patient Information

Child's Name:_____ Date of Birth:_____

Child's Address:_____ City:_____ State_____ Zip_____

Home Telephone: ( ) _____ **Child's Social Security Number**:_____

Parent Information:
Name:_____
Date of Birth:_____

Parent Information:
Name_____
Date of Birth:_____

Social Security Number:_____
(Social Security Numbers needed for insurance purposes)

Social Security Number:_____

Address: □ same as above, or:
Street:_____
City:_____ State_____ Zip_____
Home Telephone: ( )_____
Mobile Telephone: ( )_____
Work Telephone: ( )_____
May we contact at work? □no □yes
Stepparent's name (if applicable): _____

Address: □ same as above, or:
Street_____
City:_____ State_____ Zip_____
Home Telephone: ( )_____
Mobile Telephone: ( )_____
Work Telephone: ( )_____
May we contact at work? □no □yes
Stepparent's name (if applicable):_____

Marital status: □married □single □cohabitation □divorced □separated □widowed
Number of marriages:_____

Marital status: □married □single □cohabitation □divorced □separated □widowed
Number of marriages:_____

Name of insurance:_____
Insurance address from back of card:_____
Provider/Customer service phone number from card: _____
Policy/Member ID :_____ Group #: _____
Who holds the insurance:_____ Date of Birth:_____
Name of Employer:_____
Full Time: _____ Part Time: _____
Your Email Address:_____

Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino _____ Patient refused _____ Unknown____
Race: American Indian or Alaska native _____ Asian _____ Black or African American _____
Native Hawaiian or Pacific Islander _____ White_____ Other _____ Patient refused _____
Unknown _____
Who currently has legal custody of the child?_____
Is child in foster care? □no □yes, list Bureau of Milwaukee Child Welfare case worker name and telephone:_____
Is child adopted: □no □yes, at what age?_____
Child's Place of Birth:_____ Primary Language Spoken:_____

Siblings (please list)

Name	*Gender*	*Age*	*Current living situation*

II. Developmental History

Did mother experience any illnesses during pregnancy? □no □yes, explain_____
Did mother smoke cigarettes during pregnancy? □no □yes, amount_____
Did mother use alcohol during pregnancy? □no □yes, amount_____
Was the child premature? □no □yes, age at delivery_____Birth Weight:_____
Were there any problems during delivery? □no □yes: explain_____
Please describe the child's early:
Sleep patterns:_____
Personality:_____
Please give the approximate age at which the child first began to:
Roll over_____ Sit up_____ Crawl _____ Walk_____
Speak words_____ Toilet Train (day)_____ Toilet Train (night)_____

Difficulties with child's hearing: □no □yes ,explain_____
Difficulty with child's vision: □no □yes ,explain_____

III. Mental Health History

Has the child received mental health care? □ no (skip to section IV) □ yes (please describe):
Current or previous psychiatrist? (name, address, telephone, dates of treatment)_____
_____
Current or previous therapist? (name, address, telephone, dates of treatment)_____
_____
Previous psychiatric hospitalizations? (where, reason, dates of treatment)_____
_____
Please list any *previous psychiatric* medications the child used:

Name	*Dose*	*Frequency*	*Date started/stopped*	*Reason for taking*	*Reason stopped*

IV. Medical History

Child's Current Primary Care Provider:_____
Address:_____ City:_____ State_____ Zip_____
Telephone:( )_____ Fax ( )_____

Please list all medications the child is currently taking: Including over the counter meds and nutritional supplements.

Name	*Dose*	*Frequency*	*Reason*	*Date started*

Please list any allergies the child has (including medications, food, environmental):

Item allergic to	*Typical reaction*	*Standard treatment*

Please list any ongoing health problems the child has (e.g., asthma, diabetes, etc.)

Condition	*Treatment*	*First Diagnosed*

Has the child ever experienced a seizure? □no □yes, type_____

Has the child ever experienced a head injury (from fall, car accident, sports, etc.) that resulted in loss of consciousness/blackout? □no □yes, explain_____
Has the child ever had surgery? □no □yes ,explain (when, why)_____
_____

Has the child ever been hospitalized overnight? □no □yes, explain (when, why, duration)_____
_____

Please list any family member(s) with the following illnesses:

Condition	*Child*	*Mother*	*Father*	*Sibling*	*Grandparent*	*Other (who)*
Allergies						
Sexually Transmitted Disease						
AIDS or HIV						
Neurological Disorders						
Alcohol or Drug Abuse History						
Physical and/or Sexual Abuse History						
Head Injury						
Seizures						
Migraines						
Alzheimer's Disease						
Depression						
Bipolar (Manic-Depression)						
Schizophrenia						
ADHD or ADD						
Obsessive-Compulsive						
Anxiety						
Autism Spectrum Disorder						
Suicide (including attempts)						
Other medical:						

Are the child's immunizations up to date? □yes □no, explain_____

V. Educational History

Child's current school:_____ Grade level:_____
School address:_____ City:_____ State:_____ Zip:_____
Primary teacher's name:_____

Level of Schooling	*Where, Dates*	*Any Concerns/Difficulties*
Early Education (0-3 services)		
Preschool		
Elementary School		
Middle School		
High School		

Has the child ever received any of the following services? If yes, please describe and give dates:
Tutoring: □no □yes, explain_____
Special Education: □no □yes, explain_____
Physical Therapy: □no □yes, explain_____
Occupational Therapy: □no □yes, explain_____
Speech Therapy: □no □yes, explain_____
Other: _____

Does the child have a history of:
Learning disabilities: □no □yes, explain_____
Reading problems: □no □yes, explain_____
Mathematics problems: □no □yes, explain_____
Speech problems: □no □yes, explain_____
Coordination problems: □no □yes, explain_____

Please report the parent's educational histories:
Mother's highest level of education:_____
Does mother have a history of educational difficulties? □no □yes, explain_____
Father's highest level of education:_____
Does father have a history of educational difficulties? □no □yes, explain_____

VI. Social History

Is mother currently employed? □no □yes, job_____
Is father currently employed? □no □yes, job_____
Is stepmother currently employed? □n/a □no □yes, job_____
Is stepfather currently employed? □n/a □no □yes, job_____

Has child ever worked? □no □yes, job_____ hours per week?_____
Describe child's social activities:_____
How many close friends does child have?_____
How much time per week does child spend with friends?_____
Please describe child's special skills/hobbies/talents_____

What is your religious/spiritual preference, if any?_____
How important is your spiritual life for you and your family?_____

Please check all that describe your child:

___Follows directions
___Does chores
___Polite
___Tolerant
___Fidgets
___Often loses things
___Often does not listen
___Easily distracted
___Often talks excessively
___Difficulty playing quietly
___Difficulty following instructions
___Difficulty sustaining attention
___Often blurts out answers to questions before they have been completed
___Trouble concentrating
___Shifts from one activity to another
___Often blames others for own mistakes
___Poor concentration or difficulty making decisions
___Difficulty remaining seated
___Often interrupts or intrudes on others
___Often does things that annoy other people

___Easy going
___Talks about feelings
___Cooperative
___Patient
___Marked inability to relax
___Low self esteem
___Avoidance of being alone
___Repeated nightmares
___Suicidal thoughts or attempts
___Worries about future events
___Worries about past behavior
___Excessive need for reassurance
___Is often touchy or easily or easily annoyed by others
___Feelings of worthlessness or excessive guilt
___Marked self-consciousness
___Often loses temper
___Friendly
___Worries about possible harm to others
___Worries about separation from parents
___Interacts with family

___Has many interests
___Responsible
___Trustworthy
___Truthful
___Often argues with adults
___Often swears or uses obscene language
___School refusal
___Cruel to animals
___Outgoing
___Lies often
___Runs away from home overnight
___Often initiates physical fights
___Often actively defies or refuses adult requests or rules
___Often engages in physically dangerous activities
___Is often angry or resentful
___Physically cruel to people
___is often spiteful or vindictive
___Has stolen
___Deliberate fire setting

___Healthy
___Plays Well
___Energetic
___Sleep Problems
___Decrease or increase in appetite
___Complaints about body (headaches, stomach aches)

Please describe the nature of the problem(s) for which you and your child are seeking treatment:

What question(s) do you want answered:

_____

_____

_____

_____

_____

_____

Form completed by: _____ Relationship to patient:_____

Thank you for completing the form. The provider will review it with you at your initial appointment.

For office use only

I have reviewed the preceding information with the patient/family.

*Signature*_____ *Date:*_____