• W C B H •

Western Connecticut Behavioral Health, LLC

Minor Information Form

Child's Full Name: _____

Child's Date of Birth: _____ Age: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Mother's Full Name: _____

Address (if different): _____

Phone: _____ Cell: _____

Email: _____

Father's Full Name: _____

Address (if different): _____

Phone: _____ Cell: _____

Email: _____

Parent's Marital Status: _____

Current Custody Arrangement (if applicable): _____

_____

Are you the child's legal guardian (please circle)? YES NO

If no, please list the name and phone number for the legal guardian: _____

_____

How do you prefer communication, such as to schedule or reschedule appointments (please circle)? Home phone Cell phone E-mail

May I leave a message on the answering machine (please circle)? YES NO

Emergency contact person: _____

Relationship to your child:_____ Phone: _____

Physician Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

Family Information: Please list any siblings, including full/half/step

Name Relationship Age History of illness

_____

_____

_____

_____

Other people living in the home: _____

Primary language spoken in the home: _____

Developmental Information

Was your child premature (please circle): YES NO

Any prenatal problems (please circle): YES NO

Please list when your child achieved these milestones

Smiled: _____ Sat up independently: _____

Walked: _____ Talked: _____

Said first word: _____ Said first sentence: _____

Any speech, hearing, or language difficulties (please circle): YES NO

Did your child qualify for Early Intervention Services (please circle): YES NO

Medical History

Date of most recent physical exam: _____

Has your child ever had a concussion or serious head trauma (please circle): YES NO

Has your child ever had a seizure (please circle): YES NO

Does your child have any allergies (please circle): YES NO

Please list any medications your child currently is prescribed, including name and dosage.

_____

_____

_____

Please list any significant medical conditions your child has been diagnosed with, including follow-up care instructions. _____

_____

Educational History

Name of your child's current school: _____

Current grade: _____ Teacher: _____

Was your child ever retained (please circle): YES NO

Does your child have an IEP (please circle): YES NO

Please list any special school accommodations: _____

_____

Family Mental Health History

Is there a history of mental illness in your family (please circle): YES NO

If so, please describe _____

_____

Is there a history of learning disabilities in your family (please circle): YES NO

If so, please describe _____

_____

Is there a history of substance abuse in your family (please circle): YES NO

If so, please describe _____

_____

Mental Health History

Has your child ever previously attended counseling or therapy (please circle): YES NO

If so, please describe _____

_____

Has your child ever been hospitalized for a psychological reason (please circle): YES NO

If so, please describe _____

_____

In your own words, please describe the reason for today's appointment, including any current concerns _____

_____

_____