NEXT STEP PSYCHOLOGY PLLC

Dr. Carolyn Pender Roche, Ph.D, NCSP
carolyn@nextsteppsychology.com
Phone: (919) 228-8845
Fax: (919) 251-9660

CHILD OR ADOLESCENT PATIENT INFORMATION

DATE: **ACCOUNT NO.:** **DX:**		
CHILD OR TEEN PATIENT INFORMATION		
Last Name:	First Name:	Nickname:
Birthdate: / /	Age:	Gender:
Is child/teen adopted? Y or N	Yes, age at adoption:	Languages spoken at home:
Street Address: City: State: Zip Code:		
Home Phone:	Child's cell phone:	Best number to leave messages:
Has your child/teen or a family member been seen by Dr. Pender before? Y or N		
Who has physical custody of this child/teen?		
Who has legal custody of this child/teen?		
REFERRAL INFORMATION		
Referred by:	How did you learn about this practice: □ Doctor □ Lawyer □ Friend □ School □ Co-worker □ Internet search □ Presentation/Talk □ Marketing □ Other	
SCHOOL INFORMATION		
Current School: □ Public □ Private		□ Year Round □ Traditional □ Other
Teacher's Name: Grade:		Retained: Y or N If yes, which grades:
Special Education: □ IEP □ 504	AIG: □ Reading □ Math	Tutoring: Y or N

PARENT INFORMATION		
	MOTHER	**FATHER**
Name		
Age		
Highest Education Level		
Occupation		
Employer		
Cell Phone		
Work Phone		
Home Phone (if different from child)		
Email Address		
Address (if different from child)		
	STEPMOTHER	**STEPFATHER**
Name		
Age		
Highest Education Level		
Occupation		
Employer		
Cell Phone		
Work Phone		
Home Phone (if different from child)		
Email Address		

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Address (if different from child)		

SIBLINGS		
Names: 1-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
2-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
3-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
4-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted

MEDICAL INFORMATION			
Child's doctor:	Name of Practice:	Phone:	Fax:
Street Address:	City:	State:	Zip Code:
Medical Problems (list):			
Allergies:			
Hospitalizations/Surgeries:			
Medication Name:	Dosage:	X per day:	Reason:

BIRTH AND DEVELOPMENTAL HISTORY				
Length of Pregnancy:	Birth weight:	Complications:		
Used During Pregnancy:	□ Alcohol	□ Tobacco	□ Illicit Drugs	□ Prescription Medication
Medical Problems at Birth:				
MILESTONES (Please list age child met each milestone)				
Motor	Sat:	Crawled:	Walked:	Current Difficulties: Y or N
Language	Single word:	3 words:	Full sentences:	Current Difficulties: Y or N
Toileting	Trained for day:	Trained for Night:		History of Accidents: Y or N
Sleep Issues: □ Trouble Falling Asleep	□Trouble waking up	□ Sleepwalks	□Night Terrors	□ Nap issues

MENTAL HEALTH HISTORY					
Mental Health Diagnoses:					
Previous Professionals Seen:	Name(s):				Date(s):
Previous Evaluations:	□ Psychological	□ Educational	□ Speech and Language	□ Occupational Therapy	
	□ Neuropsychological	□ Emotional	□ Behavioral		

FAMILY STRESSORS					
□ Abuse	□ Deaths	□ Job Change	□ Relocation	□ Stepchildren	□ Trauma
□ Births	□ Divorce	□ Marriage	□ School	□ Substance Use	□ Other(s):
□ Bullying	□ Finances	□ Medical	□ Separation	□ Substance Abuse	

FAMILY STRENGTHS
Please Describe:
REASON FOR SEEKING HELP AT THIS TIME:
Please Describe:
Signature: Date:
Relationship to Child/Teen: