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REGISTRATION FORM FOR CLIENTS UNDER 18

CLIENT INFORMATION								
Name			Referred by					
Street								
City			State		Zip			
Phone (H)			Cell					
Date of Birth			Gender ☐M ☐F					
Marital Status	**Single**	☐	**Married**	☐	**Divorced**	☐	**Other**	☐
Relationship to Policyholder	**Self**	☐	**Spouse**	☐	**Child**	☐	**Other**	☐
Employment Status	**Full Time**	☐	**Part Time**	☐	**Unemployed**			☐
School Status	**Full Time**	☐	**Part Time**	☐	**Does not attend school**			☐
Is treatment related to	**Employment**	☐	**Auto Accident**	☐	**Other Accident**	☐	**N/A**	☐

Dr. Jacobs does not participate with any insurance plans, and her practice is a "fee for service" practice. Although full payment is expected at the time of the visit, Dr. Jacobs can file a claim for the services provided to you. However, if additional phone calls are required due to claim issues, the client is responsible for making any follow up calls or additional corrected claim filing. You can also be provided with a monthly statement that includes all necessary information to file a claim yourself or to use with your Health Service Account or Flex Spending Account. ONLY PROVIDE INSURANCE INFORMATION IF YOU WANT SHERYL R. JACOBS PH.D. P.C. TO FILE A CLAIM FOR YOU.

POLICYHOLDER/INSURANCE INFORMATION			
Name			Group #
Street	Member ID #.		
City	State		Zip
Phone (H)	(W)		Other
Date of Birth	Gender ☐M ☐F		
Insurance Company	Phone		
Street	City	State	Zip
Employer	Authorization #		

Child's Name_____ Date of Birth_____

Home Address_____

School_____ Phone_____

Grade_____ Teacher_____

School Address_____

Pediatrician_____ Phone_____

Pediatrician's Address_____

Mother/Parent A's Name_____ Date of Birth_____

Parent's Address_____

Parent's Home Phone_____ Work_____

Cell Phone_____ Email_____

School level completed_____ Occupation_____

Father/Parent B's Name_____ Date of Birth_____

Parent's Address_____

Parent's Home Phone_____ Work Phone_____

Cell Phone_____ Email Address_____

School level completed_____ Occupation _____

Other Family Members	**Relationship**	**Date of Birth**

Status of Parent's Marriage:

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

How long married?_____ How long divorced?_____ Child's age at divorce_____

If parents are divorced, separated, or single who has legal custody of the child?

☐ Mother/Parent A ☐ Father/Parent B ☐ Mother/Parent A and Father/Parent B ☐ Other _____

Child's Name_____

Please list the problems with which you want help for this child:

1._____

2._____

3._____

4._____

What have you said to the child about this evaluation?_____

_____

Whose idea was it that this child have an evaluation?_____

Has this child received any *evaluations* or any *treatment* prior to this contact such as psychological testing, counseling, psychiatric help, speech therapy, medications, diets, etc.? ☐ Yes ☐ No

If so, please describe below:

Approximate Date(s)	Type of Evaluation of Treatment	Name/Address of Provider

Medical Issues

Hospitalizations_____

Chronic Medical Conditions (i.e. asthma, ear infections) _____

Allergies_____

Current Medical Concerns _____

Medication Currently Being Taken by Child: _____

Family History

Following is a list of problems that sometimes run in families. We are interested in whether anyone else in the family has had any problems in these areas.

Family History	**Mother/ Parent A**	**Father/ Parent B**	**Brother(s)**	**Sister(s)**	**Others (e.g. aunt)**
Hyperactive as child					
Behavior Problems					
In trouble as a teen					
Trouble learning to read					
Trouble learning to write					
Trouble with math					
Kept back in school					
Drug/alcohol Problems					

Child's Name_____

BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy
Length in months_____

Any illness or complications during pregnancy? ☐Yes ☐No

If yes, please explain_____

Medications taken by the mother during pregnancy_____

Substances used during pregnancy? ☐Yes ☐No
☐ Cigarettes How many?_____
☐ Alcohol How many drinks?_____
☐ Drugs Please describe types of drug use and frequency_____

Was the father using any substances during the time of conception? ☐Yes ☐No

If yes, please describe_____

Labor and Delivery
Was the birth of the child "normal"?_____

Did mother or baby stay in Special or Intensive Care? ☐Yes ☐No If yes, please explain_____

Early Development
Please describe the child as an infant (temperament, sleeping, eating patterns, etc.).

_____

Ages at Milestones

Gross motor:		***Fine motor***:		***Language development***:	
Crawled	_____	Fed self with spoon	_____	Single words	_____
Walked alone	_____	Scribbled	_____	Used sentences	_____
Sat by self	_____	Tied shoes	_____	(2+ words)	_____
Ran well	_____			Spoke clearly	_____

Potty trained: Urine for day_____ Bowels for day_____
Urine for night_____ Bowels for night_____

Rate of development overall: ☐Slow ☐Normal ☐Fast

Educational History
Has this child been retained in a grade? ☐Yes ☐No If so, what grade?_____

Does this child receive any special education services? ☐Yes ☐No
If so, what types of services, and at what grade?_____

Personality and Behavior: please circle all traits that apply to the child now:

☐Sad	☐Happy	☐Leader	☐Follower	☐Moody	☐Friendly
☐Quiet	☐Overactive	☐Independent	☐Dependent	☐Sensitive	☐Affectionate
☐Fearful	☐Cooperative	☐Tantrums	☐Lethargic	☐Sleep Problems	☐Oppositional
☐Even Tempered	☐Loner	☐Social	☐Anxious	☐Compulsive	☐Forgetful

Please describe this child's strengths and interests_____

Signature of Person Completing Form_____

Relationship to child_____ **Date**_____