MIDSTEP CHILD PSYCHOLOGY CENTER
PARENT APPLICATION
(Revised: 06/13/06)

(Application completed by: _____ *Date:* _____*)*

I. DEMOGRAPHIC INFORMATION:

CHILD Name: _____ DOB: _____

Gender: M / F Age: _____ Grade: _____ SS#: _____

Race: _____ Religion: _____

	MOTHER:	FATHER:
CIRCLE ONE →	(Biological / Adoptive / Foster)	(Biological / Adoptive / Foster)
Name		
Date of Birth		
Address - Street		
City, State, Zip		
Home Phone		
Work Phone		
Cell Phone		
E-mail		
Occupation		
Employer		
Education Level		

Parents' Marital Status:
___ Married Since (mm/yr): _____
___ Separated Since (mm/yr): _____
___ Divorced Since (mm/yr): _____
___ Remarried Since (mm/yr): _____

Custody Arrangement (if applicable): _____
_____

Other Family Members and Significant Relations:

NAME:	Age:	Relationship to Child? (eg., brother, stepmom)	Living Where? (eg., in home, college…)

DEMOGRAPHIC INFORMATION (CONTINUED):

CHILDCARE PROVIDER (None / Relative / Friend / In-Home / Daycare Center):
Person's Name: _____ Title: _____
Agency: _____ Phone: _____
Address: _____
When is the child there? _____
Other childcare arrangements: _____

SCHOOL: _____ District: _____
Address: _____
Phone: _____ Grade: _____
Teacher(s): _____
Counselor: _____ Principal: _____

PRIMARY CARE PHYSICIAN / PEDIATRICIAN: _____
Group: _____ Phone: _____
Address: _____
Health Insurance: _____

II. REFERRAL INFORMATION

Who referred you to Midstep? Name: _____
__ Physician __ Insurance __ Psychologist __ School __ Church __ Court/Attny
__ Friend __ Relative __ Self __ Ads __ Other: _____

What type of services are you seeking? _____
__ Evaluation __ Consultation Treatment for: __ Child __ Parent(s) __ Family

For what purpose? _____

Has any family member (including the child) received previous psychological services?
NO / YES. If yes, please describe:

WHO (patient)?	WITH WHOM (provider)?	FOR WHAT (problem)?	WHEN (yr.)?

III. PRESENTING PROBLEMS:

What are the main problems or concerns?

1. _____

2. _____

3. _____

What are your main goals? How do you want things to be different or better?

1. _____

2. _____

3. _____

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IV. DEVELOPMENTAL HISTORY

During pregnancy, did the child's mother use any of the following substances:
__ Cigarettes __ Caffeine __ Alcohol (_____)
__ Illicit Drugs (_____)
__ Prescription Drugs (_____)

Any prenatal or pregnancy problems? No / Yes: _____

_____

Any perinatal or birth complications? No / Yes: _____

_____

Labor Duration: _____ hrs. Delivery: __ Normal __ Breech __ Forceps __ Caesarian
__ Premature (_____ wks.)

Child's Birth Weight: _____ Apgar Scores (if known): _____

Problems during **infancy** (Check all that apply and describe briefly):
__ Colicky (_____)
__ Feeding problems (_____)
__ Sleep problems (_____)
__ Temperament problems (_____)
__ Other (_____)

Early developmental milestones:	(Circle one:)	Age (if known):
Sit up	Early / Normal / Late	_____
Crawl	Early / Normal / Late	_____
Walk	Early / Normal / Late	_____
Feed himself/herself	Early / Normal / Late	_____
Understand words/directions	Early / Normal / Late	_____
Talk (understandable words)	Early / Normal / Late	_____
Talk (understandable sentences)	Early / Normal / Late	_____
Toilet-trained (bladder control)	Early / Normal / Late	_____
Toilet-trained (bowel control)	Early / Normal / Late	_____

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HEALTH HISTORY & FUNCTIONING: (Current Height: _____ Weight: _____)

Please rate child's health history:		Comment on any problems:
Gross Motor Skills	Good / Fair / Poor	
Fine Motor Skills	Good / Fair / Poor	
Speech	Good / Fair / Poor	
Hearing	Good / Fair / Poor	
Vision	Good / Fair / Poor	
Appetite	Good / Fair / Poor	
Sleep	Good / Fair / Poor	
Bladder Control	Good / Fair / Poor	
Bowel Control	Good / Fair / Poor	
Overall Health	Good / Fair / Poor	

Any concerns or history…?	*Circle One:*	*If Yes, Describe:*
Major weight loss or gain	NO / YES	
Onset of puberty	NO / YES	
Allergies or Asthma	NO / YES	
Chronic illness	NO / YES	
Significant injuries	NO / YES	
Surgery/Operations	NO / YES	
Hospitalizations	NO / YES	
Physical Abuse	NO / YES	
Sexual Abuse	NO / YES	
Suicidal Ideas	NO / YES	
Homicidal Ideas	NO / YES	
Alcohol or Drug Use	NO / YES	
Other health issues	NO / YES	
Current Medications?	**NO / YES**	

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FAMILY HISTORY & FUNCTIONING:

How many times has the family moved since this child was born? _____

Significant life events in the family? _____

_____

What are the major stresses in the family? _____

_____

What are the family's strengths? _____

_____

Please list any family members or relatives who have had any problems with…

	(If YES - Specify relationship, eg., brother, mother, uncle, etc.)
Seizures	No / Yes:
Learning Disabilities	No / Yes:
Attention Problems	No / Yes:
Behavior Problems	No / Yes:
Anxiety	No / Yes:
Depression	No / Yes:
BiPolar Mood Disorder	No / Yes:
Schizophrenia	No / Yes:
Autism/Aspergers/PDD	No / Yes:
Drugs or Alcohol	No / Yes:
Physical Abuse	No / Yes:
Sexual Abuse	No / Yes:
Other: _____	No / Yes:

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SCHOOL HISTORY & FUNCTIONING:

Average report card grades: Last year? _____ This year? _____
Academic Strengths: _____
Academic Weaknesses: _____

Any problems with…?	*Circle One:*	*If Yes, Describe:*
Attendance	NO / YES	
Attention	NO / YES	
Behavior	NO / YES	
Classwork	NO / YES	
Homework	NO / YES	
Teachers	NO / YES	
Peers	NO / YES	
Bus	NO / YES	

Has the child had…?	*Circle One:*	*If Yes, Describe:*
To repeat a grade	NO / YES	
EI Services	NO / YES	
IU Services	NO / YES	
Title I Reading	NO / YES	
IST Services	NO / YES	
504 Services	NO / YES	
OT or PT Services	NO / YES	
Speech & Lang. Serv.	NO / YES	
School Based MH Serv.	NO / YES	
MDE (Evaluation)	NO / YES	
IEP (Spec. Ed. Plan)	NO / YES	
Special Ed. Support (LS, ES, AS, or Other)	NO / YES	
Wrap-Around Services (TSS, BSC, or MT)	NO / YES	

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SOCIAL & EMOTIONAL HISTORY AND FUNCTIONING:

EXTRA-CURRICULAR ACTIVITIES (Sports, music, arts, youth groups, clubs, etc.):

WHAT? (ACTIVITY)	WHERE? (GROUP / ORGANIZATION)	WHEN? (DATES – YRS.)

FAVORITE ACTIVITIES/HOBBIES/INTERESTS: _____
_____
_____
_____

BEST FRIENDS (Names and ages): _____
_____
_____
_____

What makes your child HAPPY: _____
What makes your child SAD: _____
What makes your child MAD: _____
What makes your child WORRY: _____

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