Client Information and History

Minor Version

Child Information:

Today's Date: _____

Name of client: _____ DOB: _____ Age: _____ Grade: _____

Nickname:_____ Gender: Male ☐ Female ☐ Handedness: _____

Completed By: _____ School:_____

Father's name: _____ Mother's name: _____

Stepfather's: _____ Stepmother's: _____

Siblings' names & age: _____ ____ _____ _____

_____ ____ _____ _____

Street Address: _____

City/State/Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Email Address*: _____ *Email is not a secure form of communication

Please initial if it is okay to communicate by email regarding appointments, info related to treatment, clinic updates/newsletters _____

Which method of communication do you prefer? Cell ☐ Home ☐ Work ☐ Other: ☐ _____

Is it okay to leave a message on: All numbers ☐ Cell ☐ Home ☐ Work ☐ Other: ☐ _____

If divorced or not married, parents have: Joint Custody ☐ Mother has Custody ☐ Father has Custody ☐

Emergency Contact #1: _____ Relationship? _____ Phone #: _____

Emergency Contact #2: _____ Relationship? _____ Phone #: _____

Medical & Mental Health Information:

Pediatrician: _____ Phone #: _____

Address: _____

Permission to contact pediatrician? Yes ☐ No ☐

Is your child currently being treated by a medical physician for any medical condition? If so, please describe:

_____

_____

Has your child ever seen a Psychiatrist or any other mental health provider? Yes ☐ No ☐

If yes, When? _____ Focus of treatment? _____

_____ Helpful? Yes ☐ No ☐

Approximately 16% of children with ADHD have convergence insufficiency (makes focusing on nearby targets difficult).

When did your child last have an eye exam? _____

When did your child last have a physical exam? _____

Your child's sleep patterns (*please circle all that apply*): Restless Nightmares Night Terrors Other_____

What time does your child: Go to bed? _____ Get up? _____

Does your child sleep through the night? Yes ☐ No ☐

Have there been previous evaluations? By whom? Results? _____

_____

_____

_____

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Can we obtain copies of results? Yes ☐ No ☐

What brought you and your child in today? _____

_____

How long has you child experienced this problem? _____

_____

Has your child received any treatment for this problem? If so, what? Why was it not successful? _____

_____

_____

_____

_____

How will you know if we have been helpful? _____

_____

_____

How did you find out about Oxford Recovery Center?

__ Radio (WMUZ) Bob Dutko _____ Chris Stevenson_____ Robin Sullivan _____

__ WJR (760 AM) Host: _____

__ Radio 1300 AM

__ Internet/Website

__ Physician Name:_____ Specialty: _____ Phone#: _____

__ WDIV/Channel 4 commercial

__Friend/Relative

__Other

Personal and Family History

Has the client or any of the client's parents, grandparents, siblings, and parents' siblings had any of the following? (If client is adopted, answer to reflect birth parents and birth siblings to whatever degree you have access to).

Symptoms	Client	Family Member(s)
"Rocker" as a child	Yes ☐ No ☐	_____
Considered to be a difficult child	Yes ☐ No ☐	_____
Developmental delays: coordination, walking, speech, etc.	Yes ☐ No ☐	_____
Bedwetting after age 5	Yes ☐ No ☐	_____
Head banging	Yes ☐ No ☐	_____
Sleep walking or night terrors	Yes ☐ No ☐	_____
Learning Disability	Yes ☐ No ☐	_____
Difficulty learning: reading, writing, math	Yes ☐ No ☐	_____
Behavioral problems in school	Yes ☐ No ☐	_____
Truancy	Yes ☐ No ☐	_____
Held back in school/repeated grade	Yes ☐ No ☐	_____
Considered bright, but unmotivated	Yes ☐ No ☐	_____
Achieved less academically/professionally than parents/siblings	Yes ☐ No ☐	_____
Underachiever in school, sports, work, or social life	Yes ☐ No ☐	_____
ADD, ADHD	Yes ☐ No ☐	_____
Tourette syndrome	Yes ☐ No ☐	_____

Personal and Family History continued…

Symptoms		Client	Family Member(s)
Seizure Disorder		Yes ☐ No ☐	_____
Conduct Disorder		Yes ☐ No ☐	_____
Oppositional/Defiant Disorder		Yes ☐ No ☐	_____
Frequent fights		Yes ☐ No ☐	_____
Few/or no fiends, a loner		Yes ☐ No ☐	_____
Fire setting		Yes ☐ No ☐	_____
Temper tantrums		Yes ☐ No ☐	_____
Depression or Manic Depression		Yes ☐ No ☐	_____
Anxiety/Panic Attacks		Yes ☐ No ☐	_____
Emotional problems		Yes ☐ No ☐	_____
Excessive or inappropriate use of alcohol		Yes ☐ No ☐	_____
Use of illegal drugs		Yes ☐ No ☐	_____
Excessive use of prescription or over the counter drugs		Yes ☐ No ☐	_____
Nicotine use or dependence		Yes ☐ No ☐	_____
Uses caffeine more than 1 or 2 cups		Yes ☐ No ☐	_____
Obesity or eating disorder		Yes ☐ No ☐	_____
Problem habit:	Pornography	Yes ☐ No ☐	_____
	Nail biting	Yes ☐ No ☐	_____
	Masturbation	Yes ☐ No ☐	_____
	Compulsive self-injury	Yes ☐ No ☐	_____
Workaholism		Yes ☐ No ☐	_____
Gambling		Yes ☐ No ☐	_____
Risk-taking behaviors		Yes ☐ No ☐	_____
Problems with the law		Yes ☐ No ☐	_____
Bankruptcy/excessive debt/bad checks		Yes ☐ No ☐	_____
Premenstrual Syndrome		Yes ☐ No ☐	_____
Irritable Bowel Syndrome		Yes ☐ No ☐	_____
Frequent gas or diarrhea		Yes ☐ No ☐	_____
Migraines		Yes ☐ No ☐	_____
High blood pressure		Yes ☐ No ☐	_____
Reacts to drugs differently than others		Yes ☐ No ☐	_____
Asthma or frequent respiratory infections		Yes ☐ No ☐	_____
Skin blotching under stress		Yes ☐ No ☐	_____
Bully		Yes ☐ No ☐	_____
Class clown		Yes ☐ No ☐	_____
Unusually sensitive to light, noise, touch, etc.		Yes ☐ No ☐	_____
Allergies		Yes ☐ No ☐	_____

In addition, has the client experienced:

Numerous ear infections? Yes ☐ No ☐

Frequent earaches? Yes ☐ No ☐

Mixed left/right dominance for handedness? Yes ☐ No ☐

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Medical History of Client:

1. 1-3 months prior to pregnancy were either of the birth parents using drugs (legal or illegal; alcohol, nicotine)?Yes☐No☐
2. During the pregnancy, did the birth mother use drugs (legal or illegal; alcohol, nicotine)? Yes☐ No☐
3. Were there any complications during the pregnancy? _____
4. Were there any complications during the delivery? _____
5. Were there any complications during neonatal period? _____
6. Did the client have colic or feeding problems in infancy? _____
7. Has the client ever had *any* head injury? Yes ☐ No☐
   Has the client ever had *any* loss of consciousness? Yes ☐ No☐

   If yes to either question, please rate the severity of the following symptoms on a scale of 0 to 8 (8 being severe)

   _____ Client has had one or more concussions
   _____ Client has had mild headaches
   _____ Client experiences loss of balance, dizziness and/or unsteady walking
   _____ Client has problems with his/her memory
   _____ Client has difficulty organizing daily activities
   _____ Client has difficulty making decisions/solving problems
   _____ Client gets lost easily
   _____ Client is tired all the time
   _____ Client is moody

8. Has the client ever had a stroke? Yes☐ No☐
9. Has the client experienced long-term use of medication? Yes☐ No☐
   If yes, what? _____
   _____
   _____
   _____
   _____
10. Has the client experienced severe illness, hospitalization or surgery? Explain. _____
    _____
    _____
    _____
    _____
    _____

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11. Has the client ever been diagnosed with an autoimmune disorder (see list below):

Chronic Fatigue Syndrome	Yes ☐ No ☐	Scleroderma	Yes ☐ No ☐
Fibromyalgia	Yes ☐ No ☐	Epstein - Barr virus	Yes ☐ No ☐
Lupus	Yes ☐ No ☐	Other	Yes ☐ No ☐
Hashimoto's Thyroiditis	Yes ☐ No ☐	If yes, what? _____	

If yes to any above, please describe nature of symptom and rate severity on scale of 0 to 8 (8 being most severe).

Symptom	**Rating**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

12. Has the client ever been diagnosed with any of the following disorders?

Cerebral Palsy	Yes ☐ No ☐	Migraines	Yes ☐ No ☐
Environmental Toxin Syndrome	Yes ☐ No ☐	Multiple Sclerosis	Yes ☐ No ☐
(Due to black mold, carbon monoxide, chemicals or inhalants)		Parkinson's	Yes ☐ No ☐
Fetal Alcohol Syndrome	Yes ☐ No ☐	Asperger's Syndrome	Yes ☐ No ☐
Hypoxia	Yes ☐ No ☐	Autism	Yes ☐ No ☐

If yes to any above, please describe nature of symptom and rate severity on scale of 0 to 8 (8 being most severe).

Symptom	**Rating**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____