Marital Status

Sibling Information:

Name	Age	Gender	Relationship to Child	Currently at home?	Any learning, behavior or emotional challenges? (Please describe)
				Y ☐ N ☐	
				Y ☐ N ☐	
				Y ☐ N ☐	

Have there been any deaths or separations from caregivers, family members, babysitters, or friends with whom your child had close contact? If yes, please explain and include dates of separation/loss:

_____

_____

Medical History

Allergies: Y/N If yes, please describe _____
Treatment for allergies? _____

Please list all major illnesses, injuries, surgeries, or other medical conditions that your child has experienced:

Dates	Details	Physician/Clinic or Hospital

Please list all mental health services your child has received including neuropsychological, outpatient, or psychiatric:

Dates	Reason/Type of Treatment/Outcome	Therapist/Clinic or Hospital

Please list any prescription medications that your child is currently taking:

Medication	Dosage/ Times a day	Days/week?	Reason Taken	Physician/Clinic or Hospital
		-School days ☐ -7 days/week ☐ -As needed ☐		
		-School days ☐ -7 days/week ☐ -As needed ☐		

Family Medical History

Place a check next to any illness or condition that any member of the immediate family (i.e., brothers, sisters, aunts, uncles, cousins, grandparents) has had. Please note the family member's relationship to the child.

	Relationship to child		Relationship to child
☐ Seizures or Epilepsy	_____	☐ Neurological illness or disease	_____
☐ Attention deficit	_____	☐ Mental illness	_____
☐ Hyperactivity	_____	☐ Depression or anxiety	_____
☐ Learning disabilities	_____	☐ Tics or Tourette's syndrome	_____
☐ Mental retardation	_____	☐ Alcohol or drug abuse	_____
☐ Childhood behavior problems	_____	☐ Suicide attempt	_____

Child's Perinatal Health and Early Developmental History

List any complications during pregnancy (excessive vomiting, blood loss, threatened miscarriage, infections, toxemia, fainting, dizziness, etc.): _____

Duration of pregnancy (weeks): _____ Duration of labor (hours): _____ Birth weight: _____

What was your first impression of your baby? _____

Check any that apply to the birth: ☐ Labor induced ☐ Forceps ☐ Breech ☐ Caesarean

If yes on any of other above, for what reason? _____

Check any that apply following birth: ☐ Jaundice ☐ Breathing problems ☐ Incubator ☐ Birth defect

If yes, please describe: _____

Were there any other complications? Yes/No No If yes, please describe: _____

Was there any maternal depression? Yes/No No If yes, please describe: _____

Were there any feeding problems? Yes/No No If yes, please describe: _____

Were there any sleeping problems? Yes/No No If yes, please describe: _____

Were any of the following present (to a significant degree) during infancy or the first few years of life?

- ❑ Unusually quiet or inactive
- ❑ Did not like to be held or cuddled
- ❑ Not alert
- ❑ Difficult to soothe
- ❑ Colic
- ❑ Excessive restlessness
- ❑ Excessive sleep
- ❑ Diminished sleep
- ❑ Head-banging
- ❑ Constantly into everything
- ❑ Excessive number of accidents compared to other children

Is or has this child ever been overly sensitive to:

- ❑ Touch (e.g. tags in clothing, wet diapers, textures)
- ❑ Sights (e.g. lights, different colors, other visual stimuli)
- ❑ Tastes
- ❑ Smells (e.g. perfumes, etc.)
- ❑ Noises (e.g. vacuum, telephone ring, etc.)

For each behavior, please specify age in months or if the behavior was Early; Late; or Never:

- ❑ Sit without assistance _____
- ❑ Crawl _____
- ❑ Walk _____
- ❑ Babble _____
- ❑ First word _____
- ❑ Sentences _____
- ❑ Dress self _____
- ❑ Tie shoelaces _____
- ❑ Fed self _____
- ❑ Bladder trained, day _____
- ❑ Bladder trained, night _____
- ❑ Bowel trained _____
- ❑ Rode tricycle _____

Expand on any growth or development problems during the first few years of life: _____

_____

_____

_____

Reason for Referral to Union Square Practice

- ❑ Speech and language problems
- ❑ Poor school work
- ❑ Behavior problem at school
- ❑ Behavior problem at home
- ❑ Immaturity
- ❑ Activity (hyperactive, underactive)
- ❑ Tantrums
- ❑ Discipline/compliance
- ❑ Difficulties being soothed
- ❑ Peer difficulties/bullying
- ❑ Social skills problems
- ❑ Shy/socially withdrawn
- ❑ Sleep difficulties
- ❑ Eating and/or appetite issues
- ❑ Excessive fears (phobias)
- ❑ Excessive worries
- ❑ Sadness/depression
- ❑ Low self-esteem
- ❑ Grief/bereavement
- ❑ Family problems/conflict
- ❑ Coping with divorce/family changes
- ❑ Self-injurious behavior (e.g, cutting)
- ❑ Drug and/or alcohol problems
- ❑ Suicide attempts
- ❑ Other (please describe):

_____

_____

_____

For all the reasons checked, please specify the problem and describe why you are seeking treatment for your child:

Does your child/adolescent agree on the nature of the presenting problem? If not, please describe your child/adolescents point of view on your concern:

Please include any other issues, questions, or concerns you have about your child here.

Thank you for taking the time to complete this form. We look forward to meeting with you and your child.

Union Square Practice
138 West 25th St. 10th Floor
New York, NY 10001
Phone: (212) 335-2100
Fax: (646) 775-4142
Text: (347) 657-7425

Credit Card Authorization Form

Your credit card information will be securely stored in our electronic medical record system and used for all charges accrued. The statement for all the charges incurred will be available to you on the patient portal at the end of each month.

Patient Name: _____

Cardholder Name: _____
As it appears on your card

Cardholder Billing Address: _____
Street Apartment

_____
City State Zip Code

Phone Number: _____

Card Number: _____

Expiration Date: _____

Security Code:* _____

** This number is 3 digits and is the non-embossed number printed on the signature panel on the back of your card immediately following the card account number. This number is recorded as an additional security precaution. If you have an American Express card, this number is the 4-digit non-embossed code on the front of your card.*

Typing your name below will be equivalent to a signature

Cardholder Signature: _____

Date: _____