

# Life Development Resources, P.A.

Date \_\_\_\_\_ Therapist \_\_\_\_\_ DX Code \_\_\_\_\_

## Patient Information

Patient Name (Print) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Work Phone \_\_\_\_\_  
Okay to Leave Message? \_\_\_ Yes \_\_\_ No  
Okay to Leave Message? \_\_\_ Yes \_\_\_ No  
Soc Sec # \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Emergency Phone \_\_\_\_\_  
Sex: \_\_\_ M \_\_\_ F Age \_\_\_\_\_ Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Other  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Referred by \_\_\_\_\_

## Primary Insurance

Primary Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Ins Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy/ID \_\_\_\_\_ Group/Plan ID \_\_\_\_\_  
For Health Partners Only: Policy Holder's ID \_\_\_\_\_  
Name of Policyholder \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Soc Sec # \_\_\_\_\_ Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Secondary Insurance

Secondary Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Ins Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy/ID \_\_\_\_\_ Group/Plan ID \_\_\_\_\_  
Name of Policyholder \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Soc Sec # \_\_\_\_\_ Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

## Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the healthcare provider to release all necessary information to A.C.E. Billing, Inc, to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature Relationship Date

LIFE DEVELOPMENT RESOURCES, P.A.

**CHILD INTAKE (Age 2-12)**

Name of child: \_\_\_\_\_

Age: \_\_\_\_\_

Birth date: \_\_\_\_\_

Sex: Male Female

**Parent**

Name	
Street address	
City, State, Zip	
Home phone	Work phone
Education	Occupation

**Parent**

Name	
Street address	
City, State, Zip	
Home phone	Work phone
Education	Occupation

**Family status:**

Married     Separated (in \_\_\_\_/\_\_\_\_)     Divorced (in \_\_\_\_/\_\_\_\_)     Never married

Does your child have stepparents?  No     Yes. If yes, please complete below:

**Parent**

Name	
Street address	
City, State, Zip	
Home phone	Work phone
Education	Occupation

**Parent**

Name	
Street address	
City, State, Zip	
Home phone	Work phone
Education	Occupation

Is your child adopted?  No     Yes. If yes, how old was child at time of adoption? \_\_\_\_\_

Is your child aware of the adoption?  No     Yes

If separated, child's primary residence is with whom? \_\_\_\_\_

Name of child's legal guardian \_\_\_\_\_

Name of child's foster parents \_\_\_\_\_

Foster parent's address \_\_\_\_\_

**PURPOSE:**

What are the main reasons for coming to therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has this been a problem for your child? \_\_\_\_\_

**SPACE BELOW RESERVED FOR THERAPIST**

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**HISTORY:**

**Pregnancy Complications:**  No  Yes. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_

**Delivery Complications:**  No  Yes. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_

**Post Delivery Period Complications for Baby:**  No  Yes. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_

**Infancy-Toddler Period:**

Were any of the following present – to a significant degree – during the first few years of life?  
If so, describe.

- Did Not Enjoy Cuddling \_\_\_\_\_
- Was Not Calmed by Being Held and/or Stroked \_\_\_\_\_
- Colic \_\_\_\_\_
- Excessive Restlessness \_\_\_\_\_
- Diminished Sleep Because of Restlessness and Easy Arousal \_\_\_\_\_
- Frequent Head banging \_\_\_\_\_
- Constantly Into Everything \_\_\_\_\_
- Excessive Number of Accidents Compared to Other Children \_\_\_\_\_

Developmental Milestones – Within Normal Limits (smiled, crawled, walked without assistance, toilet training, etc.)  
 Yes  No. If no, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**School:**

Name of current school: \_\_\_\_\_

Rate your child's school experiences related to academic learning:

Good                      Average                      Poor

Daycare \_\_\_\_\_

Nursery School \_\_\_\_\_

Kindergarten \_\_\_\_\_

Current Grade \_\_\_\_\_

To the best of your knowledge, at what grade level is your child functioning:

Reading \_\_\_\_ Spelling \_\_\_\_ Arithmetic \_\_\_\_

Has your child ever had to repeat a grade? If so, when \_\_\_\_\_

Present Class Placement: Mainstream \_\_\_\_ Special Class (if so, specify) \_\_\_\_\_

Kinds of special therapy or remedial work your child is currently receiving \_\_\_\_\_

Describe briefly any academic school problems \_\_\_\_\_

Any testing \_\_\_\_\_

Rate your child's school experience related to behavior:

Good                      Average                      Poor

Nursery School/ Daycare \_\_\_\_\_

Kindergarten \_\_\_\_\_

Current Grade \_\_\_\_\_

Does your child's teacher describe any of the following as significant classroom problems?

- Fidgets in his/her seat \_\_\_\_
- Frequently gets up and walks around the classroom \_\_\_\_
- Shouts out/ Doesn't wait to be called upon \_\_\_\_
- Has difficulty waiting for his/her turn \_\_\_\_
- Does not cooperate will in group activities \_\_\_\_
- Typically does better in one-to-one relationships \_\_\_\_
- Has difficulty respecting the rights of others \_\_\_\_
- Is distracted during storytelling \_\_\_\_

Describe briefly any other classroom behavioral problems: \_\_\_\_\_

**Peer Relationships:**

Does your child seek friendships with peers? \_\_\_\_

Is your child sought by peers for friendship? \_\_\_\_

Does your child play primarily with children his/her own age? \_\_\_\_

If no, are they generally younger? \_\_\_\_ Older \_\_\_\_

Describe briefly any problems your child may have with peers \_\_\_\_\_

Describe briefly the strengths your child may have with peers \_\_\_\_\_



**Presents Medical Status:**

Present Height \_\_\_\_\_ Present Weight \_\_\_\_\_  
Present Illness(es) for which child is being treated \_\_\_\_\_

Medications child is taking on an ongoing basis \_\_\_\_\_

**SPACE BELOW RESERVED FOR THERAPIST (Medical)**

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**Social History:**

Does your child have a history of any of the following types of abuse?

	<u>When</u>	<u>By Whom</u>
Physical	_____	_____
Sexual	_____	_____
Emotional	_____	_____
Neglect	_____	_____

Any other type of victimization such as bullying?  No  Yes. If yes, please explain. \_\_\_\_\_

Have there been any other adults or children living in the home either past or present?  
 No  Yes. Comments: \_\_\_\_\_

**Family History –**

**Mother:** Age \_\_\_\_\_ Age at time of pregnancy with patient \_\_\_\_\_  
Number of previous pregnancies \_\_\_\_\_ Number of Spontaneous Abortions (Miscarriages) \_\_\_\_\_  
Number of Induced Abortions \_\_\_\_\_  
Infertility Problems (specify) \_\_\_\_\_  
School: Highest Grade Completed \_\_\_\_\_  
Learning Difficulties (specify) \_\_\_\_\_  
Behavioral Difficulties (specify) \_\_\_\_\_  
Medical Problems (specify) \_\_\_\_\_  
Have any of your biological relatives (not including patient and siblings) ever had problems similar to those of your child? If so, describe. \_\_\_\_\_

**Father:** Age \_\_\_\_\_  
School: Highest Grade Completed \_\_\_\_\_  
Learning Difficulties (specify) \_\_\_\_\_  
Behavioral Difficulties (specify) \_\_\_\_\_  
Medical Problems (specify) \_\_\_\_\_  
Have any of your biological relatives (not including patient and siblings) ever had problems similar to those of your child? If so, describe. \_\_\_\_\_



Most children exhibit, at one time or another, one or more of the symptoms listed below. Place a X in either the Past or Current column next to the symptoms that your child exhibits now or has exhibited in the past. Only mark those symptoms that have been or are at present exhibited over a period of time. Only check as problems behavior that you suspect is unusual or atypical when compared to what you consider to be the normal for your child's age.

<u>Past</u>	<u>Current</u>	<u>Symptom</u>	<u>Past</u>	<u>Current</u>	<u>Symptom</u>
_____	_____	Thumb Sucking	_____	_____	Preoccupied with Food/ What to Eat/Not to Eat
_____	_____	Baby Talk	_____	_____	Preoccupied with Bowel Movement
_____	_____	Overly Dependent for Age	_____	_____	Constipation
_____	_____	Frequent Temper Tantrums	_____	_____	Encopresis (soiling)
_____	_____	Excessive Silliness and Clowning	_____	_____	Insomnia (difficulty sleeping)
_____	_____	Excessive Demands for Attention	_____	_____	Enuresis (bed wetting)
_____	_____	Cries Easily and Frequently	_____	_____	Frequent Nightmares
_____	_____	Generally Immature	_____	_____	Night Terrors
_____	_____	Eats Non-Edible Substances	_____	_____	(terrifying nighttime outbursts)
_____	_____	Overeating with Overweight	_____	_____	Sleepwalking
_____	_____	Eating binges with Overweight	_____	_____	Excessive Sexual Interest
_____	_____	Under eating with Underweight	_____	_____	and Pre-Occupation
_____	_____	Long Periods of Dieting/ Food Abstinence with Underweight	_____	_____	Frequent Sex Play with Other Children
_____	_____	Excessive Masturbation	_____	_____	Doesn't Respect the Rights of Others
_____	_____	Frequently Likes to Wear Clothing of the Opposite Sex	_____	_____	Wants Things Own Way With Exaggerated Reaction if Thwarted
_____	_____	Exhibits gestures and Intonation of the Opposite Sex	_____	_____	Trouble Putting Self In Other Persons Shoes
_____	_____	Frequent Headaches	_____	_____	Egocentric (self-centered)
_____	_____	Frequent Stomach Cramps	_____	_____	Frequently Hits Other Children
_____	_____	Frequent Nausea and Vomiting	_____	_____	Argumentative
_____	_____	Often Complains of Bodily Aches and Pains	_____	_____	Excessively Taunts Other Children
_____	_____	Worries Over Bodily Illness	_____	_____	Ever Complaining
_____	_____	Poor Motivation	_____	_____	Is Often Picked On and Easily Bullied By Other Children
_____	_____	Apathy	_____	_____	Anxiety Attacks with Palpitations (heart pounding), Shortness of Breath, Sweating, etc.
_____	_____	Takes Path of Least Resistance	_____	_____	Disorganized
_____	_____	Ever Trying to Avoid Responsibility	_____	_____	Suspicious, Distrustful
_____	_____	Poor Follow-Through	_____	_____	Aloof
_____	_____	Low Curiosity	_____	_____	Wise-guy or Smart Aleck Attitude
_____	_____	Open Defiance of Authority	_____	_____	Braggs or Boasts
_____	_____	Blatantly Uncooperative	_____	_____	Bribes Other Children
_____	_____	Persistent Lying	_____	_____	Excessively Competitive
_____	_____	Frequent Use of Profanity To Parents, Teachers, and Other Authorities	_____	_____	Often Cheats When Playing Games
_____	_____	Truancy from School	_____	_____	Sore Loser
_____	_____	Runs Away from Home	_____	_____	'Doesn't Know When To Stop
_____	_____	Violent Outbursts of Rage	_____	_____	Poor Common Sense in Social Situations
_____	_____	Stealing	_____	_____	
_____	_____	Cruelty to Animals, Children and Others	_____	_____	
_____	_____	Destruction of Property	_____	_____	
_____	_____	Criminal and/or Dangerous Acts	_____	_____	
_____	_____	Trouble with Police	_____	_____	
_____	_____	Violent Assault	_____	_____	
_____	_____	Fire Setting	_____	_____	

<u>Past</u>	<u>Current</u>	<u>Symptom</u>	<u>Past</u>	<u>Current</u>	<u>Symptom</u>
_____	_____	Little, if any, Guilt	_____	_____	Often Feels Cheated
_____	_____	Over Behavior that Causes	_____	_____	or Gyped
_____	_____	Others Pain and Discomfort	_____	_____	Feels Others are Persecuting
_____	_____	Quietly, or Often Silently	_____	_____	Him When There is no
_____	_____	Defiant of Authority	_____	_____	Evidence for Such
_____	_____	Feigns or Verbalizes	_____	_____	Typically Wants His or
_____	_____	Compliance or Cooperation	_____	_____	Her Own Way
_____	_____	But Doesn't Comply with Requests	_____	_____	Very Stubborn
_____	_____	Drug Abuse	_____	_____	Obstructionistic
_____	_____	Alcohol Abuse	_____	_____	Negativistic (does just
_____	_____	Very Tense	_____	_____	the Opposite of What is Required
_____	_____	Little, if any,	_____	_____	Excessive Self-Criticism
_____	_____	Response to Punishment	_____	_____	Very Poor Toleration
_____	_____	for Anti-Social Behavior	_____	_____	of Criticism
_____	_____	Few, if any, Friends	_____	_____	Feelings Easily Hurt
_____	_____	Doesn't Seek Friendships	_____	_____	Dissatisfaction with
_____	_____	Rarely Sought by Peers	_____	_____	Appearance or Body Parts
_____	_____	Not Accepted by Peer Group	_____	_____	Excessive Modesty
_____	_____	Selfish	_____	_____	Over Bodily Exposure
_____	_____	Nail Biting	_____	_____	Asks to be Punished
_____	_____	Chews on Clothes,	_____	_____	Low Self-Esteem
_____	_____	Blankets, Etc.	_____	_____	Mute (Refuses to Speak
_____	_____	Head Banging	_____	_____	But is Able to)
_____	_____	Hair Pulling	_____	_____	Gullible and/or Naive
_____	_____	Picks on Skin	_____	_____	Passive and Easily Led
_____	_____	Speaks Rapidly	_____	_____	Excessively Fantasizing,
_____	_____	Under Pressure	_____	_____	'Lives in His or Her
_____	_____	Irritability, Easily	_____	_____	Own World'
_____	_____	'Flies off the Handle'	_____	_____	Perfectionistic, Rarely
_____	_____	Fears Dark	_____	_____	Satisfied with Performance
_____	_____	Fears New Situations	_____	_____	Irritation of Certain Clothes
_____	_____	Fears Strangers	_____	_____	(i.e. tags, certain fabrics)
_____	_____	Fears Being Alone	_____	_____	Difficulty Changing from
_____	_____	Fears Death	_____	_____	One Activity to Another
_____	_____	Fears Separation From Parent	_____	_____	Without Warning
_____	_____	Fears School	_____	_____	Extra Sensitivity to Loud
_____	_____	Fears Visiting Other	_____	_____	Noises and/or Smells
_____	_____	Children's Homes	_____	_____	Frequently Blames Others
_____	_____	Fears Going Away to Camp	_____	_____	as a Cover-up for Own
_____	_____	Fears Animals	_____	_____	Shortcomings
_____	_____	Has Other Fears (name)	_____	_____	Little Concern for Personal
_____	_____	Withdrawn	_____	_____	Appearance or Hygiene
_____	_____	Fears Asserting Self	_____	_____	Little Concern for or Pride in
_____	_____	Inhibits Open Expression	_____	_____	Personal Property
_____	_____	of Anger	_____	_____	Gets Hooked on Certain
_____	_____	Allows Self	_____	_____	Ideas and Remains Preoccupied
_____	_____	to be Easily Taken Advantage of	_____	_____	Compulsive Repetition of
_____	_____	Frequently Pouts and/or Sulks	_____	_____	Seemingly Meaningless
_____	_____	Ticks, Such as Eye-Blinking	_____	_____	Physical Acts
_____	_____	Grimacing or Other Spasmodic	_____	_____	Shy
_____	_____	Repetitions	_____	_____	Inhibited Self-Expression
_____	_____	Involuntary Grunts,	_____	_____	In Dancing, singing, Laughing
_____	_____	Vocalizations	_____	_____	Etc.
_____	_____	(understandable or not)	_____	_____	Recoils from Affectionate
_____	_____	Stuttering	_____	_____	Physical Contact



