PRIMACARE, LLC
Mental Health and Consultation Services

AN AFFILIATED COMPANY OF
SPECTRUM HUMAN SERVICES

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RICHARD RIZZO, Ph.D., LP
PRESIDENT

MINOR AUTHORIZATION

I, ____, hereby authorize treatment of my

minor child, _______________________________________, by Primacare staff.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of this account for any professional services rendered.

____
Patient/Parent/Legal Guardian Signature

____
Witness

____
Patient/Parent/Legal Guardian SS#

____
Date

____
Address, Street Name

____
City, State, Zip

____
Work Phone #

____
Date

PRIMACARE, LLC
MENTAL HEALTH & CONSULTATION SERVICES
DEVELOPMENTAL HISTORY
(17 YEARS OLD AND YOUNGER)

PATIENT NAME: ________________________________

PREGNANCY OF MOTHER:

Age of Mother at time of pregnancy ___________
Was child planned? ______Yes ______No
Adopted? ______Yes ______No
Length of Pregnancy _________months
This child was pregnancy number ___________
Birth number ________ for mother
Any problems in pregnancy? ______Yes ______No (If yes, please circle)

Anemia	Emotional Problems	Drugs/Alcohol/Tobacco
High Blood Pressure	High Fevers	Previous Miscarriages
Vaginal Infections	Kidney Problems	Diabetes
Measles	Other: ______________________________	

BIRTH OF CHILD:

What was child's birth weight? ______________________________/ Unknown
How long was labor? ____________________ Premature? ______Yes ______No
What type of delivery? (natural, forceps, caesarean, breech) _________________________
Did baby have any breathing problems? ______Yes ______No
Was oxygen needed? ______Yes ______No
Incubator needed? ______Yes ______No
Did baby require blood transfusion? ______Yes ______No
Medication: ______Yes ______No
Electroencephalogram (EEG)? ______Yes ______No
Did baby have yellow jaundice? ______Yes ______No
Do you know infant apgar score? ______Yes ______No If yes, number __

CHILDHOOD HISTORY:

INFANCY:

Was baby breast fed? ______Yes ______No How long? ____
Did baby feed well? ______Yes ______No
Was child colicky? ______Yes ______No
Did child have sleep problems? ______Yes ______No
Was child alert? ______Yes ______No
Was child markedly hyperactive? ______Yes ______No
Did child display tantrums? ______Yes ______No
At what age did child crawl? _________ Stand alone? ______________
At what age did child walk? _________ At what age was child toilet trained? __________
When did child tie his/her own shoes? ____________
When did child dress himself/herself? ____________
When did child ride a tricycle? ______________ Bicycle? _________
When did child first speak? ______________ In sentences? _________

Patient Name: ___________________________

SPEECH/HEARING/VISUAL HISTORY:

Has child had any speech difficulties? ______Yes ______No When? __________________
What? ____
Was child in speech therapy? ______Yes ______No When? _________________________
Has child had any hearing difficulties? ______Yes ______No When? __________________
What? ____
Has child had any vision difficulties? ______Yes ______No When? __________________
Does child wear glasses? ______Yes ______No

IMMUNIZATION HISTORY:

List immunizations child has had (if known): ____
____

EDUCATIONAL HISTORY: School Age

Did child attend a pre-school daycare program? ______Yes ______No
What age? _________ How Long? _________
What is child's current grade level? _________
Recent average grade in school? _________
Any recent changes: ______Yes ______No Up or Down?
Were any grades repeated? ______Yes ______No When? ______________________
Any special tutoring needed? ______Yes ______No When? ______________________
What? ____
Was child ever in special education classes? ______Yes ______No
When? _________________________ How long? _________________________
What type? ____
How would informant rate child's behavior in school?
______Excellent ______Good ______Fair ______Poor
How would informant rate child's behavior with teacher?
______Excellent ______Good ______Fair ______Poor
With peers? ______Excellent ______Good ______Fair ______Poor
Was child ever suspended or expelled from school? ______Yes ______No
When? _________________________ How long? _________________________
Why? ____
How many different schools has child attended? ______________________________________

CHILD'S VOCATIONAL HISTORY:

Does child help with household chores? ______Yes ______No
What? ____
Does child work? ______Yes ______No
Where? ______________________________ What Hours? _________________________
What are child's future vocational aspirations? ____________________________________

CHILD'S LEGAL HISTORY:

Has child ever been in trouble with the legal system? ______Yes ______No
If yes, explain ____

Patient Name: ___________________________

CHILD'S PRESENT FAMILY STRENGTHS/LIVING ARRANGEMENT:

Child is currently living with: ____

Are parents married, never married, divorced, divorcing, widowed? ________________________

How would you rate child's relationship with siblings? (if applicable)
______Excellent ______Good ______Fair ______Poor

With mother (if applicable)
______Excellent ______Good ______Fair ______Poor

With father (if applicable)
______Excellent ______Good ______Fair ______Poor

Does child share a room? ______Yes ______No

How many residences has the child been in since birth? _______________________________

CHILD, PARENT OR FAMILY ISSUES: (Check all that apply)

______Emotional – i.e. depression, anxiety, hyperactivity, etc.

______Behavioral – i.e., lying, stealing, destruction of property, etc.

______Social – i.e., withdrawal, fighting, etc.

______School – i.e., poor grades, conflict with peers or teachers, etc.

______Substance Abuse – any use of suspected use of alcohol or drugs for patient or family

______Vocational – i.e., work conflict, absenteeism, etc.

______Home stress – i.e., divorce, marital conflict, sibling rivalry, etc.

______Parenthood – i.e., feeling overwhelmed due to responsibilities of parenthood, understanding maturation process, etc.

____ ______________________________

Parent/Legal Guardian Date

____ ______________________________

Therapist Date