Norma Faye Pierce, Ph.D.

6576 AIRPORT BLVD. SUITE 200B
PHONE | 251.342.4707
EMAIL | PSYCHNFP@GMAIL.COM

Please answer ALL information on this form about the CHILD being seen. In order to provide the most effective and comprehensive services possible, please complete the following packet as thoroughly and accurately as possible.

## Patient Information

Name: _____ Date: _____
(Last) (First) (Middle Initial)

Social Security # _____ Date of Birth _____ Age _____ Gender _____ Race _____

Address _____ City _____ State _____ Zip _____

Day Time Phone: _____ May we leave a message? ☐ Yes ☐ No

E-mail: _____

School: _____ Grade: _____

Who may we thank for referring you to this office? _____

## Primary Guardian Information

Name: _____ Relationship: _____
(Last) (First) (Middle Initial)

Address _____ City _____ State _____ Zip _____
(If Different)

Date of Birth: _____ SSN# _____ Employer: _____

## Additional Guardian Information

Name: _____ Relationship: _____
(Last) (First) (Middle Initial)

Address _____ City _____ State _____ Zip _____
(If Different)

Date of Birth: _____ SSN# _____ Employer: _____

Name of person completing this form:_____ Relationship to Patient: _____

## Chief Complaint
(**Must** be completed)

Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.):

Has your child received any previous treatment for the problem? ☐ Yes ☐ No If yes, explain:

## Medical History

Name of Pediatrician or Family Doctor: _____ Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? □ Yes □No

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed:

- ☐ Seizures
- ☐ Asthmatic condition
- ☐ Chronic Hearing Loss
- ☐ Heart Problems
- ☐ Chronic Fatigue
- ☐ Stomach Problems
- ☐ Weight Problems
- ☐ Chronic Headaches
- ☐ Suicidal Thoughts
- ☐ Head Injury
- ☐ Depression
- ☐ Surgeries
- ☐ Other _____

**Current Medications** (Please list all of your child's current medications):

## Past Psychiatric/Psychological History

Has your child ever received psychiatric services or counseling? ☐ Yes ☐No

If yes, please explain and include dates of service, location, clinician's name:

## Developmental History:

Your child's weight at birth: ____lbs.____ oz.

Was this a full term birth? ☐ Yes ☐No If no, explain:_____

Did either parent use drugs or alcohol at the time of conception? ☐ Yes ☐No

If yes, explain:_____

Were there any complications with the labor & delivery? ☐ Yes ☐No

If yes, explain:_____

Were there any problems after birth? ☐ Yes ☐No

If yes, explain:_____

**Pre-school/Toddler Temperament** Please check the following items that apply:

| | | |
|---|---|---|
| ☐ Did not enjoy being held | ☐ Sleep problems | ☐ Head-banging |
| ☐ Feeding problems | ☐ Fussy or unhappy | ☐ Difficulty bonding |
| ☐ Excessive restlessness | ☐ Colic | ☐ Sensitive to light/noise/texture |

**Developmental Milestones:** Please indicated the approximate age in month when your child achieved the following tasks

Sitting alone _____ Walking _____ Put words together _____ Toilet trained_____

**Unusual behaviors/Speech patterns:**

| | | |
|---|---|---|
| ☐ Spinning | ☐ Putting things in the mouth | ☐ Repeating words or phrases inappropriately |
| ☐ Hand flapping | ☐ Sniffing excessively | ☐ Saying "I" for "You" |

## Education History

Did your child attend daycare? ☐ Yes ☐No If yes, what was their age? _____

Are you currently enrolled in school? ☐ Yes ☐No If yes, where?_____ Grade:_____

Please identify any school-related problems:

| | | |
|---|---|---|
| ☐ Inattentiveness | ☐ Suspensions or Expulsion | ☐ Current problems with truancy |
| ☐ Bullying/Being bullied | ☐ Refusing to do or complete work | |
| ☐ School-related anxiety | | |

Has your child ever been evaluated for a learning disability? ☐ Yes ☐ No If yes, when? _____

Placed in Special Education Classes? ☐ Yes ☐ No If yes, what type of class? _____

Tested by the school system? ☐ Yes ☐ No If yes, when? _____

Expelled or suspended? ☐ Yes ☐ No If yes, please described:

Does your child have a current IEP (Individual Education Plan) or 504 plan? ☐ Yes ☐ No

## Legal History:

Have you ever been arrested? ☐ Yes ☐ No

If yes, date of arrest_____ Charge _____ Punishment _____

If yes, date of arrest_____ Charge _____ Punishment _____

If yes, date of arrest _____Charge _____ Punishment _____

Do you have any current, pending, or expected future legal issues? ☐ Yes ☐ No

If yes, Please explain:

## Social/Family History

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, what is the level of your involvement? _____

Please state or describe your faith or belief _____

Are there any ethnic or cultural practices or beliefs which we need to be aware of? ☐ Yes ☐ No

If yes, please describe _____

Favorite hobbies or activities: _____

Favorite movies, books or TV shows:_____

Personal strengths: _____

Biological mother's full name: _____ Biological father's full name: _____

Biological parents marital status: Married to each other Divorced Separated

If the biological parents are divorced or separated, who has custody of the patient? _____

Stepmother's full name: _____ Stepfather's full name: _____

List all relatives who presently live in the same household as your child:
(if more than 5 please list on back of this sheet)

| Name | Relationship | Type of Employment/Student Grade Level |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

5. _____

Please check any of the following stressors that presently affect your child:

| | | |
|---|---|---|
| ☐ Family financial problems | ☐ Family relationships | ☐ Abuse behavior |
| ☐ Child rearing problems | ☐ Drug or alcohol problems | ☐ School problems |
| ☐ Health Problems | ☐ Employment problems | ☐ Frequent moves |
| ☐ Peer relationships | ☐ Legal problems | ☐ "Other" problems |

Please explain how any item you check affects your child:

## Permission to Treat

I am legally authorized to as the parent/guardian of _____ to enroll him/her in psychological services. I hereby authorize Dr. N. Faye Pierce to evaluate/treat this patient.

Signature _____

Date _____

Thank you for your cooperation and patience. Dr. Pierce will see you shortly and discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with these issues.