



Anne K. Conley-Goldstein, Ph.D., HSPP
3077 East 98th Street, Suite 170
Indianapolis, IN 46280
Phone: 317.566.2814 Fax: 317.566.2815

Registration Form

Client's Name: _____	
Client's Date of Birth: _____ Client's Gender: _____	
Client's School and Grade: _____	
Address: _____ Street: _____ City: _____ Zip Code: _____	Other Address (if applicable): _____ Street: _____ City: _____ Zip Code: _____
Client's Parent(s)/Guardian(s) Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Mother Remarried <input type="checkbox"/> Father Remarried <input type="checkbox"/> Mother Deceased <input type="checkbox"/> Father Deceased	Relationship to Client: <input type="checkbox"/> Parent(s) <input type="checkbox"/> Legal Guardian(s) <input type="checkbox"/> Health care custodial parent(s) <input type="checkbox"/> Other authorized person(s)
Mother's Name: _____	
DOB: _____ Years of Education: _____	
Occupation: _____ Work Phone #: _____	
Home Phone #: _____ Alternate Phone #: _____	

Father's Name: _____	
DOB: _____	Years of Education: _____
Occupation: _____	Work Phone #: _____
Home Phone #: _____	Alternate Phone #: _____
Names and Ages of Siblings:	

Emergency Contact Information:	
*Please provide Name, Address, Phone Number(s), and Relationship to the Patient	

Separated or Divorced Caregivers

If the Client's primary caretakers are separated, divorced, or remarried, please provide additional visitation and contact information below (e.g., schedule for visitation, names of step-parents, additional addresses and phone numbers, other important relatives, etc.)

*****NOTE: IF PARENTS HAVE JOINT LEGAL CUSTODY, CHILD WILL NOT BE SEEN UNTIL PERMISSION IS OBTAINED FROM BOTH PARENTS. ADDITIONAL CONSENT FORMS NEED TO BE SIGNED IN THESE CASES*****

Reasons for Seeking Psychological Services

What are your primary concerns at this time? (Please be as specific as possible)

What would you consider to be your child's best qualities or strengths?

Please circle any of the following behaviors that your child has shown in the past 12 months:

- Problems with Feeding or Eating Temper Tantrums Excessive Hitting Biting**
Self-Injurious Behaviors Social Withdrawal Rocking Social Problems
Sleeping Problems Excessive Fears Excessive Activity Level Difficulty Sitting Still
Attention Problems Disorganization Shyness Hand Flapping or Toe-Walking
Learning Problems Repetitive or Compulsive Behaviors Repetitive Vocalizations
Defiance Lying Drug or Alcohol Problems Suicidal Thoughts or Attempts
Legal Problems Running Away Truancy Cutting Sexual Acting Out

Sexual Molestation or Abuse: (Specify: Victim and/or Perpetrator)

Please elaborate on any of the behaviors that you circled:

Family Psychiatric History

(Please circle any problems/diagnoses that apply to either mother's or father's side of the family)

Depression Suicide Attempted Suicide Anxiety Bipolar Disorder
Panic Attacks Phobias Obsessive/Compulsive Disorder Trauma Disorder
Sexual/Physical Abuse Substance Abuse Eating Disorder Seizures Tics
Developmental Delays Retardation Learning Problems Dementia

During the past 12 months, has your family experienced:

_____ Death/Serious illness of a family member _____ Change in address
_____ Unemployment _____ Change in school
_____ Marital problems _____ Birth or adoption of a new baby or child in household

Other: _____

How did you find out about this practice? _____

Who is your child's current pediatrician? (Please list name and address of practice):

Past Treatment History and Diagnoses

Please list any previous therapists or psychiatrists your child has seen or is seeing. Please include start and stop dates, reasons for treatment, and any formal diagnoses given:

If your child is currently taking any prescription medications, please list them below with the dosage and frequency for each medication:

Developmental History

Was this a planned pregnancy? _____

Was regular medical care given during the pregnancy? ____ Were prenatal vitamins used? _____

Were there any problems or complications during the pregnancy? (If yes, please describe the problem and the time it occurred during the pregnancy, such as diabetes, excess vomiting, bleeding, high blood pressure, toxemia, weight loss, fever, accidents, etc.)

Were cigarettes or alcohol used during the pregnancy? (If yes, please provide details about how much and how often)

Were there any problems or complications during the delivery or shortly after the child's birth? (If yes, please provide details, such as emergency C-Section, slow heart rate, cord around neck, oxygen or medications needed, etc.)

Weight at Birth: _____ APGAR score (if known): _____

Please circle the word(s) that best describe(s) your child's temperament as a baby:

- | | |
|---------------|-------------------------|
| Easy | Self-Soother |
| Anxious/Fussy | Cheerful |
| Good Sleeper | Responsive when Cuddled |

Additional Notes: _____

At what age did your child:

- | | |
|---------------------------------------|--------------------------------------|
| Sit without help? _____ | Say single words meaningfully? _____ |
| Crawl? _____ | Combine 2 or more words? _____ |
| Walk without help? _____ | Use sentences? _____ |
| Become toilet trained? _____ | |
| Stop having accidents at night? _____ | |
| Start sleeping independently? _____ | |

School History

Does/Did your child attend pre-school? _____ Age at Kindergarten entrance: _____

Has your child ever repeated a grade? _____ If yes, which grade(s)? _____

Have you ever requested an evaluation through your school or through another public school system: _____

If yes, please provide date(s) of and reasons for evaluations/reports:

Does your child have an IEP or 504 plan? _____

Please indicate any services and/or resources that your child receives:

Speech/language therapy _____ Physical therapy _____ Occupational therapy _____

Special Education Instruction _____

If yes, please specify subject(s): _____

Tutoring _____

If yes, please specify subject(s): _____

Please list any concerns you have about your child's ability to learn at an age/grade-appropriate level and/or to socialize with other children:

Who is/are the appropriate person(s) to contact for details about your child's school work?

Medical History

Has your child ever had serious accidents, injuries, or been hospitalized? If yes, please list dates and reasons.

Has your child ever had surgery? If yes, please list dates and reasons.

Has your child ever had a seizure or convulsion? If yes, please indicate if a high fever occurred with the seizure or convulsion.

Has your child ever had any head injuries? If yes, please list dates and what happened. Please indicate if your child was unconscious, dizzy, experienced headaches, or vomited.

Please list any allergies that your child has. _____

Please describe any eating difficulties that your child has:

Does your child have frequent abdominal pain or vomiting? If yes, please list how often and any known reasons.

Please describe any vision or hearing problems that your child has.

If your child has a history of frequent ear infections, please specify how often, at what ages, and any specific medical treatments provided.

Insurance Information

Insurance Company:	Policy Number:	Group Number:
Name and DOB of Subscriber:	Subscriber's Employer:	Insurance Phone:

I hereby certify that the information provided on this form is true and complete to the best of my knowledge.

Parent/Guardian Signature

Today's Date