Dr. Romi Mann

Clinical Psychologist (PSY 25226)

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Today's Date: ____/____/______ Your Name: ____

Your relationship to the child: _____________________________

How did you hear about my practice?

- ☐ Friend or acquaintance: ___________________________
- ☐ Referring provider, if so, provider's name: ___________________________
- ☐ Insurance panel directory
- ☐ Good Therapy
- ☐ Network Therapy
- ☐ Psychology Today
- ☐ Other therapy directory or website, if so, please list: ___________________________
- ☐ Internet search (Google, Bing, Yahoo, etc.)
- ☐ Other, specify: ___________________________________

Child's Biographical Information

Child's First Name: _______________________ Last Name: _______________________________MI __

Date of Birth: ____/____/______ Current Age: _____________

Ethnic/Cultural Identity: ____

Gender Identity: ___________________________

Who is the child's legal guardian(s)? ____

Who has physical custody of the child? ____

Is this child a ward of the court? ☐ No ☐ Yes If yes, since what date? ___________________

Was this child adopted? ☐ No ☐ Yes, If yes, at what age? ___________

Child's School Information

School Name: ____ City: __________________________

Grade: ________ Classroom teacher: _______________________________________

Does this child have any learning disabilities? ☐ No ☐ Yes, If yes, specify _____________________

Does this child have an IEP (Individualized Education Plan)? ☐ No ☐ Yes

Special education teacher (if applicable): ____

Learning specialist (if applicable): ____

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Family Information

Please list all the people currently living in the same household with the child, including non-family members (add additional lines, if needed). If the child lives in two homes, both homes need to be described.

Name	Age	Relationship to the child

Second Home (if applicable). List all the people currently living in the child's second home:

Name	Age	Relationship to the child

List other significant people who do not live in the homes above:

	Name	Age	City and State
Parents not living in child's home			
Siblings not living in child's home			
Grandparents			
Babysitters			
Others			

Pre-Natal and Birth History

Was this child full-term? ☐ Yes ☐ No If no, number of weeks when born ________

Did mother experience any complications with any of the following and, if so, please describe:

- Pregnancy ☐ No ☐ Yes: ____
- Labor ☐ No ☐ Yes: ____
- Delivery ☐ No ☐ Yes: ____

Developmental Milestones

Did this child experience any delays with any of the following and, if so, please describe:

- Walking ☐ No ☐ Yes: ____
- Talking ☐ No ☐ Yes: ____
- Toileting ☐ No ☐ Yes: ____
- Muscle coordination ☐ No ☐ Yes: ____
- Social relationships ☐ No ☐ Yes: ____

Developmental Problems

Has this child had a history of any of the following and, if so, please describe

- Sleep problems ☐ No ☐ Yes: ____
- Temper tantrums ☐ No ☐ Yes: ____
- Eating problems ☐ No ☐ Yes: ____
- Unusual crying spells ☐ No ☐ Yes: ____
- Refusing to go to school ☐ No ☐ Yes: ____
- Aggressive behavior ☐ No ☐ Yes: ____
- Oppositional behavior ☐ No ☐ Yes: ____
- Special fears ☐ No ☐ Yes: ____
- Other problems ☐ No ☐ Yes: ____

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Health and Social History

How would you describe this child's physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

	No	Yes	Details
Has this child had any significant medical problems, now or in the past?			
Does this child have any chronic or recurring medical conditions?			
Has this child ever been hospitalized for medical reasons?			
Has this child ever been hospitalized for psychiatric reasons?			
Has this child experienced any other significant medical issues (serious injuries, loss of consciousness, surgeries, etc)?			
Is this child currently taking any medication (including psychiatric medication)?			
Has this child taken psychiatric medications in the past?			
Has this child ever attempted suicide or tried to harm him/herself?			
Has this child had problems with substance use (alcohol, prescription medications, or recreational drugs)?			
Has this child ever been in a physical fight that resulted in injury to self or others?			
Has this child ever been injured or hurt by physical or sexual abuse?			

Physical and Mental Health Care

Health Insurance Company (even if not using for therapy) ______________________________

Does this child have a primary care physician (or clinic)? ☐ No ☐ Yes
If yes (Name/Location/Phone Number):

____

____

Has this child ever participated in psychotherapy? ☐ No ☐ Yes
If yes, when and for how long?

____

____

Is this child currently under the care of a psychiatrist, psychologist, or therapist? ☐ No ☐ Yes
If yes (Name/Location/Phone Number):

____

____

____

____