Patient's Initial: _____

William J. Mace, Ph. D.
Child Information Form

Mobile: *2560 Old Shell Rd.*
Mobile, Al 36607
P: 251-378-8635
F: 251-378-8636

Daphne: *28080 US Hwy 98*
Daphne, AL 36535
P: 251-517-9025
F: 251-517-9026

The information you provide is for professional use only. Please answer all questions to the best of your ability.

Patient's Full Name _____ **Date**_____

Birth Date_____ Age _____ Sex_____

Address_____ City_____ State_____ Zip _____

Phone: Home_____ Cellular_____Email _____

General Physician_____ Referred By_____

As a means to do our best to help you, please explain your expectations regarding Focus. What do you hope to accomplish? What do you expect to gain from your visits? _____

_____

FAMILY

Father's Name _____ Birth Date _____

Address (if different) _____ Phone _____

Education/Degree _____ Occupation _____

Mother's Name _____ Birth Date _____

Address (if different) _____ Phone _____

Education/Degree _____ Occupation _____

Parents' marital status: Single Married Separated Divorced Never married

Parents divorced? _____ If yes, your age at the time ? _____

If deceased, when? _____ If yes, your age at the time? _____

If not your parents, who is your legal guardian/primary caregiver? (if applicable)

Name(s) (if not provided above) _____

Relationship to patient (if applicable) _____

Address (if different) _____ Phone _____

Education/Degree _____ Occupation _____

Guardian's marital status: Single Married Separated Divorced Never Married

	Name	Age	Any related difficulties?
Siblings:			

HOME BEHAVIOR

Please explain child's relationship with:

MOTHER _____

FATHER _____

DESCRIBE HOW THE RELATIONSHIP DIFFERS :

_____

_____

Does your child create more problems, either purposeful or non-purposeful, within the home setting than his/her siblings? _____

Does your child have difficulty benefiting from his/her experiences? _____

_____

Types of discipline you use with your child _____

_____

Is there a particular form of discipline that has proven effective? _____

_____

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? _____

_____

Others currently living in your home: _____

What important things have happened to you or your family in the last six months?

_____

_____

Have there been any recent changes or difficulties in the home that you think are important for me to know?

_____

_____

Tell anything else about your family in the space below that you think would be helpful for me to know.

_____

BIO-MEDICAL and DEVELOPMENTAL HISTORY

Is child:

Biological: _____ Adopted: _____/what age: _____ Foster: _____

Pregnancy

If natural, did you experience problems during your pregnancy?

Excessive vomiting _____ Excessive Staining _____ Infection _____

Toxemia/Operations _____ Other illness _____ Smoking during pregnancy _____

# of cigarettes per day _____ #packs per day _____ Medications taken _____

Alcoholic consumption during pregnancy (describe if beyond occasional drink) _____

X-ray studies during pregnancy _____ Duration of pregnancy (weeks) _____

Birth weight: _____ Normal birth? _____

Labor/Birth

Type of labor (spontaneous/induced/hours): _____

_____

Were there any complications during your child's birth? If yes, please describe.

_____

_____

Infancy

How was his/her development during infancy and toddler years?

_____

Did he/she enjoy cuddling? _____ Was he/she calmed by being held or stroked? _____

Difficult to comfort? _____ Colic? _____ Excessive restlessness? _____

Excessively irritable? _____ Diminished sleep? _____ Head banging? _____

Difficulty nursing? _____ Constantly into everything? _____

Early Development

Did your child meet all developmental milestones around the correct age? _____ If not, please explain: _____

_____

Speech Problems (include difficulty in expressing self verbally) _____

_____

MEDICAL HISTORY

List any physical or medical conditions that affect your child's functioning:

_____

_____

What aches, pain, or physical discomforts has your child experienced? _____

_____

When was the date of his/her last medical check-up?_____

Any significant findings? _____

_____

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Does your child get regular exercise? _____ If yes, how often? _____

Have you ever experienced a significant accident (i.e. wreck, concussion, serious injury)? _____

_____

Surgical Operations? _____

When was your child's last *formal* eye exam? _____ Results: _____

When was your child's last *formal* hearing exam? _____ Results: _____

Family history of mental illness/substance abuse/learning disabilities? _____

_____

Please list all medications that your child is taking including natural supplements:

Name	Frequency	Dosage	Reason

BEHAVIORAL OR EMOTIONAL CHARACTERISTICS

Head Banging		Temper Tantrums		Destructive		Daring	
Excessive Talking		Hard to Make Friends		Excessive Story Telling		Short Attention Span	
Cautious		Hostile		Aggressive		Bites Nails/Sucks Fingers	
Hard to Manage		Unhappy or Sad					

COMPREHENSION & UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his/her age?

If not, why not? _____

_____

SCHOOL HISTORY

Please provide all schools/preschools/day cares attended in chronological order, performance and specific problems at each school.

School _____ City/St _____Grades _____

Problems? _____

School _____ City/St _____Grades _____

Problems? _____

School _____ City/St _____Grades _____

Problems? _____

Your grades: ☐ Above average ☐ Average ☐ Below Average

In what subjects were the highest grades earned? _____

_____

In what subjects were the lowest grades earned? _____

_____

Were there any repeated or skipped grades?_____

_____

Favorite subjects? _____

_____

Homework problems? _____

_____

Problems with tests? _____

_____

Special school problems experienced? _____

_____

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

_____ Doesn't sit still in his/her seat _____ Doesn't cooperate well in group activities

_____ Frequently gets up and walks around _____ Typically does better one on one

_____ Shouts out, doesn't wait his/her turn _____ Doesn't respect the rights of others

_____ Doesn't pay attention during storytelling or show and tell

Briefly describe any other classroom behavioral problems _____

_____

As best as you can recall, please provide a general description of your child's school progress in each grade.

_____

_____

PEER RELATIONSHIPS

Does your child seek friendships with peers? _____

Is your child sought by peers for friendships? _____

Does your child play with children primarily his/her own age? _____ Younger? _____ Older?_____

Briefly describe any problems your child may have with peers. _____

_____

Are there learning difficulties, behavior and/or attention problems in any other members of the family including aunts, uncles, cousins, grandparents, etc.). Please describe. _____

_____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interest? _____

_____

What are your child's areas of greatest accomplishment? _____

_____

What does your child enjoy doing most? _____

What does your child dislike doing most? _____

PREVIOUS EVALUATION OR TREATMENT

Has your child ever had a psychological/educational evaluation? _____ If so, what tests were given?

_____

Results/Recommendations? _____

Who performed the assessment? _____ When? _____

Other assessments:

Occupational Therapist _____ If so, what tests were given: _____

Who performed the assessment? _____ When? _____

Results/Treatment? _____

Language/Speech Pathologist _____ If so, what tests were given: _____

Who performed the assessment: _____ When? _____

Results/Treatment? _____

Has your child ever had therapy or counseling? _____ When? _____ How long? _____

If yes, counselor's name : _____

What changes have you noticed recently in his/her behavior and/or mood (if applicable)? _____

_____

_____

_____

PRESENTING PROBLEM

What are the current problems or difficulties your child is experiencing? _____

_____

_____

_____

What has been tried on your own to help with the difficulties? _____

_____

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PARENT'S WRITTEN CONSENT TO
COMMUNICATE WITH PHYSICIAN OR
ANOTHER DESIGNATED PROVIDER

Date:

To:

I, _____ authorize Dr. William Mace to release the results of

psycho-educational testing to my child's teacher/school and to discuss his/her difficulties and/or

progress.

I, _____ authorize Dr. William Mace to release the results of

My psycho-educational testing to the above-named provider and to discuss my difficulties and/or progress.

_____ _____
Parent/Guardian/Name (Please Print) Signature

Address _____ City _____ St _____ Zip _____

Child's Name _____ School _____

Ph ( ) _____

Teacher _____ Counselor _____