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Information Form

Today's Date: _____

Child's Name: _____ Birth Date: _____ Gender: _____

Address: _____

School: _____ Grade: _____

Mother's Name: _____ Tel: _____ Cell _____

Father's Name: _____ Tel: _____ Cell _____

Parent's Marital Status: _____ Which parent(s) does the child live with? _____

Other children who live with the child: _____

If the child is currently taking medication for any kind of ailment, please list the name(s) of the medication:

_____

Has the child ever taken any medication for mood or behavioral problems? Yes_____ No _____

If yes, what kind? _____ How long? _____

Child's physician: _____

Who will be responsible for the medical bill? _____ SS# _____

Insurance: _____ ID: _____ Group # _____

I certify that my dependent has the insurance coverage with the above insurance company and assign directly to Dr. Yie-Wen Y. Kuan all payments of insurance benefits for her psychological services. I understand that I am financially responsible for deductibles, co-pays and non-covered services. I authorize the use of my signature on all insurance submissions. I authorize the release of any medical or other information necessary to process the claim.

_____ _____
Signature of Client, or Parent, Guardian of a minor Date

_____ _____
Print Name of Client or Parent, Guardian of a minor Relationship to client

Pregnancy and Birth Don't Know ___; skip to the next section

1. Was there any illness during the mother's pregnancy? No__ Yes, _____

2. Was the pregnancy full term nine month? Yes____ No, How long? _____

3. How much did the child weigh at birth? _____

4. Did the child have any trouble during delivery? No___ Yes, _____

5.Did the child stay in the hospital after mother went home? No_____ Yes _____

6. If the child stayed in the hospital, how long did he/she stay? _____

What was the reason of his/her stay in the hospital? _____

7. Did the mother smoke, use illegal drugs or heavily consume alcohol during pregnancy? No____ Yes_____

Development

1.Did the child sit at about the same age as other children? Yes_____ No _____

2. When could the child walk by him/herself? _____

3. Did the child say any words by or around one year old? Yes_____ No _____

4. Is the child as quick at learning as other children in the family? Yes____ No _____ N/A_____

5. Does the child have friends of his/her age? Yes ____ No _____

6. Does the child speak English to his/her parents? Yes _____ No _____

General Health

1. Is the child in good health? Yes ____ No, please describe _____ _____

2. Did the child ever have any illness that required him/her to stay in the hospital ?

No____ Yes _____ How long? _____ What was it? _____

3. Is the child taking medication currently? No _____ Yes, _____

4. Has the child taken medication for an extended time in the past? No ____ Yes _____

5. Does the child have any other health problems that might affect his learning or activities?

No _____ Yes _____

6. Does the child have any allergies? No ____ Yes _____

7. Does the child have trouble seeing? No ____ Yes ____ Wears glasses? _____

8. Does the child have trouble hearing? No ____ Yes ____ Need to have hearing aid? _____

Behavior

1. How does the child get along with others in school? _____

2. How does the child get along with other children in the house (if applicable)? _____

3. Are there any complaints from the child's school teachers? _____

4. Does the child get along with adults other than his/her parents or immediate family members? _____

5. List your concerns of the child _____