The Steven A. Cohen Military Family Clinic at the University of Pennsylvania

Child's Personal Information

Child's Name: _____ **Birth Date:** _____
Last *First* *M.I.* *mm/dd/yyyy*

Child's Preferred Name: _____ **Child's Pronouns:** Select one

Gender: Select one *Gender not listed (please describe):* _____

Name of person completing this form: _____

Your relationship to the child: _____

Your custodial relationship to this child: Select one

If joint, does the other parent agree to this child's treatment? No

If other, please explain: _____

Your child's insurance will NOT be billed for today's visit. The following questions are for informational purposes only.

Do you currently have health insurance? ◯ Yes ◯ No *If yes, what type?* _____

In the future, if there was an option to have treatment billed to insurance, would you consider this option? ◯ Yes ◯ No

Child's Emergency Contact Information

Full Name: _____ **Relationship:** _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP*

		Mobile phone?	Ok to leave message?
Primary Phone:	_____	◯ Yes ◯ No	◯ Yes ◯ No
Alternate Phone:	_____	◯ Yes ◯ No	◯ Yes ◯ No

If the child is 14 or older:

		Mobile phone?	Ok to leave message?
Child's Phone:	_____	◯ Yes ◯ No	◯ Yes ◯ No

Mobile Provider / Network *(ex: AT&T, Verizon)*: _____

Who currently lives in the child's home?

Name	Age	Relationship to Child

Military Background

Is the child a family member of a veteran and/or military service member? ◯ Yes ◯ No

Branch: _____ **National Guard:** Select one **Reserves:** Select one

Veteran/Service Member's Rank: _____ **MOS:** _____

Veteran/Service Member's Service Dates: _____

Military Discharge Status: Select one **If a veteran, are they VA-eligible?** Select one

If a veteran, are they currently enrolled in the VA for healthcare? Select one

Mental Health History

Does this child have any history of mental health concerns (e.g., depression)? ◯ Yes ◯ No

If yes, please explain: _____

Has the child ever received counseling, psychological, or psychiatric treatment? ◯ Yes ◯ No

Type of Problem	Treatment Type	Treatment Duration	Where did you receive treatment?
	Select one		
	Select one		
	Select one		
	Select one		

Were you satisfied with their treatment? ◯ Yes ◯ No

Is the child currently receiving counseling, psychological, or psychiatric treatment? ◯ Yes ◯ No

If yes, please explain: _____

Is there any family history of mental health concerns (e.g., depression)? ◯ Yes ◯ No

If yes, please explain: _____

Has any family member received mental health services? ◯ Yes ◯ No

If yes, please explain: _____

Medical History

Name of child's pediatrician: _____ **Phone**: _____

Date of child's last physical exam: _____ **Weight**: _____ **Height**: _____
mm/dd/yyyy

In regards to your child, were there any complications with pregnancy, labor or delivery? ◯ Yes ◯ No

Did your child achieve developmental milestones on time? ◯ Yes ◯ No

Is there any family history of significant medical problems? ◯ Yes ◯ No

Has your child experienced any significant health problems? ◯ Yes ◯ No

If yes, please explain: _____

Is your child taking any prescription or non-prescription medications? ◯ Yes ◯ No

If yes: Type of medication Dose size Dose frequency

_____

_____

_____

_____

_____

_____

In the past 2 weeks, were there any changes in medication? ◯ Yes ◯ No

If YES, what were the changes? _____

How often does your child miss a dose of medication(s)? _____

Have you noticed any side effects of the child's medications? _____

Is your child up to date on their immunizations? Select one

Social & School Background

Please list any other family members or adults who are significantly involved in your child's life:

Name	Age	Relationship to Child

Has your child or family experiences any significant stressors? ◯ Yes ◯ No

If yes, please explain: _____

Have you or any family member living in the child's household had any involvement with the legal system? ◯ Yes ◯ No

If yes, please explain: _____

What school does your child attend? _____
Name of School

_____
City *State*

Current grade: _____

Approximately how many days has your child missed school during this school year? _____

How does your child perform academically at school? Select one

Has your child ever received any special education services? ◯ Yes ◯ No

If yes, please explain: _____

Has your child ever repeated a grade? ◯ Yes ◯ No

If yes, please explain: _____

Has your child ever undergone a psychological or educational evaluation for school? ◯ Yes ◯ No

If yes, please explain: _____

Has your child ever had any academic or other problems in school? ◯ Yes ◯ No

If yes, please explain: _____

Is there a family history of learning or school problems? ◯ Yes ◯ No

If yes, please explain: _____

Please list any sports/hobbies/activities that your child most likes to participate in:

Please list any organizations/clubs/teams/groups that your child belongs to:

Please list any jobs/chores that your child has (inside and outside of the home):