Greg Milbourne, Psy.D.
Pennsylvania Licensed Psychologist (# PS015613)
PA and NJ Certified School Psychologist

Child Information Sheet

Today's date:_____
Child's Name_____

Why are you seeking treatment for your child?_____
_____
_____
_____

List the symptoms that have you concerned:_____
_____
_____

When did this difficulty begin?_____
_____
_____

Personal Information

Child's Full Name_____Birthdate_____Age_____

Address_____City_____Zip_____

Social Security #_____Home Phone_____

School/Day Care_____Grade_____

Parents: Mother's Name_____Birthdate (Age)_____

Address_____City_____

Social Security #_____Zip_____

Employer_____Work #_____

Email:_____(Mother)_____(Father)

Father's Name_____Birthdate (Age)_____

Address_____City_____

Social Security #_____Zip_____

Employer_____Work #_____

Name_____

Developmental and Medical History

Place of Birth_____Religious Affiliation_____active? (y/n)

Did you experience any problems during pregnancy or delivery?_____
_____
_____

Did your child have any health related problems following delivery?_____
_____
_____

Any early medical concerns, illnesses, hospitalizations, surgeries?_____
_____
_____

Was there anything significant during your child's early developmental milestones (walking, talking, toileting, etc.)?_____
_____
_____

Any involvement in early intervention or specialized preschool services?_____
_____

Has your child experienced any learning/school difficulties, been diagnosed with a Learning Disability or Attention Deficit Disorder?_____
_____

Is your child currently being treated for any medical illnesses? If so, what conditions?__
_____
_____

Please list all medications your child is taking:_____
_____
_____

Has your child taken medication for behavioral health symptoms in the past? If so, please explain_____
_____
_____

Has your child been involved in counseling in the past? If so, when and with whom?___
_____
_____

Name_____

Family History

Is there any family history of the difficulty your child is experiencing?_____
_____
_____

Has anyone in the family been treated for mental illness or substance abuse?_____
_____
_____

Is the family experiencing any criminal, financial or legal stresses?_____
_____
_____

Is there any additional information you feel may be important?_____
_____
_____

Statement of Confidentiality

As a psychologist, I seek to provide the quality of services required by the standards of professional psychologists. In keeping with those standards, strict confidentiality of all records of contact is maintained. It is policy **not** to release personally identifiable information concerning the use of services without prior permission of the person receiving the services. Legally and ethically, confidentiality cannot be maintained when: (1) there is a clear and present danger than someone's life is at risk; (2) in the apparent abuse of a minor; and (3)subpoenaed in a criminal (not civil) judicial preceding. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government. If you are concerned about or have questions regarding confidentiality, please discuss them with me. **I have read the above statement**.

_____ _____
Parent/Guardian Signature *Therapist Signature*

_____ _____
Parent/Guardian Signature *Date*

Your signature below indicates that you have read the **HIPAA Agreement** and agree to its terms and also serves as an acknowledgement of your familiarity with the **HIPAA Notice Form**.

_____ _____
Parent/Guardian Signature *Date*

_____ _____
Parent/Guardian Signature *Date*