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**CONSENT FOR TREATMENT OF A MINOR**

(Ages 5-12)

I agree to therapeutic services provided to my minor child by Daniel P. Kohen, M.D., at this office.

Client's Name _____

Address _____

Parent(s)/Guardian(s) Signature _____

_____

Address (if different than client's address)._____

Date_____

I/we understand that I/we have the right to information concerning my minor child in therapy, except where otherwise stated by law. (Minnesota Stat 144.341-342 except when the minor is married, legally emancipated, or has borne a child, or when information in the records concern venereal disease, chemical dependency, or pregnancy related conditions. Minnesota Statute 144.343)

I also understand that this clinician/therapist believes in providing a minor child with privacy in which to disclose herself/himself to facilitate treatment/therapy. I therefore give permission to this clinician/therapist to use his discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me. (Minnesota Stature 144.335 subd 2)

Parent(s)/Guardian(s) Signature _____

Date _____

# CHILD DEVELOPMENTAL HISTORY

## IDENTIFYING INFORMATION

Name of Child _____Sex (M) □ (F) □

Birth Date _____Place of Birth _____ Age _____

Address (number and street) _____

(City) _____ (State) _____ (Zip Code) _____

Telephone _____ Religion (optional) _____

Education (grade) _____Present School _____

Referral Source _____

With whom does child live? _____

If parents are divorced, who has physical custody of child? _____

## CHIEF CONCERNS / PROBLEMS: Presenting Problems (please check all that apply):

| | | |
|---|---|---|
| □ Very unhappy | □ Impulsive | □ Irritable |
| □ Stubborn | □ Stealing | □ Temper outbursts |
| □ Disobedient | □ Lying | □ Withdrawn |
| □ Infantile | □ Sexual trouble | □ Daydreaming |
| □ Mean to others | □ School performance | □ Fearful |
| □ Destructive | □ Truancy | □ Clumsy |
| □ Trouble with the law | □ Bed wetting | □ Overactive |
| □ Running away | □ Soiled pants | □ Slow |
| □ Self-mutilating | □ Eating problems | □ Short attention span |
| □ Head banging | □ Sleeping problems | □ Distractible |
| □ Rocking | □ Tobacco Use | □ Alcohol Use |
| □ Drug Use | □ Lacks initiative | □ Undependable |
| □ Peer conflict | □ Shy | □ Strange behavior |
| □ Strange thoughts | □ Suicide talk | □ Phobic |

□ Other (Explain) _____

How long have these problems been happening (number of weeks, months, years)? _____

---

What happened that makes you seek help at this time? _____

_____

**Problems perceived to be:** □ **very serious** □ **serious** □ **not serious**

What are your expectations of your child? _____

_____

What changes would you like to see in your child? _____

_____

What changes would you like to see in yourself? _____

_____

What changes would you like to see in your family? _____

_____

## CURRENT FAMILY

**Mother**—Relationship to Child □ biological parent □ step parent □ adoptive parent □ relative
Occupation_____ Religion_____
Education_____DOB_____Birthplace_____
Age _____

**Father**—Relationship to Child □ biological parent □ step parent □ adoptive parent □ relative
Occupation_____ Religion_____
Education_____ DOB_____Birthplace_____
Age _____

Marital History of Parents

Biologic Parents: □ married When?_____Age_____
□ separated When?_____Age_____
□ divorced When?_____Age_____
□ deceased Who? M or F _____When_____

Step Parents: □ married When?_____

**If child is adopted**:
Adoption source:_____
Reason and circumstances: _____
_____
Age when child first in home:_____ Date of legal adoption: _____
What has the child been told:_____
_____
_____

**LIVING ARRANGEMENTS** Places Dates
Number of moves in child's life_____ _____
_____

Present Home: □ renting □ buying/own □ house □ apartment

Does the child share a bedroom with anyone else? □ Yes □ No If yes, with whom? _____

If no, how long has he/she had own room?_____ Was the child ever placed, boarded, or living away from the family? □ Yes □ No Explain: _____

Are there any major family stresses at the present time? If yes, please note: _____
_____
_____

**BROTHERS AND SISTERS** (Please indicate if "half" siblings, step-brothers or step-sisters):

| Name | Age | Sex | School (grade) or Occupation | Living (Y/N) at home? | Use Drugs Alcohol (Y/N) | Treated drug abuse (Y/N) |
|---|---|---|---|---|---|---|
| _____ | ___ | ___ | _____ _____ | _____ | _____ | _____ |
| _____ | ___ | ___ | _____ _____ | _____ | _____ | _____ |
| _____ | ___ | ___ | _____ _____ | _____ | _____ | _____ |
| _____ | ___ | ___ | _____ _____ | _____ | _____ | _____ |
| _____ | ___ | ___ | _____ _____ | _____ | _____ | _____ |

Others living in the home and their relationship
1._____
2._____

**HEALTH OF FAMILY MEMBERS (excluding patient):**

| **Name** | **Relationship to child** | **Problem/Illness** | **When?** |
|---|---|---|---|
| 1._____ | _____ | _____ | _____ |
| 2._____ | _____ | _____ | _____ |
| 3._____ | _____ | _____ | _____ |
| 4._____ | _____ | _____ | _____ |

Does or did any member of the child's family have any problems with:
□ reading □ spelling □ math □ speech

If yes, please explain:_____

Is there any history in the child's family of: If yes, please indicate WHO and treatment given:

□ mental retardation □ epilepsy □ birth defects □ Bipolar Disorder □ Depression

□ Anxiety (Panic Attacks, OCD) □ ADHD □ Learning Disability □ Autism Spectrum Disorder

CHILD HEALTH INFORMATION

Please note all health problems that child has had or has now

| | AGE | | AGE | | AGE |
|---|---|---|---|---|---|
| □ High fevers | _____ | □ Dental problems | _____ | □ Pneumonia | _____ |
| □ Weight problems | _____ | □ Flu | _____ | □ Encephalitis | _____ |
| □ Meningitis | _____ | □ Allergies | _____ | □ Skin problems | _____ |
| □ Asthma | _____ | □ Convulsions | _____ | □ Headaches | _____ |
| □ Unconsciousness | _____ | □ Concussions | _____ | □ Head injury | _____ |
| □ Abdominal Pain | _____ | □ Accident prone | _____ | □ Anemia | _____ |
| □ Fainting | _____ | □ Dizziness | _____ | □ Tonsils out | _____ |
| □ Vision problems | _____ | □ Hearing problems | _____ | □ Earaches | _____ |
| □ High / low BP | _____ | □ Sinus problems | _____ | □ Heart problems | _____ |

□ Hyperactivity (ADHD) ____ □ Other illnesses (explain) _____

_____

_____

Has the child ever been **hospitalized?** If yes, please explain:_____
Age_____ How long_____
Reason_____

Has the child had any **surgery?** If yes, please explain age and type of surgery_____

_____

Has the child ever taken, or is he/she presenting taking any prescribed **medications**? □ Yes □ No Please list medications, diagnosis, dosage, and prescribing physician:

| Medication | for? | Dose? | Prescribing Physician? |
|---|---|---|---|

_____

_____

Are Immunizations up to date? □ Yes □ No Varicella (Chicken Pox)Vaccine? □ Yes □ No

MMR □ Yes □ No Hepatitis □ Yes □ No □ Yes □ No □ Yes □ No

**Primary Care Physician**:
Name:_____

Address _____Phone_____

**DEVELOPMENTAL HISTORY**

Pre-natal: Child wanted? □ Yes □ No Planned for? □ Yes □ No

Normal pregnancy? □ Yes □ No

If mother ill or upset during pregnancy, please explain:_____
_____

During pregnancy did mother use any of the following:

Alcohol? □ Yes □ No Cigarettes / other tobacco? □ Yes □ No Drugs? □ Yes □ No

Prenatal Vitamins & Iron? □ Yes □ No Other medications? □ Yes □ No (Please specify:_____

_____

Length of pregnancy:_____Parental support and acceptance (please explain):_____

**BIRTH**

Length of active labor: _____hours □ Easy □ Difficult APGAR Score: 1 minute____5 minutes

Full term: □ Yes □ No If premature, how early:_____

If overdue, how late: _____

Delivery: □ spontaneous vaginal □ caesarean □ head first □ breech

Was it necessary to give the infant oxygen? □ Yes □ No If yes, for approximately how long?_____

Did infant require blood transfusions? □ Yes □ No Did infant require X-ray? □ Yes □ No

Physical condition of infant at birth:_____

Did infant have Jaundice (yellowing of skin)? □ Yes □ No

Was Phototherapy (light treatment) needed? □ Yes □ No If yes, for about how long?_____

Did mother abuse alcohol/drugs

**NEWBORN PERIOD –** Please indicate presence or absence of:

Irritability □ Yes □ No Duration:

Vomiting □ Yes □ No Duration:

Difficulty Breathing □ Yes □ No Duration:

Difficulty Sleeping □ Yes □ No Duration:

Convulsions/Twitching □ Yes □ No Duration:

Colic □ Yes □ No Duration:

Normal Weight Gain □ Yes □ No Duration:

Was Child Breast Fed? □ Yes □ No Duration:

**DEVELOPMENTAL MILESTONES** - Age at which child:

Crawled: _____ Spoke single words:_____

Bladder trained: Daytime:_____Nighttime:_____Bowel trained_____

Sat up:_____ Walked: _____ Spoke sentences:_____

Please describe method of toilet training :_____
_____

**EARLY SOCIAL DEVELOPMENT**

Relationship to siblings and peers:

□ individual play □ competitive □ leadership role □ group play □ cooperative

□ more of a follower

Please describe any special habits, fears, or idiosyncrasies and any treatments or therapies given:
_____
_____
_____
_____

**EDUCATIONAL HISTORY**

| | Name of School | City/State | Grades completed |
|---|---|---|---|
| Preschool | _____ | _____ | _____ |
| Elementary School | _____ | _____ | _____ |
| Middle School/Jr High (Circle) | _____ | _____ | _____ |
| High school | _____ | _____ | _____ |

Current Grade:_____Name of teacher(s) if Preschool/Elementary _____

Types of class: □ Regular □ Special Ed (reason:_____)
□ gifted and talented □ learning disability (please specify)_____
□ other (please explain_____)

Did child skip a grade: □ Yes □ No Repeat a grade? □ Yes ( If yes, when and how many years?
Appropriate grade level at present time?)_____

Has child ever had a tutor or other special help with school work? □ Yes □ No

Does child attend school on a regular basis? □ Yes □ No

Does child appear motivated for school? □ Yes □ No

Has child ever been suspended or expelled from school? □ Yes □ No

**ACADEMIC PERFORMANCE** (If convenient please bring a copy of most recent report card/progress report)

Favorite subject?_____

Least favorite subject?_____

Does child participate in extracurricular activities? □ Yes □ No Please describe:
_____

In school, how many friends does child have: □ a lot □ a few □ none

What are child's educational aspirations? □ Quit school □ Graduate from high school

□ Go to post-secondary education (Vocational School, College, other –please circle)

Has child had special testing in school? (If yes, what were the results?)

Psychological □ Yes □ No Vocational □ Yes □ No

What is your child best at? _____
_____
_____

What is/are your child's favorite thing(s) to do?_____

What are the favorite things to do as a family?_____

Has the child ever had difficulty with the police? □ Yes □ No (If yes, please explain)
_____

Has the child ever appeared in juvenile court? □ Yes □ No (If yes, please explain)
_____

Has the child ever been on probation? □ Yes □ No (If yes, please explain)
_____

**ADDITIONAL COMMENTS (Please use the back or additional sheets to let us know anything else you'd like us to know.)**

**Thank-you for completing this form!**

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