Wellness PSI, LLC
Dr. Sherri Gallagher
222 N Verde Street
Flagstaff, AZ 86001
480-993-5048

PEDIATRIC REGISTRATION

Patient's Name:_____Birthdate:_____
Street Address:_____
City:_____State:_____Zip:_____Sex: M/F
Parent's Names/Ages:_____
Other Caregiver's Name and relationship to patient: _____
Contact Email_____
Home Phone:_____ Mobile Phone:_____
Emergency Contacts:_____
Insurance Company:_____ Plan Name_____
ID #:_____ Employer/School Name:_____
Valid From :____/____/____ Until: ___/____/____ is this primary insurance: Y/N
Insured Person's Relation to Patient:_____ Name:_____
Insured Person's Address (if different from above):_____
City_____State:_____Zip:_____
How did you hear about us? _____

Reason for Office Visit:

_____
_____

Child Information:

Tell me about your child's strengths:

_____
_____

Diagnosis or explanations given to you about your child:

_____
_____

Please describe your child to me: (attach more information if necessary):

_____
_____

When did you first notice your child's problems:

_____

What things did you first notice:

_____

Did this happen suddenly or gradually:_____
Was there anything that may have contributed to this problem:

_____
_____

Current Living Situation

Who is the child presently living with (biomother, stepfather, etc.):

_____

How many people are in the current household, please list ages, names, relationships:

_____

_____

_____

Are there any current stressors in the home (Marital, violence, drug abuse)

_____

_____

Is the child adopted? If so, describe age of adoption and circumstances:

_____

Parents

How long have the parents been: Married__ Separated___ Divorced___ Widowed___ Living together____

If parents are separated or divorced, please describe custody (physical or legal) and visitation rights: Also bring in documents supporting this:_____

If married, please describe current relationship:

_____

_____

Please list any previous marriages:

_____

Biological Mother

Name_____Age:_____

Education level_____Occupation_____

Do any medical illnesses run in her family:

_____

Has the biological mother or any of her relatives ever had any of the following illnesses (list self or relation):

Depression_____Autism_____

Suicide attempts_____ Mental Retardation_____

Anxiety disorders_____Attention Problems_____

Psychosis or thought problems_____Learning Disabilities_____

Aggression_____Physical or Sexual Abuse_____

Alcohol Abuse_____Substance Abuse_____

Bipolar Disorder_____Legal Trouble_____

Biological Father

Name_____Age:_____

Education level_____Occupation_____

Do any medical illnesses run in his family:

_____

Has the biological father or any of his relatives ever had any of the following illnesses (list self or relation):

Depression_____Autism_____

Suicide attempts_____Mental Retardation_____

Anxiety disorders_____Attention Problems_____

Psychosis or thought problems_____Learning Disabilities_____

Aggression_____Physical or Sexual Abuse_____

Alcohol Abuse_____Substance Abuse_____

Bipolar Disorder_____Legal Trouble_____

BROTHERS and SISTERS: (indicate if step-brother or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living At home (yes or no)	Use Drugs Or alcohol (yes or no)	Treated for Drug abuse (yes or no)

Have there been any significant conflicts between this child and his/her siblings, if so please describe:

_____

_____

Birth History

Mother's age at time of birth:_____ Father's age at time of birth:____

Did the mother ever smoke during pregnancy: _____Cigarettes per Day_____

Was alcohol ever consumed during alcohol:_____If yes, how many drinks per day_____

Were any drugs used during pregnancy: _____if so please list, type and amount consumed:

_____

_____

Were there any complications during the pregnancy:_____

Was the child premature or late:_____ _____

Were there any exposures of mother to stress, physical trauma, or abuse:

_____

Was birth a cesarean section:_____Was the child normally active:_____

Baby's birth weight_____Apgar Scores:_____ Were there any defects noted at birth:

_____

Did either parent have any problems adjusting to the birth of your child: Y/N

_____

_____

Where there any physical or emotional separations from the caregivers in the first years of life:

_____

_____**I**

Infancy Period

Circle all that apply (Infancy, toddler, preschool period)

Jaundice Y/N
Diarrhea Y/N
Constipation Y/N
Eating Problems Y/N
Hyperactive Y/N
Growing Pains Y/N
Anemia Y/N
Asthma Y/

Bed Wetting Y/N
Tantrums Y/N
Defiance Y/N
Fears Y/N
Early Puberty Y/ N
Warts Y/N
Nightmares Y/N
Stomach Aches Y/N

Child Breastfeed: Y/N and for how long:_____When was child put on formula:_____

Did mother have problems with depression after birth: Y/N, if yes, please explain:

_____

_____

Developmental History

Speech Development: (ages) First words_____ First Sentences_____ Phrases _____
Motor Development: (ages)Sitting up_____ Crawling_____ Pulling/Standing_____Walking_____
Self Help Skills: Average Early Late
Bowel Trained(age)_____Bladder Trained_____Started to read_____
Does this child have more accidents than other children:
_____
Athletic abilities: _____ Handedness: Left/Right/Both
Did your child have any problems with the following (if yes please explain):
Not enjoy cuddling: _____
Was difficult to comfort: _____
Was colicky: _____
Was excessively restless: _____
Was excessively irritable: _____
Had sleep difficulties: _____
Difficulty feeding or nursing: _____

Environmental Exposures

Has this child or mother while pregnant ever lived near a refinery, polluted area or in a home with lead paint?
_____
_____
Has this child ever lived in a house that had new carpeting, paint, or other items that seem to affect the child's health: _____
Does the child seem sensitive to perfumes or dyes: _____
Are pesticides, herbicides, or other chemicals used around your home:
_____
What year was your apt/house built: _____
Do you live near a (please circle) : Swamp/River/High voltage power lines/Industrial area/ Large city
Type of flooring child spends most time around:_____

Behaviors
(Infancy, toddler, preschool)

Adaptable	Shy or timid	Fearful
Rocking	Sleeping difficulties	Curious
Able to play alone	Responds well to challenges	Staring spells
Difficulty with attention	Moody	Breath holding spells
Easy to manage	Easily frustrated	Happy
Underactive/passive	Aggressive	Head banging
Deals with frustration	Wants to left alone	Stuttering
Stubborn	Sensitive	Sad
Hyperactive	Playful	Irritable
Eating difficulties	Severe tantrums	
Cautious	Slow to warm up	

Current Behaviors

Do you have any concerns about your child's self esteem:_____
Sexual knowledge or awareness:_____
Gender Identity:_____
Sexual Orientation:_____

Please circle any of the following that this child currently demonstrates or demonstrated in the past:

Bedwetting	Arguing	Cruelty to animals/people
Immaturity	Fearful	Substance abuse
Involuntary vocalizations	Eating problems	Alcohol abuse
Depression	Sexual problems	Impulsiveness
Behaviors	Anxiety	Inattention
Obsessions	Panic	Self injury
Compulsions	Moodiness	Running away
Soiling	Tantrums	Suicidal talk
Weight change	Aggression	Poor motivation
Shyness	Violence	Irritability
Sleep problems	Lying	Strange ideas of behaviors
Oppositional	Stealing	Crying episodes
Defiance	Setting fires	Problems with the law

Please list types of discipline you have tried to use with this child and its effectiveness:

_____

_____

_____

Have you moved recently (if so, please describe circumstances)?

_____

_____

Any significant loses or other trauma in the family?

_____

_____

How would you rate this child's intelligence as compared to others his age? _____

Free Time

Please describe how this child spends his free time (plays alone, friends, games, etc?)

_____

_____

Please list the number of hours the child spends watching TV daily:_____ Are the programs age appropriate or violent:_____

Please list the number of hours the child spends playing video games daily____, please list types of games and examples:_____

School History

Did this child attend daycare or preschool: _____ How many hours per week:_____

What are your current arrangements before and after school:

_____

Beginning with kindergarten, list school name and indicate performance both academically and behaviorally:

KG_____

_____

Elementary_____

_____

Middle School_____

_____

High School_____

_____

Are there any known learning disabilities? If so please list

_____

_____

Is your child on an IEP or 504 plan?_____
Has this child ever repeated a grade or skipped a grade (if so, please list grade and circumstances)?

_____
Does this child enjoy school: Y/N
School subjects strengths:_____
School subject weaknesses:_____

Circle any of the following problems this child has with school

Problems with poor handwriting	Difficulty with bullying	Requires aide
Losing homework	Bulling others	Interferes with others
Forgetting homework	Poor attention	Test anxiety
Doesn't remain seated	Disorganized	Excessive time to complete
Impulsive	Skips school	tasks
Forgets instructions	Fights with peers	Makes careless mistakes
Doesn't make friends	Daydreams	Frequently punished
Difficulty being quiet	Makes careless mistakes	

Is your child involved in extra-curricular activities (if so, please list):

_____
_____
Any additional school comments:

_____
_____

Social Development

As a child, did he socialize with peers?

_____
_____
Does your child have age appropriate friends?

_____
_____
Circle any of the following that apply with your child regarding interactions with peers:

Plays well with others	Aggressive or mean
Is often teased by others	Frequent fights
Cooperative	Jealous
Empathetic	Bossy or controlling
Shares well	Uncooperative
Primarily plays with older children	Feelings get hurt easily
Primarily plays with younger children	Rejected by others
Afraid to socialize	Few friends
Afraid to speak in front of peers	No friends
Is a leader	Bragging/boastful
Is lead by others	

Medical History

If this child has experienced any of the following please list the age and other pertinent information:

Seizures_____
Surgeries_____
Deformities_____
Failure to grow_____
Pneumonia_____
Asthma_____
Allergies_____
Diabetes_____
Skin problems_____
Obesity_____
Ear infections_____
Hearing problems_____
Movement problems_____
Head injuries_____

Other physical problems_____
Eye problems_____
Stomach problems_____
Poisoning_____
Constipation_____
Rubella_____
Chickenpox_____
Mumps_____
Mono_____
Thrush_____
Sinus infections_____
Frequent colds_____
other_____

Has this child ever had a neurologic evaluation (exam, MRI, CT, EEG) if yes please describe:

_____

_____

Has this child's vision been tested: age_____ results_____

Has this child's hearing been tested: age _____results_____

Please describe the child's vaccination history:

_____

Nutrition Status

Current Height_____ Current Weight_____

Describe the child's appetite and diet:

_____

_____

Please indicate which is most accurate regarding your child's diet: Mostly Baby Foods__Mostly meat__Mostly vegetarian__Mostly Carbohydrates__Mostly Organic__Mostly Processed__Mostly microwaved__Mostly dairy__ Other_____

Have any dietary modifications been tried with your child:

_____

Any known allergies to food: if yes was it tested:

_____

Please describe your child's stool pattern, frequency and consistency (loose, large, brown, daily, foul smelling):

_____

How much water does your child drink during the day:_____

Child's Present Medical Status

Primary Care Doctor: _____Phone number:_____ Last seen:_____

List any present illness this child is being treated for:

_____

_____

When was child's last physical exam:_____ Was blood work done : Y/N_____

List all prescribed and over the counter medications that this child is currently taking: (please include doses)
1)_____
2)_____
3)_____
4)_____
5)_____

List all supplements that this child is also prescribed or taking:
1)_____
2)_____
3)_____
4)_____
5)_____
Any known allergies to medications, environmental allergens, or allergies to animals:
_____
_____
Does this child frequently complain of (please circle):

Headaches	Painful urination
Dizziness	Chest pain
Sleep problems	Trouble with vision
Nightmares	Trouble hearing
Stomach aches	Menstrual problems
Staring into space	Skin problems
Losing track of time	Palpitations
Difficulty breathing	

Please describe when this child falls asleep and describe his sleep:
_____
_____

Past Psychiatric/Psychological Treatment

Please list if this child has ever been seen by any psychiatrist or psychologist, or academic evaluation in the past:

Person or Institution	Dates	Address	Telephone/Fax

Please list dosages/medications/effects/side effects of any medications used in this child's past:
_____
_____
What was most helpful in his past treatment:
_____
_____

Spiritual Orientation

Please describe your family's religious or spiritual affiliation/belief:
_____
How active in these beliefs is the child and family:_____

Other concerns or questions (Please describe on back if necessary) :
_____
_____
_____