Bright Side Psychiatry

Jessica Halpern, MD
Specializing in Children, Adolescents & Women
608 Sherwood Parkway, Suite 106
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PATIENT DEMOGRAPHICS AND INTAKE FORM

Patient Information:
Name: _____ DOB: _____ Sex: _____

Street Address/Apt#: _____

City, State & Zip Code: _____

Contact Number: _____

Guardian Information:
Parent Name #1: _____ Age: _____ Relation:_____

Phone Number: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Marital Status: ☐ single ☐ married ☐ divorced ☐ separated ☐ widowed

☐ Check if address same as patient address, otherwise complete below
Street Address/Apt#: _____

City, State & Zip Code: _____

Parent Name #2: _____ Age: _____ Relation:_____

Phone Number: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Marital Status: ☐ single ☐ married ☐ divorced ☐ separated ☐ widowed

☐ Check if address same as patient address, otherwise complete below
Street Address/Apt#: _____

City, State & Zip Code: _____

Emergency Contact: ☐ Parent #1 ☐ Parent #2

Person completing this form: ☐ Parent #1 ☐ Parent #2

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Birth and Developmental History:

Weeks at delivery: _____ Type of delivery: ☐ vaginal ☐ c-section (Reason:_____)

Birth Weight: _____ lbs _____ oz Days/Weeks spent in NICU (if applicable): _____

Baby's temperament: ☐ easy to soothe/warm up ☐ anxious

Check any delays that your child has/had: ☐ speech ☐ motor

Did your child receive early intervention services: ☐ yes ☐ no

Services my child currently receives: ☐ Physical Therapy (# of days/wk: _____) ☐ Occupational Therapy (# of days/wk: _____) ☐ Speech Therapy (# of days/wk: _____)

Medical History:

Diagnoses: _____

Does your child have a history of recurrent ear or throat infections: ☐ yes ☐ no

Has your child began menstruation: ☐ yes (at what age? _____) ☐ no ☐ n/a

Past Surgeries: _____

Allergies: _____

Current Medications: _____

_____

Physician's Name: _____ Phone number: _____

Psychiatric History:

Current Psychiatrist: _____ Phone number: _____

Reason for leaving: _____

Current Therapist: _____ Phone Number: _____

Has your child ever had neuropsychological testing: ☐ yes (Please bring copies to your appointment) ☐ no

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Family Psychiatric History:

☐ Not Applicable

Diagnosis: _____ Relation: _____

Diagnosis: _____ Relation: _____

Diagnosis: _____ Relation: _____

Diagnosis: _____ Relation: _____

Diagnosis: _____ Relation: _____

Educational History:

Did your child attend a special education pre-school: ☐ yes ☐ no

Current School: _____ Grade: _____

Type of Education (check all that apply): ☐ regular ☐ special education ☐ 504 ☐ IEP ☐ self-contained

Social History:

Family members who live in the home:

_____ Relation: _____ Age: _____

_____ Relation: _____ Age: _____

_____ Relation: _____ Age: _____

_____ Relation: _____ Age: _____

_____ Relation: _____ Age: _____

_____ Relation: _____ Age: _____

_____ Relation: _____ Age: _____

Has Child Protective Services ever been involved: ☐ yes ☐ no

Does anyone in the home smoke cigarettes or abuse alcohol or drugs: ☐ yes ☐ no

Are there firearms in the home: ☐ yes ☐ no

Are you concerned that your child might be using drugs or alcohol? ☐ yes ☐ no