dell children's
Ascension

Texas Child Study Center
PATIENT INFORMATION
Psychology Supplemental Form

Date_____

Name_____ DOB_____

CURRENT CONCERNS

Briefly, please describe the concerns about your child and/or reason you are seeking services (e.g., any behavioral, emotional, or learning concerns at home and or school, difficulties with peer relationships, etc.)

_____

_____

_____

_____

_____

When did your child first start experiencing the problem(s)?_____

_____

How often does the problem occur? _____

_____

How long does it last? _____

BEHAVIOR AND DISCIPLINE

Please describe briefly any ***behavioral*** problems at home and/or school: _____

_____

Who ordinarily disciplines your child? _____

Please check the types of discipline used with your child:

- ☒ Verbal reprimands
- ☒ Time out
- ☐ Ignoring your child's behavior
- ☐ Reasoning
- ☐ Sending child to room
- ☐ Removal of privileges
- ☐ Physical punishment
- ☐ Other:

Which forms of discipline have proven to be the most effective? _____

How often do you need to use discipline? _____

PERSONAL/SOCIAL

How many close friends does your child have? _____

How easily does your child make friends?

○ Better than average ◉ Average ○ Worse than average

How well does your child get along with friends?

○ Better than average ○ Average ◉ Worse than average

Who does your child get along best with?

☐ Older children ■ Children of the same age ■ Younger children

Does your child have problems keeping friends? ◉ Yes ○ No

Are there any problems with bullying or teasing? ◉ Yes ○ No

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MEDICAL HISTORY

Please check any of the following your child has experienced and note the age, any complications, and frequency below:

Yes	No		Yes	No	
☐	☐	Hospitalizations	☐	☐	Vision problems
☐	☐	Surgery	☐	☐	Hearing problems
☐	☐	Trauma (stitches/broken bones)	☐	☐	Asthma
☐	☐	Head trauma	☐	☐	Allergies
☐	☐	Loss of consciousness	☐	☐	Stomachaches
☐	☐	Coma	☐	☐	Excessive vomiting
☐	☐	Seizures	☐	☐	Pica (eating nonfood items)
☐	☐	Tics (motor)	☐	☐	Diabetes
☐	☐	Tics (vocal)	☐	☐	Malnutrition
☐	☐	Staring spells	☐	☐	Gastrointestinal difficulties
☐	☐	Tremor	☐	☐	Chronic ear infections
☐	☐	Poor muscle tone	☐	☐	PE tubes placed
☐	☐	Falls frequently	☐	☐	Elevated lead levels
☐	☐	Anemia	☐	☐	Accidental poisoning
☐	☐	Persistent high fever	☐	☐	Leukemia
☐	☐	Headaches	☐	☐	Neoplasm (tumor)
☐	☐	Migraine headaches	☐	☐	Cancerous neoplasm (tumor)
☐	☐	Respiratory difficulties	☐	☐	Sickle cell
☐	☐	Cardiovascular/heart disease	☐	☐	Stool soiling
☐	☐	Endocrine/thyroid problems	☐	☐	Colic
☐	☐	Obesity/weight problems	☐	☐	Bedwetting
☐	☐	Pain	☐	☐	Sleep problems
☐	☐	Abnormal heart rhythm/heart abnormality	☐	☐	Other: _____

Additional information: _____

_____

OTHER INFORMATION

What are your child's strengths?

_____

What are your family's strengths?

_____

Please add any other information you feel may help us understand your child:

_____

_____

PLEASE REMEMBER TO BRING THE FOLLOWING ITEMS TO THE INTAKE (IF APPLICABLE):
1) Divorce decree
2) Previous reports (i.e., neuropsychological, educational, emotional, speech/language)