

Greg Milbourne, Psy.D.
Pennsylvania Licensed Psychologist (# PS015613)
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 # _____

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 proceeding. 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.**

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