STAATS
PSYCHIATRIC SERVICES

ADDENDUM TO NEW PATIENT REGISTRATION PACKET FOR MINOR

Please complete ALL sections below

Patient Information:

Child's Legal Name: _____
Preferred Name: _____ Pronoun: He: ____ She: ____ They: _____
Grade in School: _____ Date of Birth: _____
Street: _____
City: _____ State: _____ Zip: _____

Guardian Information:

Mother / Legal Guardian's Name: _____ Lives w/Child: Yes: ___ No: ___
Natural Parent: ___ Relative: ___ Step-Parent: ___ Adoptive Parent: ___ Other: _____

Email: _____ Cell #: _____

Father / Legal Guardian's Name: _____ Lives w/Child: Yes: ___ No: ___
Natural Parent: ___ Relative: ___ Step-Parent: ___ Adoptive Parent: ___ Other: _____

Email: _____ Cell #: _____

Emergency Contact / Relationship: _____ Cell #: _____

Brief Personal History:

Where was Child born? _____ Raised: _____ # of Moves: ____
Ever placed, boarded or lived away from family: Yes: ___ No: ___
If yes, please explain: _____
_____

List all members presently in Child's household and their relationship to the Child:
_____
_____

Are there any custody or visitation plans in place: Yes: ___ No: ___
If yes, what are they: _____
_____

Did mother have any illness or complications before delivery: Yes: ___ No: ___
If yes, please explain: _____
Full term pregnancy: Yes ___ No ___ Length if not full term: _____
Complications at Birth: Yes ___ No ___ Explain: _____

STAATS
PSYCHIATRIC SERVICES

As far as you know, did your child meet developmental milestones at an appropriate age?
(i.e. rolling, sitting up, babbling, eating, etc.): _____

Did the Child attend daycare and/or preschool: Yes: ___ No: ___ How Long: _____

Does the Child receive special services/therapy at school: Yes: ___ No: ___
If yes, which services: Counseling: _____ / week Speech Therapy: _____ / week Occupational Therapy: _____ / week Physical Therapy: ____ / week

Any other services: Yes: ___ No: _____
If yes, please explain: _____
_____

Does the Child attend extracurricular activities: Yes: ___ No: ____
If yes, please list: _____
_____

In school, does the child have friends and interact well: Yes: ____ No: ___
Please explain: _____
_____
_____

Employment & School			
Name of School:	Yes ☐	No ☐	
Does the Child work?	Yes: ☐ No: ☐ If Yes, Where: _____		

Printed Patient/Legal Guardian Name: _____

Patient/Legal Guardian Signature: _____ Date: _____