MINOR INTAKE FORM

Name of Minor: ____________________

S.S. #: ____________________ Date of Birth: __________ Age: _____

Current Grade in School: __________ Name of School: ____________________

Home Address: ____________________

City/State: ____________________ Zip: __________

Current Address (if different from above): ____________________

City/State: ____________________ Zip: __________

Primary Contact Name: ____________________

Phone: ____________________ Email : ____________________

Parent/Guardian Name(s): ____________________

Parent/Guardian Home Address (if different) ____________________

City/State: ____________________ Zip: __________

Home Phone: ____________________ Place of Employment: ____________________

Work Phone: ____________________ Can we call at Work? Yes No

Primary Pediatrician: ____________________ Phone: ____________________

Address: ____________________

Is it ok to contact the Pediatrician if necessary? Yes No

Current Medications: ____________________

Past Medications: ____________________

BayBrooke Center
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Phone: (727) 827-7890 Fax: (727) 279-4631
Email: info@baybrookecenter.com

MINOR INTAKE FORM

Family Members:

Father :____________________________Age:______Occupation:______________________

Mother :____________________________Age:______Occupation:______________________

Siblings:

Name:______________________________Age:______Occupation:_____________________

Name:______________________________Age:______Occupation:_____________________

Name:______________________________Age:______Occupation:_____________________

Name:______________________________Age:______Occupation:_____________________

Please list other persons living in the household with the patient:

Name	Age	Sex	Relation to Patient

Elementary: ____

Middle School: ____

High School: ____

Does Minor have behavioral problems at School? Yes or No
If so, what types of behavioral problems? ____

Has the Minor ever been disciplined with suspension or expultion? Yes or No
Which, if any?____

Does Minor have behavioral problems at Home? Yes or No
If so, what types of behavioral problems? ____

Has the Minor ever been in trouble with the law? Yes or No
If so, please explain ____
____
____

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MEDICAL QUESTIONNAIRE FOR A MINOR

What medical problems, if any, is your child currently experiencing?

____

____

____

Are those problems being treated? **YES** or **NO**

____

____

____

____

By whom? ______________________________Phone: ____________

Last medical examination (date): ____________________

Primary care doctor: ______________________________

Current medications (if any):

____

____

____

Prescribing Physician: ______________________

List past hospitalizations, operations, or serious illnesses:

Year: ____________
Issue: ______________________________

Year: ____________
Issue: ______________________________

Year: ____________
Issue: ______________________________

Check any of the following medical problems your child has experienced:
Colic: Yes or No
Chronic ear infections: Yes or No
Measles: Yes or No
Strep infection: Yes or No
Skin problems: Yes or No
Asthma: Yes or No
Allergies: Yes or No If so to what?_________________________
Broken bones: Yes or No
Tonsillitis: Yes or No
Urinary tract infections: Yes or No
Other______________________________

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MEDICAL QUESTIONNAIRE FOR A MINOR

What is your child's usual sleep pattern?

Describe usual eating pattern, food preferences, and any problems with weight or diet.

Has your child used drugs or alcohol (to your knowledge)? If yes, please describe:

Has there been any known or suspected child abuse (verbal, physical, or sexual)?
If yes, please explain.

____

____

____

Are there any concerns about sexual development?

____

Is your child sexually active? Yes___________ No____________

Please list any other areas of concern and provide additional information as needed.

____
____
____
____
____

____

Parent/Guardian Signature Date

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