Kari Lenox, Ph.D.

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Phone: (919) 237-2250
Fax: (919) 251-9660

CHILD OR ADOLESCENT PATIENT INFORMATION

DATE: **ACCOUNT NO.:** **DX:**		
CHILD OR TEEN PATIENT INFORMATION		
Last Name:	First Name:	Nickname:
Birthdate: / /	Age:	Gender:
Is child/teen adopted? Y or N	Yes, age at adoption:	Languages spoken at home:
Street Address: City: State: Zip Code:		
Home Phone:	Child's cell phone:	Best number to leave messages:
Has your child/teen or a family member been seen by Dr. Lenox before? Y or N		
Who has physical custody of this child/teen?		
Who has legal custody of this child/teen?		
REFERRAL INFORMATION		
Referred by:	How did you learn about this practice: □ Doctor □ Lawyer □ Friend □ School □ Co-worker □ Internet search □ Presentation/Talk □ Marketing □ Other	
SCHOOL INFORMATION		
Current School: □ Public □ Private		□ Year Round □ Traditional □ Other
Teacher's Name: Grade:		Retained: Y or N If yes, which grades:
Special Education: □ IEP □ 504	AIG: □ Reading □ Math	Tutoring: Y or N

PARENT INFORMATION		
	MOTHER	**FATHER**
Name		
Age		
Highest Education Level		
Occupation		
Employer		
Cell Phone		
Work Phone		
Home Phone (if different from child)		
Email Address		
Address (if different from child)		
	STEPMOTHER	**STEPFATHER**
Name		
Age		
Highest Education Level		
Occupation		
Employer		
Cell Phone		
Work Phone		
Home Phone (if different from child)		
Email Address		
Address (if different from child)		

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SIBLINGS		
Names: 1-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
2-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
3-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
4-	Gender : Age:	□ Full Sibling □ Half □ Step □ Adopted
MEDICAL INFORMATION		
Child's doctor:	Name of Practice:	Phone: Fax:
Street Address:	City:	State: Zip Code:
Medical Problems (list):		
Allergies:		
Hospitalizations/Surgeries:		
Medication Name:	Dosage: X per day:	Reason:
Medication Name:	Dosage: X per day:	Reason:
Medication Name:	Dosage: X per day:	Reason:
BIRTH AND DEVELOPMENTAL HISTORY		
Length of Pregnancy:	Birth weight:	Complications:
Used During Pregnancy: □ Alcohol	□ Tobacco □ Illicit Drugs	□ Prescription Medication
Medical Problems at Birth:		
MILESTONES (Please list age child met each milestone)		
Motor Sat:	Crawled: Walked:	Current Difficulties: Y or N
Language Single word:	3 words: Full sentences:	Current Difficulties: Y or N
Toileting Trained for day:	Trained for Night:	History of Accidents: Y or N
Sleep Issues: □ Trouble Falling Asleep	□Trouble waking up □ Sleepwalks	□Night Terrors □ Nap issues
MENTAL HEALTH HISTORY		
Mental Health Diagnoses:		
Previous Professionals Seen: Name(s):		Date(s):
Previous Evaluations: □ Psychological	□ Educational □ Speech and Language	□ Occupational Therapy
□ Neuropsychological	□ Emotional	□ Behavioral
FAMILY STRESSORS		
□ Abuse □ Deaths	□ Job Change □ Relocation	□ Stepchildren □ Trauma
□ Births □ Divorce	□ Marriage □ School	□ Substance Use □ Other(s):
□ Bullying □ Finances	□ Medical □ Separation	□ Substance Abuse
FAMILY STRENGTHS		
Please Describe:		
REASON FOR SEEKING HELP AT THIS TIME:		
Please Describe:		
Signature:		Date:
Relationship to Child/Teen:		