Dear Parent,

Thank you for your interest in bringing your child to us. In order to get the most out of our first meeting, it is often useful to gather some information before the appointment. Although it seems a little long complete the enclosed form, entitled "Patient and Family History," and return by mail to the GLENDALE address below, even if you will be seen in the Oak Creek office, or fax (414-247-0894). Once we have received the form, we will call you to schedule the appointment.

The initial appointment will last about 60-90-minutes. The child should come with his/her legal guardian. If both parents share in raising the child, it is best to have both parents present at the first appointment. Of course if the grandparent or other caretakers wish to come, they are welcome. **If you must bring the child's sibling(s) to the appointment, please bring an adult to care for these children in the waiting room while you and your child are with the doctor.** Please bring all bottles of prescription medication your child is taking, and bring contact information (name, address, telephone number) for your child's school and the name of his/her primary teacher and for your child's primary care doctor and any other professionals (medical specialists, therapists, counselors, etc.) your child sees regularly

If it becomes necessary to cancel your initial appointment, please call us as soon as possible. Failure to cancel an initial appointment within 24 hours prior to the appointment may result in dismissal from the clinic.

Call us if you have any further questions prior to the appointment. We look forward to seeing you.

Sincerely,

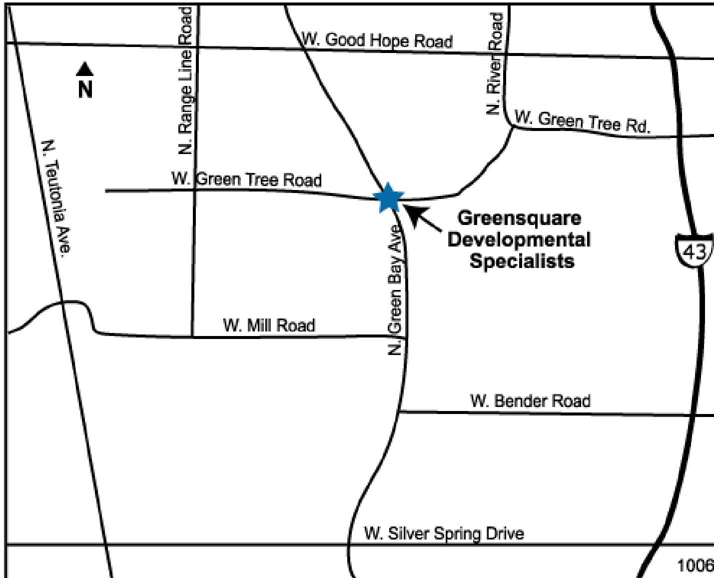
Greensquare Developmental Specialists
Children's Medical Group

See reverse side for map and directions

Office addresses and directions: **Phone:** (414) 228-4800 **Fax:** (414) 247-0894

6791 N. Green Bay Avenue
Glendale, WI 53209

To reach the office from I-43, take the Good Hope Road exit (Exit 80). Take the Good Hope Road West ramp and merge onto W. Good Hope Road (PP West). Turn left onto N. Green Bay Avenue (Highway 57 South). The office is located on the right at the intersection of Green Bay Avenue and Green Tree Road.



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7300 S 13th ST. Suite 201
Oak Creek, WI 53154

From I-94, exit on Rawson Avenue. Go east to the stoplight. Turn right onto 13th St. It is a group of 3 brownish red brick building we are the one farthest to the south(to your right when entering). You can park anywhere outside the door and the suite is at the top of the stairs when you enter the building.

Patient and Family History

Greensquare Developmental Specialists

If you have not already contacted our clinic, please call before sending this paperwork.

Which provider? ___Dr Norton ___ Tamara Makhlouf, LPC ___ Michelle Stoneburner, LCSW ___ Robert Jarvis, LCSW

I. Patient Information

Child's Name:________________________________ Date of Birth:________________________

Child's Address:_________ __________________ City:_____________ State______ Zip__________

Home Telephone: ( ) __________________ **Child's Social Security Number**:________________

Parent Information:	Parent Information:
Name:__________________________________	Name__________________________________
Date of Birth:_____________________________	Date of Birth:______________________________
Social Security Number:__________________	**Social Security Number:____________________**

(Social Security Numbers needed for insurance purposes)

Address: □ same as above, or:	Address: □ same as above, or:
Street:__________________________________	Street_________________________________
City:_____________ State______ Zip__________	City:____________ State______ Zip________
Home Telephone: ( )____________________	Home Telephone: ( )__________________
Mobile Telephone: ( )____________________	Mobile Telephone: ( )_________________
Work Telephone: ( )_____________________	Work Telephone: ( )__________________
May we contact at work? □no □yes	May we contact at work? □no □yes
Stepparent's name (if applicable): _______________	Stepparent's name (if applicable):__________
Marital status: □married □single □cohabitation □divorced □separated □widowed	Marital status: □married □single □cohabitation □divorced □separated □widowed
Number of marriages:__________	Number of marriages:_______

Name of insurance:____
Insurance address from back of card:____
Provider/Customer service phone number from card: ____
Policy/Member ID :___________________________ Group #: __________________________________
Who holds the insurance:____________________________________ Date of Birth:______________
Name of Employer:____
Full Time: ______ Part Time: _______
Your Email Address:____

Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino _____ Patient refused _____ Unknown____
Race: American Indian or Alaska native _____ Asian _____ Black or African American ______
Native Hawaiian or Pacific Islander ______ White______ Other ______ Patient refused ______
Unknown _____
Who currently has legal custody of the child?____
Is child in foster care? □no □yes, list Bureau of Milwaukee Child Welfare case worker name and telephone:____
Is child adopted: □no □yes, at what age?_________
Child's Place of Birth:__________________________ Primary Language Spoken:_________________

Siblings (please list)

Name	*Gender*	*Age*	*Current living situation*

II. Developmental History

Did mother experience any illnesses during pregnancy? ☐no ☐yes, explain_____________________

Did mother smoke cigarettes during pregnancy? ☐no ☐yes, amount___________________________

Did mother use alcohol during pregnancy? ☐no ☐yes, amount_______________________________

Was the child premature? ☐no ☐yes, age at delivery____________________Birth Weight:________

Were there any problems during delivery? ☐no ☐yes: explain________________________________

Please describe the child's early:

Sleep patterns:____

Personality:____

Please give the approximate age at which the child first began to:

Roll over____________ Sit up____________ Crawl ____________ Walk____________

Speak words___________ Toilet Train (day)____________ Toilet Train (night)____________

Difficulties with child's hearing: ☐no ☐yes ,explain____

Difficulty with child's vision: ☐no ☐yes ,explain____

III. Mental Health History

Has the child received mental health care? ☐ no (skip to section IV) ☐ yes (please describe):

Current or previous psychiatrist? (name, address, telephone, dates of treatment)__________________

____

Current or previous therapist? (name, address, telephone, dates of treatment)____________________

____

Previous psychiatric hospitalizations? (where, reason, dates of treatment)_______________________

____

Please list any *previous psychiatric* medications the child used:

Name	*Dose*	*Frequency*	*Date started/stopped*	*Reason for taking*	*Reason stopped*

IV. Medical History

Child's Current Primary Care Provider:____

Address:______________________________ City:_____________ State_______ Zip_____________

Telephone:( )___________________________ Fax ( )_______________________________

Please list all medications the child is currently taking: Including over the counter meds and nutritional supplements.

Name	*Dose*	*Frequency*	*Reason*	*Date started*

Please list any allergies the child has (including medications, food, environmental):

Item allergic to	*Typical reaction*	*Standard treatment*

Please list any ongoing health problems the child has (e.g., asthma, diabetes, etc.)

Condition	*Treatment*	*First Diagnosed*

Has the child ever experienced a seizure? ☐no ☐yes, type_______________________________________

Has the child ever experienced a head injury (from fall, car accident, sports, etc.) that resulted in loss of consciousness/blackout? ☐no ☐yes, explain____
Has the child ever had surgery? ☐no ☐yes ,explain (when, why)_________________________________
____

Has the child ever been hospitalized overnight? ☐no ☐yes, explain (when, why, duration)____________
____

Please list any family member(s) with the following illnesses:

Condition	*Child*	*Mother*	*Father*	*Sibling*	*Grandparent*	*Other (who)*
Allergies						
Sexually Transmitted Disease						
AIDS or HIV						
Neurological Disorders						
Alcohol or Drug Abuse History						
Physical and/or Sexual Abuse History						
Head Injury						
Seizures						
Migraines						
Alzheimer’s Disease						
Depression						
Bipolar (Manic-Depression)						
Schizophrenia						
ADHD or ADD						
Obsessive-Compulsive						
Anxiety						
Autism Spectrum Disorder						
Suicide (including attempts)						
Other medical:						

Are the child's immunizations up to date? □yes □no, explain_____________________________________

V. Educational History

Child's current school:____ Grade level:__________
School address:_________________________ City:______________ State:______ Zip:___________
Primary teacher's name:____

Level of Schooling	*Where, Dates*	*Any Concerns/Difficulties*
Early Education (0-3 services)		
Preschool		
Elementary School		
Middle School		
High School		

Has the child ever received any of the following services? If yes, please describe and give dates:
Tutoring: □no □yes, explain____
Special Education: □no □yes, explain____
Physical Therapy: □no □yes, explain____
Occupational Therapy: □no □yes, explain____
Speech Therapy: □no □yes, explain____
Other: ____

Does the child have a history of:
Learning disabilities: □no □yes, explain____
Reading problems: □no □yes, explain____
Mathematics problems: □no □yes, explain____
Speech problems: □no □yes, explain____
Coordination problems: □no □yes, explain____

Please report the parent's educational histories:
Mother's highest level of education:____
Does mother have a history of educational difficulties? □no □yes, explain_________________________
Father's highest level of education:____
Does father have a history of educational difficulties? □no □yes, explain__________________________

VI. Social History

Is mother currently employed? □no □yes, job____
Is father currently employed? □no □yes, job____
Is stepmother currently employed? □n/a □no □yes, job____
Is stepfather currently employed? □n/a □no □yes, job____

Has child ever worked? □no □yes, job___________________________________ hours per week?______
Describe child's social activities:____
How many close friends does child have?____
How much time per week does child spend with friends?____
Please describe child's special skills/hobbies/talents____

What is your religious/spiritual preference, if any?____
How important is your spiritual life for you and your family?_____________________________________

Please check all that describe your child:

___Follows directions
___Does chores
___Polite
___Tolerant
___Fidgets
___Often loses things
___Often does not listen
___Easily distracted
___Often talks excessively
___Difficulty playing quietly
___Difficulty following instructions
___Difficulty sustaining attention
___Often blurts out answers to questions before they have been completed
___Trouble concentrating
___Shifts from one activity to another
___Often blames others for own mistakes
___Poor concentration or difficulty making decisions
___Difficulty remaining seated
___Often interrupts or intrudes on others
___Often does things that annoy other people

___Easy going
___Talks about feelings
___Cooperative
___Patient
___Marked inability to relax
___Low self esteem
___Avoidance of being alone
___Repeated nightmares
___Suicidal thoughts or attempts
___Worries about future events
___Worries about past behavior
___Excessive need for reassurance
___Is often touchy or easily or easily annoyed by others
___Feelings of worthlessness or excessive guilt
___Marked self-consciousness
___Often loses temper
___Friendly
___Worries about possible harm to others
___Worries about separation from parents
___Interacts with family

___Has many interests
___Responsible
___Trustworthy
___Truthful
___Often argues with adults
___Often swears or uses obscene language
___School refusal
___Cruel to animals
___Outgoing
___Lies often
___Runs away from home overnight
___Often initiates physical fights
___Often actively defies or refuses adult requests or rules
___Often engages in physically dangerous activities
___Is often angry or resentful
___Physically cruel to people
___is often spiteful or vindictive
___Has stolen
___Deliberate fire setting

___Healthy
___Plays Well
___Energetic
___Sleep Problems
___Decrease or increase in appetite
___Complaints about body (headaches, stomach aches)

Please describe the nature of the problem(s) for which you and your child are seeking treatment:

What question(s) do you want answered:

____

____

____

____

____

____

Form completed by: ______________________________ Relationship to patient: ____________________

Please return this form to: Greensquare Developmental Specialists
6791 N Green Bay Rd
Glendale, WI 53209
Or via Fax (414)247-0894

Thank you for completing the form. The provider will review it with you at your initial appointment.

For office use only

I have reviewed the preceding information with the patient/family.

*Signature*______________________________ *Date:*____________________