



CHILD AND FAMILY PRACTICE
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Child's Name: _____ **Age:** _____

Birth Date: ___/___/___ **Sex:** M F

School: _____ **Grade:** _____

Home Address: _____

City: _____ **State:** ___ **Zip** _____ **Phone (_____)** _____ - _____

Both parents living at home? Yes No **Siblings: Names and Ages** _____

Mother's Name: _____ **Birth Date:** ___/___/___ **Age:** _____

Employer Name: _____

Employer Address: _____

Employer State: ___ **Zip** _____ **Work Phone (_____)** _____ - _____

Occupation: _____ **Call at Work?** Yes No **Cell Phone (_____)** _____ - _____

Home address/phone, if different from child's: _____

City: _____ **State:** ___ **Zip** _____ **Phone (_____)** _____ - _____

Marital Status: Single Married Divorced **Email** _____

Father's Name: _____ **Birth Date:** ___/___/___ **Age:** _____

Employer Name: _____

Employer Address: _____

Employer State: ___ **Zip** _____ **Work Phone (_____)** _____ - _____

Occupation: _____ **Call at Work?** Yes No **Cell Phone (_____)** _____ - _____

Home address/phone, if different from child's: _____

City: _____ **State:** ___ **Zip** _____ **Phone (_____)** _____ - _____

Marital Status: Single Married Divorced **Email** _____

Where should confidential information be left? _____

Person Responsible for Bill: Mother Father Other _____

Authorization

1. I authorize the release of any medical or other information to my insurance company in order to process claims
2. I agree to pay for all services, even if they are not covered by my insurance plan, e.g., report preparation, school visits, record reviews, and extended phone calls.

Signature: _____ **Date:** ___/___/___

Name of Referral Source: _____

Child's Medical History:

Problems during pregnancy or birth: No Yes (Describe) _____

Physical in the past 12 months? No Yes (Describe) _____

Hospitalizations: No Yes (Describe) _____

Is medication taken regularly for any reason? No Yes (Describe) _____

Are there problems with?

Vision: No Yes (Describe) _____

Speech or hearing: No Yes (Describe) _____

Eating: No Yes (Describe): _____

Sleeping: No Yes (Describe) _____

Other medical concerns (e.g., allergies): No Yes (Describe) _____

Physician's Name: _____ Phone (____) ____ - ____

Should I send summary reports to your doctor/other professional? Yes No

Physician's Address: _____

Physician's City: _____ State: ____ Zip _____

Emergency Contact: _____ Phone (____) ____ - ____

Child's Developmental History. When did these milestones occur?

Crawling: _____ Walking: _____ Babbling: _____

First words: _____ Combining words: _____

Psychological Development. When did any of these become a problem?

Thumb sucking _____ Separation anxiety _____

Tics _____ Repetitive acts/thoughts _____

Hair pulling _____ Strange habits _____

Strong fears _____ Nightmares _____

Temper tantrums _____ Nervousness _____

Sadness _____ Problem sitting still _____

Sticking to activity _____ Negativity _____

Head/stomachaches _____ Bowel/bladder control _____

Aggressive behavior _____ Attention _____

Impulsivity _____ Bonding with parents _____

Sensitivities (e.g. clothes, food) _____ Temper tantrums _____

Expressing/receiving affection _____ Excessive neatness/sloppiness _____

Gross/Fine Motor skills _____ Problems with language _____

Extreme euphoria _____ Other _____

Does child have the opportunity to interact/play with same aged children? No Yes

Does child have problems interacting/playing with other children? No Yes

(Describe): _____

What types of activity/toys does your child like? _____

Reasons for coming to see me: _____

Is there anything else you want me to know at this time? _____

