Erin C. Milhem, Psy.D.
Licensed Clinical Psychologist
528 Spokane Falls Blvd. Suite 26A
erincmilhem@gmail.com

Child Registration Form	
Child’s Name:	Date of Birth:
Parent/Guardian 1:	Parent/Guardian 2:
Address 1:	Address 2: Same as Parent/Guardian 1 Y/N
Email Address:	Email Address:
Home Phone: Cell Phone:	Home Phone: Cell Phone:
Child's School:	Child’s Teacher
School District:	School Phone Contact: Teacher Email Contact:
Emergency Contact:	Emergency Contact Phone Number:
If an emergency situation arises that requires immediate medical attention that should involve the above named child, I, the legal guardian of said child hereby authorize Erin Milhem to secure emergency medical treatment by dialing 911 or through other appropriate facilities. This authorization shall remain in effect for the period of my child's enrollment unless cancelled by written notice filed with the Erin Milhem.	
Signature:	Date:

Credit Card Information		Insurance Card Information	
Name On Card:		Provider:	
Card Number:		Policy Holder:	
CVC :		Policy Number:	
Billing Zip:		Group Number:	
Expiration Date:			

I authorize Dr. Milhem to charge my credit card for psychological services rendered. I understand that missed appointments, and late cancelations are billed at the full rate for the appointment and insurance will not reimburse these activities. I understand that Dr. Milhem will notify me in writing prior to charging my credit card.

Card Holders Signature:	Date:

Developmental History		
Did the mother receive prenatal care?	Y/N	
Did the mother take any medications?	Y/N	If yes, what medications did she take and why?
Did the mother take any drugs, consume alcohol or smoke tobacco during her pregnancy?	Y/N	If yes, which substances were used? During which trimester? What was the frequency?
Did the mother experience any medical complications during the pregnancy?	Y/N	If yes, please describe the complications and the implications on the child:
Length of Pregnancy?	________________ Weeks Gestation	
Mother's age at delivery?	________________Years	
Delivery was	Vaginal or C-Section	
List any complications that arose during delivery:		

List any medical complications for the child after the delivery (i.e. breathing, feeding, congenital, etc.)		
Did your child require additional time in the hospital following his/her birth?	Y/N	If yes, for how long? and why?
Does your child have any chronic health problems?	Y/N	If yes, please explain:
Does your child have any allergies?	Y/N	If yes, please explain
Has your child ever had a head injury?	Y/N	If yes, please explain
Has your child ever been hospitalized?	Y/N	If yes, please explain

Developmental Milestones	
Activity	Age of Acquisition
Smiled in response to your smile	
Sat up without help	
Crawled	
Walked	
Babbled	
First Words (other than mama, dada)	
2-3 Word Phrases	
Toilet Trained during the day	
Toilet Trained during the night	

Were there ever any concerns about your child's fine or gross motor development?	Y/N	If yes, please explain:
Were there every any concerns about your child's language development?	Y/N	If yes, please explain:
Were there ever any concerns about your child's social development?	Y/N	If yes, please explain:
Were there ever any concerns about your child's academic skill development?	Y/N	If yes, please explain:

Assessment History		
Has your child ever been assessed by the school district?	Y/N	If yes, please explain, by whom and the outcome of the assessment:
Has your child ever been assessed by a speech and language pathologist?	Y/N	If yes, please explain, by whom and the outcome of the assessment:
Has your child ever been assessed by a occupational therapist?	Y/N	If yes, please explain, by whom and the outcome of the assessment:
Has your child ever been assessed by a psychologist?	Y/N	If yes, please explain, by whom and the outcome of the assessment:
Does your child currently have a diagnosis from a formal assessment?	Y/N	If yes, please list all diagnoses:

Intervention History		
Has your child received IEP services or hold a 504 Plan through the school district?	Y/N	If yes, please describe the services rendered:
Has your child ever received speech therapy?	Y/N	If yes, please explain, by whom and focus of intervention:
Has your child ever received any occupational therapy?	Y/N	If yes, please explain, by whom and focus of intervention:
Has your child every received counseling services?	Y/N	If yes, please explain, by whom and focus of intervention:

Medication History		
Does your child currently take any medications?	Y/N	If yes, please list current medications and dosages:
Has your child taken any medications in the past (other than antibiotics)?	Y/N	If yes, what medication and why did the child stop taking that medication?

Parent and Family History			
Name:		Name:	
Education:		Education:	
Occupation:		Occupation:	
Employer		Employer	
Religion/Spirituality:		Religion/Spirituality:	

Siblings Names	Age	Biological	Living in the home?
		Y/N	Y/N
		Y/N	Y/N
		Y/N	Y/N
		Y/N	Y/N
		Y/N	Y/N
		Y/N	Y/N

Do you or any of your family members have a history of any of the following conditions? Please check all that apply:					
	Biological Mother	Biological Father	Maternal Family	Paternal Family	Siblings
Challenges with focus					
Challenges with hyperactivity					
ADHD					
Autism Spectrum Disorder					
Social Awkwardness					
Depression					
Anxiety					
OCD					
Trouble with the Law					
Substance Abuse					

Bipolar Disorder					
Psychotic Episodes					
Schizophrenia					
Suicide Attemps					
Suicide Completion					
Hypo-thyroidism					
Hyper-thyroidism					
Learning Challenges					
Learning Disabilities					
Developmental Delays					
Genetic Conditions					
Cognitive Deficits					
Sensory Sensitivities					
Sensory Seeking					

Please briefly describe your concerns and your goals for our work together: