MINOR LEGAL INTAKE FORM

Name: _____ S.S. #: _____

Date of Birth: _____ Age: _____ Current Grade in School:_____

Home Address: _____

City/State:_____ Zip:_____

Current Address (if different from above): _____

City/State:_____ Zip:_____

Contact Information: _____

DCF Worker:_____Phone:_____

Parent or Guardian Name(S):_____

Guardian Home Address (if different from dependent)_____

City/State:_____ Zip:_____

Home Phone: _____ Place of Employment:_____

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

Primary Pediatrician: _____ Phone: _____

Address:_____

Should contact only be made through your attorney? Yes No

Attorney Name: _____ Phone: _____

Attorney Address: _____

Is this evaluation pre- or post hearing? Pre Post

Dr. Wendy Coughlin, Ph.D.

1101 S. Belcher Rd, Suite E – Largo, FL 33771 **Phone:** (727) 532-1997

MINOR LEGAL INTAKE FORM

Charges:

_____

_____

Previous Charges:

_____

_____

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: _____

I authorize Wendy E. Coughlin, Ph.D. and _____to disclose information to each other about my case.
(attorney)

_____ _____

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Parent/Guardian Signature Date

MEDICAL QUESTIONNAIRE FOR A MINOR

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

_____
_____
_____

Are those problems being treated? **YES** ☐ **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: _____
_____
Year: _____
_____
Year: _____
_____
Year: _____

Check any of the following medical problems your child has experienced:

☐ Colic
☐ Chronic ear infections
☐ Measles
☐ Strep infection
☐ Skin problems
☐ Asthma
☐ Allergies
☐ Broken bones
☐ Tonsillitis
☐ Urinary tract infections
☐ 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.

_____

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