

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

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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)

Parent/Guardian Signature _____ Date

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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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