New Patient Information Form - Child

(Please fill out and return at or prior to first appointment)

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DEMOGRAPHIC INFORMATION

Patient Legal Name:		Preferred Name:	Date:
Date of Birth:	Age:	Gender:	
Patient's Mailing Address:	City:	State:	Zip Code:
Parent 1 Name:		Parent 2 Name:	
Parent 1 Address:		Parent 2 Address:	
Parent 1 Phone: ☐ Home ☐ Cell ☐ Work		Parent 2 Phone: ☐ Home ☐ Cell ☐ Work	
Parent 1 Email Address:		Parent 2 Email Address:	
Parent 1 Occupation:		Parent 2 Occupation:	
Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married			
Referred by?		Current School:	

CHIEF COMPLAINT

Briefly describe your reason for seeking treatment:

Describe main symptoms:

Please check any areas below which have been worsened due to your child's current problems.

- ☐ School/work performance
- ☐ Relationship with family
- ☐ Interest in keeping up appearance
- ☐ Ability to control temper
- ☐ Ability to carry out usual leisure interests/hobbies
- ☐ Ability to plan for future and set goals
- ☐ Relationships with friends
- ☐ Ability to manage usual chores at home
- ☐ Ability to control behavior
- ☐ Extracurricular activities
- ☐ Relationships with teachers/school
- ☐ Relationship with legal authorities

PATIENT PSYCHIATRIC AND MEDICAL HISTORY

HISTORY OF PRESENTING ILLNESS

When did these symptoms begin? Did something occur to precipitate them?

Have there been symptom-free periods? If yes, when and for how long?

Has patient been treated for problem in the past? If so, please give type of treatment as well as start and end dates.

Individual psychotherapy? If yes, when and with whom?

Group/Family/Couples psychotherapy? If yes, when and with whom?

Has patient ever been psychiatrically hospitalized? If yes, when, how, and under what circumstances?

Has patient ever hurt himself/herself in any way? For example, cutting or burning self. If yes, when, how, and under what circumstances?

Has patient ever thought of or attempted to commit suicide? If yes, when, how, and under what circumstances?

MEDICAL HISTORY

Current or prior medical problems:

Medical hospitalizations/surgeries:

Known drug allergies:

Primary Care Physician:	Last physical exam:

Address/Phone:	Immunizations current? ☐ Yes ☐ No

Describe current eating habits:

Describe current sleeping habits: (How many hours per night? Wake up during night? How long does it take to fall asleep?)

Describe current exercise habits:

PAST MEDICATIONS

NAME OF MEDICATION	DOSAGE	WHY PRESCRIBED?	WHO PRESCRIBED?	COMMENTS (HELPFULNESS/SIDE EFFECTS)

CURRENT MEDICATIONS

NAME OF MEDICATION	DOSAGE	WHY PRESCRIBED?	WHO PRESCRIBED?	COMMENTS (HELPFULNESS/SIDE EFFECTS)

Please comment on any substance abuse (drugs/alcohol).

What Substance?	When did you	How much did you use?	Last use?	What did it do for you?

Please mark any that the patient has or has had in the past and include dates as best you can.

- ☐ Head injury/loss of consciousness
- ☐ Seizures/convulsions
- ☐ Other neurological problems
- ☐ Ear, Nose, or Throat problems
- ☐ Dental problems
- ☐ Asthma
- ☐ Chest problems
- ☐ Stomach or bowel problems/soiling
- ☐ Urinary or bladder/wetting
- ☐ Heart problems
- ☐ Rheumatic fever/strep infections
- ☐ Liver/kidney problems
- ☐ Skin problems
- ☐ Joint/limb problems
- ☐ Hearing/vision problems
- ☐ Growth/endocrine problems
- ☐ Gynecological/menstrual problems
- ☐ Childhood measles/mumps

FAMILY HISTORY

Please list the names, ages, and relationships of people living in the home.

Name	Age	Relation

Please list family other than immediate family members not living in the home.

Name	Age	Relation

FAMILY PSYCHIATRIC HISTORY

Has any family member had any of the following? Please indicate which family member.

- ☐ Depression
- ☐ Mania/Bipolar Disorder
- ☐ Suicidal thoughts/urges/behaviors
- ☐ Anxiety
- ☐ Panic
- ☐ Obsessions/Compulsions
- ☐ Rituals
- ☐ Movement Disorders
- ☐ Tics
- ☐ Unusual noises/vocalizations
- ☐ ADHD
- ☐ Eating Disorder
- ☐ Learning Disability
- ☐ Coordination Problems
- ☐ Mental Retardation
- ☐ Autism/Asperger's Disorder/PDD
- ☐ Sleep Disorder
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Psychosis
- ☐ Legal problems
- ☐ Psychiatric hospitalizations
- ☐ Other _____
- ☐ Other _____

Please elaborate on above as needed.

Please provide information about significant medical issues on the FATHER'S side.

Please provide information about significant medical issues on the MOTHER'S side.

PRENATAL HEALTH

Was the pregnancy healthy? ☐ Yes ☐ No If not, describe problems:

Were medications used during pregnancy? ☐ Yes ☐ No	If yes, what kind? How often?
Were drugs/alcohol used during pregnancy? ☐ Yes ☐ No	If yes, what kind? How often?
Did the mother smoke during pregnancy? ☐ Yes ☐ No	If yes, how much?

Was the pregnancy full term? ☐ Yes ☐ No If preterm, how many weeks? Delivery: ☐ Vaginal ☐ C-section

Were there delivery problems such as: ☐ meconium ☐ forceps ☐ low oxygen ☐ other _____

Were there any feeding problems? ☐ Yes ☐ No	Gained weight well?

Were there any problems in the first week?

First month?

First year?

DEVELOPMENTAL HISTORY

Describe child as an infant:

- ☐ Active
- ☐ Cuddly
- ☐ Cried easily/frequently
- ☐ Soothed easily
- ☐ Active but calm
- ☐ Irritable
- ☐ Cried reasonable amount
- ☐ Difficult to soothe
- ☐ Passive
- ☐ Withdrawn
- ☐ Cried Seldom
- ☐ Average
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Response to changes: ☐ Severe ☐ Moderate ☐ Mild

Reaction to strangers: ☐ Friendly ☐ Indifferent ☐ Fearful

Describe reaction to being held: _____

Developmental Milestones (MARK ONLY IF SIGNIFICANTLY DELAYED)

MOTOR	LANGUAGE	ADAPTIVE
☐ Rolled front/back (4 mo)	☐ Smiling (4-6 wks)	☐ Mouthing (3 mo)
☐ Sit with support (6 mo)	☐ Cooing (3 mo)	☐ Transfers objects (6 mo)
☐ Sit alone (9-10 mo)	☐ Babbling (6 mo)	☐ Picks up raisin (11-12 mo)
☐ Pull to stand (10 mo)	☐ Jargon (10-14 mo)	☐ Scribble (15 mo)
☐ Crawling (10-12 mo)	☐ First Word (12 mo)	☐ Drinks from cup (10 mo)
☐ Walks alone (10-18 mo)	☐ Follows 1-step command (15 mo)	☐ Uses spoon (12-15 mo)
☐ Running (15-24 mo)	☐ 2 word combo (22 mo)	☐ Undresses
☐ Tricycle (3 yrs)	☐ 3 word sentence (3 yrs)	☐ Bowel trained
☐ Bicycle (5-7 yrs)	☐ Speech problems	☐ Bladder Trained

School:

Repeated grade? ☐ Yes ☐ No If yes, which grade? _____

Accommodations/Learning Plan? _____

Other current or past special services? (Speech/OT/PT) _____

Academic grades received: _____

Evaluations performed:

Date:	Type:	Reasons:

Results:

Date:	Type:	Reasons:

Results:

Relationships with Teachers?	With peers?

Has your child ever had truancy proceedings? ☐ Yes ☐ No	Has your child had any other legal proceedings? ☐ Yes ☐ No

If yes, please describe:

Describe your child's activities, interests, hobbies, skills, strengths:

Please use the remaining space to describe any other comments, questions, or concerns.

Problem Behavior Checklist. Does your child have any of the following problems? Please check all that apply.

	In the past	Occasionally	Often	Very Often	Comments
Short attention span					
Impulsivity (acts before thinking)					
Won't follow rules/directions					
Irritable, poor frustration tolerance					
Easily riled up					
Picks on others, bullies					
Feels picked on					
Teases others unmercifully					
Deliberately tries to annoy people					
Easily angered, bad temper					
Frequent accidents					
Gets out of control					
Gets violent and aggressive					
Cruel to animals					
Fire setting					
Steals					
Cries easily					
Gets giddy and silly					
Tiredness/listlessness					
Lack of interest in activities					
Isolates self from others					
Sadness					
Poor appetite					
Problems getting to sleep					
Early morning awakening					
Self-injurious/abusive behaviours					
Excessive sleepiness					
Weight gain/loss					
Worries a lot					
Fear of the dark					
Other specific fears (heights, etc.)					
Catastrophic fears					
Reluctance to go to school/work					
Repeated unwanted thoughts					
Compulsive behaviours					
Rituals (has to repeat same action)					
Hair pulling					
Excessive concerns: body defects					