

NOTE: Please download this form, complete it, print and bring it with you to your appointment. Thank you.

Please complete this questionnaire and bring it with to your child's first appointment. It asks about general background information that may be relevant to your child's evaluation.

Child's Name: **Age:**

Date of Birth: **Grade:** **School:**

Child's Nickname (if any):

Today's Date:

Name of Person completing form and relationship to child:

CHILD DEVELOPMENT

Note any complications related to the following in the space provided:

Pregnancy
(e.g., medications taken, drugs/alcohol, illness, complications?)

Labor
(e.g., spontaneous, induced, duration?)

Delivery
(e.g., C-section, forceps, distress, APGARS?)

Birth weight: Went home with mother? Yes No (reason):

Neonatal/Infancy
(e.g., jaundice, convulsions, colic, problems breathing, infections?)

As a baby, my child was (check all that apply):

- calm active difficult good sleeper easily upset affectionate
 quiet loud difficult to care for ate well stubborn predictable

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Estimate the age at which your child could:

Walk	<input type="text"/>	Catch a ball	<input type="text"/>
Speak Words	<input type="text"/>	Tie shoelaces	<input type="text"/>
Speak simple sentences	<input type="text"/>	Toilet trained	<input type="text"/> Day <input type="text"/> Night <input type="text"/>

If any of the following occurred as a young child, note the age:

Nonsense speech or made-up words	<input type="text"/>	Poor pronunciation	<input type="text"/>
Repeating other's speech	<input type="text"/>	Clumsiness	<input type="text"/>
Ignored people or other children	<input type="text"/>	Withdrawn	<input type="text"/>

If any of the following occurred as a young child, note the age:

Odd movements	<input type="text"/>	Head-banging	<input type="text"/>
Nightmares, night terrors	<input type="text"/>	Bedwetting (after age 6)	<input type="text"/>
Excessive anxiety about separation from parents	<input type="text"/>	Excessive anxiety about going to school	<input type="text"/>
Repeating behaviors excessively, e.g. twirling in circles, lining up toys	<input type="text"/>		

If there was testing or therapy for any of the following, note the child's age and where testing/therapy was received:

<input type="text"/>	Speech	<input type="text"/>
<input type="text"/>	Vision	<input type="text"/>
<input type="text"/>	Hearing	<input type="text"/>
<input type="text"/>	Learning	<input type="text"/>
<input type="text"/>	Neurological	<input type="text"/>
<input type="text"/>	Is child receiving special services at school?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Current or Previous Psychiatric/Mental Health/Counseling Interventions (Please note age and where/with whom):

Current Medications:

Current Medications	When Started	Doctor/Prescriber	Effects

Please complete the following describing any PAST trial of psychiatric medication, in chronological order if possible:

Past Medications	When Started	Doctor/Prescriber	Effects

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GENERAL MEDICAL HISTORY

Primary physician and/or clinic:

Would you like us to share information with this provider? No Yes If so, please complete a release of information)

Date last seen:

Note the age of onset and details related to any of the following conditions that apply to your child:

<input type="checkbox"/>	Allergies to Medications	<input type="text"/>
<input type="checkbox"/>	Surgeries	<input type="text"/>
<input type="checkbox"/>	Hospitalizations	<input type="text"/>
<input type="checkbox"/>	Serious illnesses	<input type="text"/>
<input type="checkbox"/>	Head injuries	<input type="text"/>
<input type="checkbox"/>	Seizures or Convulsions	<input type="text"/>
<input type="checkbox"/>	Meningitis, Encephalitis, or Coma	<input type="text"/>

Any current Medical Problems:

Please check any current health issues that apply to you and describe:

<u>General</u>	<u>Eyes</u>	<u>Ears/Nose/ Mouth/Throat</u>	<u>Cardiovascular</u>	<u>Respiratory</u>	<u>Gastrointestinal</u>	<u>Genitourinary</u>	<u>Genitourinary</u>
<input type="checkbox"/> weight	<input type="checkbox"/> blurry	<input type="checkbox"/> dry mouth	<input type="checkbox"/> chest pain	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> heartburn	<input type="checkbox"/> hesitancy	<input type="checkbox"/> stiffness
<input type="checkbox"/> appetite	<input type="checkbox"/> flashes	<input type="checkbox"/> congestion	<input type="checkbox"/> dizziness	<input type="checkbox"/> cough	<input type="checkbox"/> nausea	<input type="checkbox"/> retention	<input type="checkbox"/> swelling
<input type="checkbox"/> fatigue	<input type="checkbox"/> dry	<input type="checkbox"/> headache	<input type="checkbox"/> swollen feet	<input type="checkbox"/> wheezing	<input type="checkbox"/> constipation	<input type="checkbox"/> menses	<input type="checkbox"/> aches
<input type="checkbox"/> poor sleep	<input type="checkbox"/> pain	<input type="checkbox"/> ringing	<input type="checkbox"/> leg cramps		<input type="checkbox"/> diarrhea	<input type="checkbox"/> sexual	<input type="checkbox"/> injury

Neurological Skin Endocrine Hematological Immunologic Describe checked symptoms or others not listed:

<input type="checkbox"/> movements	<input type="checkbox"/> rash	<input type="checkbox"/> too cold	<input type="checkbox"/> bruising	<input type="checkbox"/> hives
<input type="checkbox"/> weakness	<input type="checkbox"/> itching	<input type="checkbox"/> too warm	<input type="checkbox"/> bleeding	<input type="checkbox"/> congested
<input type="checkbox"/> tremor	<input type="checkbox"/> dry	<input type="checkbox"/> sweating	<input type="checkbox"/> nodes	<input type="checkbox"/> infections
<input type="checkbox"/> seizure	<input type="checkbox"/> hair loss	<input type="checkbox"/> thirst	<input type="checkbox"/> anemia	<input type="checkbox"/> rashes

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FAMILY HISTORY

- Child lives with: Biological parents Adoptive parents
 Parent & stepparent Foster parents
 One parent alone Institution
 Relatives Other

- Parents are: Married Unmarried Separated Divorced Widowed

Please describe parent' marital relationship, if applicable:

- Smooth Occasional difficulties Frequent difficulties Failure

Family Composition: Names, ages, and relation of everyone who lives at home:

Name	<input type="text"/>	Age	<input type="text"/>	Relation	<input type="text"/>
Name	<input type="text"/>	Age	<input type="text"/>	Relation	<input type="text"/>
Name	<input type="text"/>	Age	<input type="text"/>	Relation	<input type="text"/>
Name	<input type="text"/>	Age	<input type="text"/>	Relation	<input type="text"/>
Name	<input type="text"/>	Age	<input type="text"/>	Relation	<input type="text"/>
Name	<input type="text"/>	Age	<input type="text"/>	Relation	<input type="text"/>

Who has custody at this time?

Please describe agreement between parents on how to deal with child's problems:

- Usually agree Sometimes agree Never agree

Has anyone in the immediate or extended family needed help for emotional, behavioral, psychiatric or neurological problems or other serious medical problems? If so, please list and describe the problems as best as you can and the family member's relation to the child.

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Was the child exposed to any type of abuse (sexual, physical, emotional, verbal etc)? If so, describe type, by whom, duration:

Have any of the following events occurred which may have affected your child? Note when and describe:

Death in family/other losses:

Change in family's financial status:

Job changes:

Divorce or separation:

Moves:

Are there any significant events that occurred in either parent's upbringing that would be important for us to know in working with the family? (e.g., chemical dependency, chronic family fighting, abuse)

Has the child smoked cigarettes or used tobacco products? If yes, please describe:

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Has the child used alcohol or street drugs? If yes, please describe:

Any legal issues in the past or present? If so, please describe:

Any employment in the past or present? If so, please describe:

Please list any other information you feel is important for us to know:

Please list questions you would like answered at this appointment if possible:

1.
2.
3.
4.
5.