

| PRESENTING PROBLEM – Please briefly describe your concern(s) | | |
|--|--------------------------|--|
| | | |
| CURRENT MEDICATIONS | PAST PSYCHIATRIC MEDS | ALLERGIES |
| | | |
| MENTAL HEALTH HISTORY | | |
| Has the child had past or current outpatient mental health treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify, include provider and dates of treatment below: | | |
| Type | Provider/Date | |
| <input type="checkbox"/> Individual Therapy | | |
| <input type="checkbox"/> Family Therapy | | |
| <input type="checkbox"/> Med Management | | |
| <input type="checkbox"/> Psychological Testing | | |
| <input type="checkbox"/> Psychiatric Hospital Admission | | |
| Additional Behavioral Health Information History | | |
| Please provide additional information regarding hospitalizations and medications: | | |
| | | |
| Current Living Situation: | | |
| Who is living in the home and their relationship to the child: | | |
| | | |
| Cultural/Ethnic/Spiritual Considerations/Identities: | | |
| | | |
| <input type="checkbox"/> Unknown Family History/Adopted | | |
| Does the child or a family member have a history or prior diagnosis of: | | |
| | Child | Family Members: |
| ADD/ADHD | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Autism Spectrum Disorder | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |

| | | |
|--------------------------------------|--------------------------|--|
| Bipolar Disorder | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| DMDD | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Eating Disorder | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Encopresis/Enuresis | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Learning Disorder | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Mania | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Obsessive-Compulsive Disorder | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Oppositional Defiant Disorder | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Panic Attacks | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| PTSD/Trauma | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Schizophrenia | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Separation Anxiety | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Social Anxiety | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Substance Use/Dependence | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Tourette's | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |

MEDICAL HISTORY

| | |
|---|---|
| Pediatrician: <input type="checkbox"/> Yes <input type="checkbox"/> No | Name/Phone #: |
| Date of Last Physician Exam: | |
| Date of Last Dental Exam: | |
| Date of Last Vision Exam: | |
| Additional Healthcare Providers: <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, include name and phone numbers: |

Has the child received immunizations? Yes No
 Are the child's immunizations up to date? Yes No

Does the child have an eating or sleeping problem? Select all that apply.

| | Child | Family Members: |
|--|--------------------------|--|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Cancer/Leukemia | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Down's Syndrome | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Encephalitis | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Epilepsy/Seizures | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Fever above 105 degrees | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Hearing Problems | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Heart Problems/Disease | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Hydrocephalus | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Lead Poisoning | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Loss of Consciousness/Head Injury | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Meningitis | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Musculoskeletal Condition | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Strep Infection | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |

| | | |
|--------------------------|--------------------------|--|
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Visions Problems: | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather |

Does the child have an eating or sleeping problem? Select all that apply.

| | |
|--|--|
| <input type="checkbox"/> Dieting <input type="checkbox"/> Overeating <input type="checkbox"/> Picky eater <input type="checkbox"/> Recent weight gain <input type="checkbox"/> Recent weight loss <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Vomiting <input type="checkbox"/> Other: | <input type="checkbox"/> Bedwetting <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Does not want to sleep alone <input type="checkbox"/> Nightmares <input type="checkbox"/> Sleeps to much <input type="checkbox"/> Soiling <input type="checkbox"/> Trouble staying asleep <input type="checkbox"/> Very restless at night |
|--|--|

How would you describe the nutritional value and balance of the child's diet? Good Fair Poor

Examples of Typical Diet:

Breakfast:

Lunch:

Dinner:

Does the child have an eating or sleeping problem? Select all that apply.

| | |
|---|--|
| Cognitive Issues: | Sensory Issues: |
| <input type="checkbox"/> Lack of varied, spontaneous make-believe play <input type="checkbox"/> Restricted patterns of behavior, activities or interests <input type="checkbox"/> Repetitive patterns of behavior, interest or activities <input type="checkbox"/> Preoccupation with parts of an object <input type="checkbox"/> Cognitive disabilities <input type="checkbox"/> Intense/all-encompassing interests | <input type="checkbox"/> Overly sensitive to sounds <input type="checkbox"/> Other sensory issues <input type="checkbox"/> Coordination problems |

DEVELOPMENTAL HISTORY

Prenatal/Birth:

Health of the mother during pregnancy: Good Fair Poor Unknown

Did the mother use any of the following during pregnancy? Yes No Unknown

Alcohol Cigarettes Marijuana Cocaine/Crack Coffee/Caffeine Drinks

Prescription Drugs (please list):

Any medical complications during pregnancy? Yes No Unknown

If yes, please specify:

Length of Pregnancy: Full-term Late preterm (32-36 weeks) Very preterm (28-31 weeks)
 Extremely preterm (Less than 28 weeks) Unknown

Birth Weight:

Were there any complications during or following birth (select all that apply)?

- Baby given oxygen Baby on heart monitor Birth defects Blood transfusions (baby)
 Delivery aided by instrument Delivery by cesarean section Incubator Jaundice Rashes
 Problems breathing Problems eating/digestion Problems sucking Very active Very quiet
 Other:

Early Development:

At what age did the child begin:

Walking (months): _____ Toilet training daytime: _____

Talking (single words): _____ Toilet training nighttime: _____

Talking (short sentences 2+ words): _____

Child can throw a ball: Yes No

Child can catch a ball: Yes No

Child had no trouble learning to hold a pencil: Yes No

Child easily learned to zip zippers, ties shoes and button clothes: Yes No

During the first 3 years of life, the child frequently exhibited (select all that apply):

- Accident-prone behavior Avoidance of cuddling Colic Distractibility Extreme mood changes
 Problems with sleeping/walking patterns Feeding problems Lack of coordination
 Overactive behavior Restless behavior Self-hurting behavior Temper tantrums
 Head banging Unresponsive to discipline

Activities of Daily Living:

Assigned chores or responsibilities: Yes No

Chores or responsibilities being done: Yes No

Needs prompting: Yes No

Please describe:

Performing self-care appropriate for age level: Yes No

Needs prompting: Yes No

Please describe:

SUBSTANCE/ALCOHOL USE HISTORY

Alcohol Use:

Does the child drink alcohol? Yes No

Additional Information/Concerns:

Smoking History:

Smoking Status: Nonsmoker Ex-smoker Cigar smoker Chew tobacco Current everyday smoker
 Current heavy tobacco smoker Current light tobacco smoker Pipe smoker Snuff user

Usage per Day: _____ Number of Years: _____

Do you vape? Yes No

Others Smoking in the Home: Yes No

Educational History:

Highest grade level completed: _____

Current grade: _____

Name of school presently attending: _____

Number of schools previously attending: _____

School-related issues (select all that apply):

- 504 Plan Advanced a grade Academic problems Attendance Behavior Bullying
- Detention Expulsion IEP Held back a grade Homework Learning disabilities
- Met with school counselor Occupational therapy Peer relationships Physical therapy
- Relationship with teacher(s) Required special help School modifications Speech therapy
- Suspension (in school) Suspension (out of school) Tested by school psychologist (ADD, ADHD, other)
- Transportation

Please describe and include any additional educational stressors:

Additional School History:

How easy is it for the child to make friends? More difficult Average Easier than average

How does the child get along with siblings? More difficult Average Easier than average

| | |
|--|--|
| What are the child's strengths? | Please describe extracurricular activities, employment and other pertinent information. |
|--|--|

Thank you for taking the time to complete this questionnaire.

Completed by: _____ Date Completed: _____

Relationship to Patient: Self Patient Guardian Other: _____