Your name: ____________________

Your relationship to patient: ☐ Mother ☐ Father ☐ Grandparent ☐ Guardian ☐ Self ☐ Other: ____________

Today's date: ____________________

General Information

Patient's full legal name: ____________________

Preferred name or nickname: ____________________

Date of birth: ____________________

Sex: ☐ Female ☐ Male ☐ Other identification

Name of therapist: ____________________ For how long? ________ Last visit: ________

Name of psychiatrist: ____________________ For how long? ________ Last visit: ________

Name of primary care physician: ____________________

Mother's name: ____________________

Mother's best phone number: ____________________ Mother's date of birth: ________

Mother's occupation: ____________________ Level of highest education: ________

Mother's place of employment: ____________________

Father's name: ____________________

Father's best phone number: ____________________ Father's date of birth: ________

Father's occupation: ____________________ Level of highest education: ________

Father's place of employment: ____________________

Who are other parental figures we should know about? (For example a step-parent or grand-parent)

____

Who has legal custody to make medical decisions? ____________________

Primary Concerns

Describe your primary concerns: ____________________

____

When did these concerns begin? ____________________

What do you hope will happen with this evaluation? ____________________

More information about your child or adolescent and their symptoms

What are their strengths? ______________________

What do they enjoy or do for fun? ______________________

What are their plans for the future? ______________________

What causes them the most stress? ______________________

Please describe their mood for the last two weeks. ______________________

Have they recently experienced major weight loss or gain? ______________________

What time do they go to bed most nights? ______________________

What time do they wake up most mornings? ______________________

Does your child or adolescent

Sleep well most nights? ☐ Yes ☐ No

Have problematic nightmares or recurring dreams? ☐ Yes ☐ No

Have a good appetite? ☐ Yes ☐ No

Have problems with the ability to focus? ☐ Yes ☐ No

Have a decreased level of energy? ☐ Yes ☐ No

Seem to constantly be angry? ☐ Yes ☐ No

Seem to have lost interest in activities they used to enjoy? ☐ Yes ☐ No

Seem to have an addiction to social media or gaming? ☐ Yes ☐ No

Have problematic, persistent feelings of anxiety? ☐ Yes ☐ No

Have panic attacks? ☐ Yes ☐ No

Seem to hear voices or see things that are not there? ☐ Yes ☐ No

Tell you often that they feel: ☐ Sad ☐ Isolated ☐ Hopeless ☐ Worthless ☐ Guilty ☐ Other

Has your child or adolescent

Participated in cutting or other self-harm activities? ☐ Yes ☐ No

Had a previous suicide attempt? ☐ Yes ☐ No

Talked about thoughts or plans to commit suicide or harm themselves? ☐ Yes ☐ No

Talked about thoughts or plans to harm others? ☐ Yes ☐ No

Your child's or adolescent's psychiatric history

Please list any previous psychiatric diagnoses: ______________________

____

Has there been a previous psychiatric hospital or psychiatric emergency room admission? ☐ Yes ☐ No

Has there ever been an eating disorder? ☐ Yes ☐ No

Has violence ever been used to cause harm to someone else? ☐ Yes ☐ No

Are there immediate blood relatives with a psychiatric diagnosis? ☐ Yes ☐ No

If yes, please give details: ______________________________

Are there immediate blood relatives who have attempted or completed suicide? ☐ Yes ☐ No

If yes, please give details: ______________________________

Are there immediate blood relatives with a substance use disorder? ☐ Yes ☐ No

If yes, please give details: ______________________________

Are there immediate blood relatives with a learning disorder? ☐ Yes ☐ No

If yes, please give details: ______________________________

Psychiatric medications tried and are no longer taken:

Medication name	Month/Year started	Month/Year stopped	How well it worked	Side effects	Why it was stopped

Your child's or adolescent's medical history

Check if they have had any of the following:

- ☐ Asthma
- ☐ Balance problems
- ☐ Belly pain
- ☐ Chest pain
- ☐ Colic
- ☐ Concussion
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Digestive problems
- ☐ Dizziness
- ☐ Fainting
- ☐ Head injury
- ☐ Headaches
- ☐ Heart condition
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hypertension
- ☐ Nausea
- ☐ Poor appetite
- ☐ Racing heart beats
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Serious accident
- ☐ Serious illness
- ☐ Skipped heart beats
- ☐ Strep throat
- ☐ Thyroid problems
- ☐ Vomiting
- ☐ Walking problems
- ☐ Other: ______________________________

Are they allergic to any medications? If so, which medications? ☐ Yes ☐ No

Please list current over-the-counter medications, alternative treatments, or supplements taken:

Are there immediate blood relatives with heart disease? If so, please explain. ☐ Yes ☐ No

Please list all prescriptions currently taken along with dosage, prescribed schedule for taking and actual schedule:

Medication name	Medication dosage	Prescribed schedule for taking this medication	If not following the prescribed schedule, what is the actual schedule

Your child's or adolescent's psychosocial history

Current school: Grade level:

List any grade levels repeated:

What are their usual report-card grades?

Please describe any problem with school attendance:

Please list any specific subjects that are a problem:

Are any of the following contributing to poor grades? ☐ Assignment completion ☐ Learning disability ☐ Attention ☐ Behavior

Have they been expelled or suspended from school? ☐ Yes ☐ No

If yes, please explain why:

Is there previous psychological and/or educational testing? (If yes, please provide copies) ☐ Yes ☐ No

Do they have an individualized learning program or a 504 plan? ☐ Yes ☐ No

Please describe any special education, tutoring or services received:

If adopted, please answer the following questions:

Where was the child adopted and at what age?

What has the child been told?

Please list all people living in the primary residence:

Name	Age	Relationship to child or adolescent

If there is a second home, please list all people living in the secondary residence:

Name	Age	Relationship to child or adolescent

Are there other siblings who live outside the primary and secondary residence? ☐ Yes ☐ No

Do they share a room? ☐ Yes ☐ No If yes, with whom? ____________________

In social relationships, do they prefer people who are: ☐ Same age ☐ Older ☐ Younger ☐ Adults

Do they prefer relationships with: ☐ Boys ☐ Girls

Please describe their behaviors with other children: ____________________

Have they ever lived apart from the family? ☐ Yes ☐ No If so, how long? ____________________

Natural parents are (check all that apply): ☐ Married ☐ Separated ☐ Divorced ☐ Deceased

If divorced, when? ____________________

How many times have they had to move? ____________________

What method(s) of discipline are used when they disobey? ____________________

Who handles the discipline in the home? ____________________

Do they have access to guns in the home or elsewhere? ☐ Yes ☐ No

If yes, are the guns locked? ☐ Yes ☐ No

Do they have a significant other? ☐ Yes ☐ No

Are they sexually active? ☐ Yes ☐ No

What is their sexual orientation? ____________________

Do they have a religious belief? ☐ Yes ☐ No Are they active in religious activities? ☐ Yes ☐ No

How many close friends do they have? ____________________

Have they ever been arrested or had trouble with the police? ☐ Yes ☐ No
Have they ever had to appear in court? ☐ Yes ☐ No
Is there a current attorney or probation officer? ☐ Yes ☐ No
Have they used or are they currently using any of the following? Check any that apply:
☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Prescription drugs not prescribed to them ☐ Other illegal drug
Have they been physically abused? ☐ Yes ☐ No
Have they suffered from neglect? ☐ Yes ☐ No
Have they been bullied or participated in bullying others? ☐ Yes ☐ No
Have they been sexually abused? ☐ Yes ☐ No
Have they been emotionally abused? ☐ Yes ☐ No
Have they witnessed domestic violence? ☐ Yes ☐ No
Have they experienced or witnessed a traumatic even where they were in significant danger? ☐ Yes ☐ No
Have they witnessed someone killed or almost killed? ☐ Yes ☐ No
Are there concerns that they are currently in an unsafe environment? ☐ Yes ☐ No

Your child's or adolescent's birth and developmental history

Please list any prescription drugs the mother took during pregnancy: ____________________

____

During pregnancy, did the mother use any of the following? Check all that apply:
☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other illegal drug (please list): ____________
Just before or after birth, did the mother experience severe anxiety or depression? ☐ Yes ☐ No
How many weeks did the mother carry the baby? What was the birth weight? ____________________
Were there any complications during the pregnancy, delivery, or newborn period? ☐ Yes ☐ No
Were they breast fed or bottle fed? ☐ Breast ☐ Bottle
As an infant or toddler, were there concerns about their mood or energy level? ☐ Yes ☐ No
If yes, in what way? ____________________
When did the following developmental milestones begin?

Walking, running, climbing skills	☐ Early	☐ On time	☐ Late	If late, when? ________
Writing, coloring, manipulating objects with fingers	☐ Early	☐ On time	☐ Late	If late, when? ________
Speech, communication, and language skills	☐ Early	☐ On time	☐ Late	If late, when? ________
Social skills	☐ Early	☐ On time	☐ Late	If late, when? ________
Bladder and bowel control (potty trained)	☐ Early	☐ On time	☐ Late	If late, when? ________

Do they have problems with wetting or soiling now? ☐ Yes ☐ No
Have they ever had speech, physical, or occupational training? ☐ Yes ☐ No

Thank you! We look forward to serving you.

Patient's Signature	Date	Time	Witness Signature	Date	Time

Signature of Authorized Person	Date	Time	Relationship to Patient

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ____________________ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)