Clinician Notes:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Age of Patient: \_\_\_\_\_\_\_ Name of person completing this form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

I. Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any previous treatment for the problem? ‬ Yes ‬ No If yes, explain:

II. Medical History:

Name of Pediatrician or Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like our findings and recommendations sent to your pediatrician? ‬ Yes ‬ No

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed:

‬ Seizures ‬ Heart Problems ‬ Weight Problems ‬ Head Injury

‬ Asthmatic condition ‬ Chronic Fatigue ‬ Chronic Headaches ‬ Depression

‬ Chronic Hearing Loss ‬ Stomach Problems ‬ Suicidal Thoughts ‬ Surgeries

‬ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain any item that you checked and list any medication(s) that were *previously* prescribed.

Allergies (Please list all of your child’s allergies):

Current Medications (Please list all of your child’s current medications other than above):

Clinician Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Notes:

III. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? ‬ Yes ‬ No If yes, please explain and include dates of service, location, physician or counselor’s name.

List any psychiatric or mood medications that your child has been prescribed in the past (if more than 3 medications, use the back of this page):

Name of medication Prescribed by Dose level Side effects

1.

2.

3.

IV: Developmental History:

A: Relating to your child’s birth:

Your child’s weight at birth: \_\_\_\_lbs. \_\_\_\_oz. Was this a full term birth? ‬ Yes ‬ No If no, explain:

Did either parent use drugs or alcohol at the time of conception? ‬ Yes ‬ No If yes, explain:

Were there any complications with the labor & delivery such as jaundice, infection etc.? ‬ Yes ‬ No If yes, explain:

Were there any problems after birth? ‬ Yes ‬ No If yes, explain:

B. Pre-school/Toddler Temperament: Please check the following items that apply.‬ Did not enjoy being held ‬ Excessive restlessness ‬ Colic‬ Feeding problems ‬ Sleep problems ‬ Head-banging‬ Sensitive to light / noise / texture ‬ Fussy or unhappy ‬ Difficulty bondingC. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:\_\_\_\_\_\_\_\_\_ Sitting alone \_\_\_\_\_\_\_\_\_\_ Walking \_\_\_\_\_\_\_\_\_ Put words together \_\_\_\_\_\_\_\_\_\_ Toilet trainedD. Unusual behaviors/Speech patterns:‬ Spinning ‬ Putting things in the mouth ‬ Repeating words or phrases inappropriately ‬ Hand flapping ‬ Sniffing excessively ‬ Saying “I” for “You”

V. School/daycare History:Did your child attend daycare? ‬ Yes ‬ No If yes, what was their age? \_\_\_\_ Any problems? \_\_\_\_\_\_\_\_\_\_\_What were your child’s grades on their last report card? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the name of your child’s primary teacher? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Notes:

Name of Dates Present Behavior Learning

Current School: Attended Grade Placement Problems Problems

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‬ Yes ‬ No ‬ Yes ‬ No

Name of Dates Present Behavior Learning

Past Schools: Attended Grade Placement Problems Problems

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‬ Yes ‬ No ‬ Yes ‬ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‬ Yes ‬ No ‬ Yes ‬ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ‬ Yes ‬ No ‬ Yes ‬ No

Has your child ever been:

evaluated for a learning disability? ‬ Yes ‬ No If yes, what grade? \_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_

placed in Special Education Classes? ‬ Yes ‬ No If yes, what type of class? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

tested by the school system? ‬ Yes ‬ No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

expelled or suspended? ‬ Yes ‬ No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a current IEP (Individual Education Plan)? ‬ Yes ‬ No

Does your child have a current 504 plan? ‬ Yes ‬ No

VI. Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child been: arrested? ‬ Yes ‬ No

assigned a probation officer? ‬ Yes ‬ No If yes, their name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

jailed? ‬ Yes ‬ No

Has your child: ever appeared in juvenile court? ‬ Yes ‬ No

or other family member ever been reported to DHR? ‬ Yes ‬ No

been assigned a DHR caseworker? ‬ Yes ‬ No

If yes, their name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ever been a victim of child physical or sexual abuse? ‬ Yes ‬ No

If you answered yes to any of these questions, please explain:

VII. Family Medical History:

Clinician

Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

‬ Sudden death ‬ Heart disease (especially dysrhythmias) ‬ Diabetes mellitus

‬ Obesity ‬ Narrow Angle Glaucoma ‬ Seizures

Clinician Notes:

VIII. Family Psychiatric History:

Has any member of your child’s family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADD/ADHD, etc.? ‬Yes ‬No If yes, please explain:

IX. Social / Family History:

Biological mothers’ full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Biological fathers’ full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Biological parents marital status: ‬ Married to each other ‬ Divorced ‬ Separated

If divorced from one another, has either remarried? Mother ‬ Yes ‬ No

Father ‬ Yes ‬ No

If the biological parents are divorced or separated, who has custody of the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of custody? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stepmothers’ name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stepfathers’ name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all relatives who presently live in the same household as your child (if more than 5 please list on back of this sheet):

Name Relationship Type of Employment / Student Grade Level

1.

2.

3.

4.

5.

Please check any of the following stressors that presently affect your child:

‬ Family financial problems ‬ Family relationships ‬ Legal problems

‬ Child rearing problems ‬ Drug or alcohol problems ‬ Abuse behavior

‬ Health problems ‬ Employment problems ‬ School problems

‬ Peer relationships ‬ Frequent change of household ‬ Frequent moves

‬ “Other” problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain how any item you checked affects your child.

Clinician Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reminder: Please bring a copy of any custody papers to the initial appointment.