MCPAP
Massachusetts Child Psychiatry Access Program

Information Gathering

Child's Name: _____ Date of Birth: _____ Male _____ Female _____

Form Completed By: _____ Relationship to Child: _____

Thank you for filling out this form. Our hope is that the information gathered here will help us take better care of your child. If you prefer to discuss some of this information in person, rather than on the form, then please let us know.

Please bring completed form to the scheduled appointment.

Brief Problem Description/Current Concerns:
Please Describe Strengths and Positive Attributes:
Please Describe Strategies/Resources Used to Help Child:

Medical History

Date of last appointment with PCP?			
Are there any specialists involved in your child's medical care? If yes, please list:	Yes ☐	No ☐	
Do you have any concerns regarding your child's physical health? If yes, please describe:	Yes ☐	No ☐	
Has your child had any surgeries? If yes, please list:	Yes ☐	No ☐	
Is your child currently being treated for any acute or chronic medical conditions? If yes, please describe:	Yes ☐	No ☐	
Does your child have any history of injuries, accidents, or physical concerns? If yes, please describe:	Yes ☐	No ☐	
Does your child have any current or recent physical symptoms that are concerning you? If yes, please describe:	Yes ☐	No ☐	
Head, Eyes, Ears, Nose & Throat:	Yes ☐	No ☐	If YES, please describe:
Respiratory	Yes ☐	No ☐	If YES, please describe:
Cardiovascular	Yes ☐	No ☐	If YES, please describe:
Gastrointestinal	Yes ☐	No ☐	If YES, please describe:
Genitourinary	Yes ☐	No ☐	If YES, please describe:
Skin or Allergies	Yes ☐	No ☐	If YES, please describe:
Neurological	Yes ☐	No ☐	If YES, please describe:

Family History of: (please circle)

Early onset (before the age of 35) sudden death	Marfan's Disorder	Palpitations
Arrhythmias	Other Connective Tissue Disorders	Type I (Childhood onset) Diabetes
High Cholesterol	Mitral Valve Prolapse	Type II (adult onset) Diabetes

Does your child have any: (please circle)

Chest Pain	Difficulty slowing heart rate	Marfan's Disorder or other Connective Tissue Disorder	Diabetes/Sugar Concerns
Chest Pain on Exertion	Excessive Thirst	Excessive Urination	High Cholesterol
Change in exercise tolerance	Palpitations	Arrhythmias	Mitral Valve Prolapse

Psychiatric History

Currently in treatment for an emotional/behavioral difficulty?	Yes ☐	No ☐
If yes, please list current providers:		
Currently taking medication for an emotional/behavioral difficulty?	Yes ☐	No ☐
Has your child ever required treatment in a psychiatric hospital or residential treatment facility?	Yes ☐	No ☐
If yes, please complete the following:		

Dates	**Hospital/Residential**	**Reason for Placement**	**Outcome**

Has your child ever taken medication to help behaviors or emotions?	Yes ☐	No ☐
If yes, has your child ever been treated with (please check all that apply) and give brief description of response, tolerability to that medication and dosage:		

Dates	**Medication**	**Reason for Taking**	**Dose**	**How well did it work?**	**Any side effects?**

Please List All Current Medications:		
Allergies:	**Adverse Drug Reactions:**	
Vitamin/Supplements?	Yes ☐	No ☐
If yes, please list:		

Suicidal Ideation	Yes ☐	No ☐	Dangerous by Threatening Others	Yes ☐	No ☐
Suicide Attempts	Yes ☐	No ☐	Aggressive Behavior to Others	Yes ☐	No ☐
Self-Mutilation	Yes ☐	No ☐	Verbally Abusive to Others	Yes ☐	No ☐
Other Danger to self:			Other Danger to Others:		

Substance Use/Abuse History

Does this child (to the best of your knowledge) experiment with, use, misuse, or abuse substances? Yes ☐ No ☐

If yes, please answer the following and describe his/her substance use.

Drug	**Age Started**	**Frequency**	**Amount**	**Current Use?**
Caffeine				
Nicotine				
Alcohol				
Cannabis				
Amphetamines				
Hallucinogens				
Cocaine				

Opioids				
Inhalants				
Sedatives (Klonopin, Xanax)				
Polysubstance				
Prescription Medications				
Other				

Has your child ever required treatment for a substance abuse/misuse problem? YES ☐ NO ☐
If yes, please list:

Family History

Often certain types of illnesses run in families. Is there any known history of any of the following in either the child's mother or father's families? Check all boxes that apply or mark UK if unknown.

Has anyone in the family ever had:	**Mother**	**Father**	**Sister**	**Brother**	**Extended Family**
Problems with Reading or Math					
Speech/Language Difficulties					
School/Learning Difficulties					
Autism					
Abuse (verbal, emotional, physical or sexual)					
Intellectual Disorder					
Attention Deficit Hyperactivity Disorder					
Alcohol and/or Drug Problems					
Tic Disorder or Tourette's Syndrome					
Anxiety and/or Panic Disorder					
Obsessive-Compulsive Disorder					
Schizophrenia					
Schizoaffective Disorder					
Depression					
Bipolar Disorder or Manic-Depressive Illness					
Eating Disorders: Anorexia or Bulimia					
Nervous Breakdown					
Psychiatric Hospitalizations					
Treatment of a psychiatric illness with medications					
Violence/Assaultive Behaviors					
Incarceration					

Prenatal History

Healthy Pregnancy	Yes ☐	No ☐	If NO, please describe:
Medications Taken During Pregnancy	Yes ☐	No ☐	If YES, please list:
Smoked Cigarettes	Yes ☐	No ☐	If YES, amount & frequency:
Consumed Alcohol	Yes ☐	No ☐	If YES, amount & frequency:
Take any Drugs	Yes ☐	No ☐	If YES, please list:
			If YES, amount & frequency:
Pregnancy Complications	Yes ☐	No ☐	If YES, please describe:
Full Term Pregnancy	Yes ☐	No ☐	If premature, how many weeks early?
Type of Delivery:			Birth Weight:
Complications during the labor and delivery?	Yes ☐	No ☐	If YES, please describe:

Social History

Who does your child prefer to spend free time with?					
Able to relate to peers?	Yes ☐	No ☐	Adults?	Yes ☐	No ☐
Are you concerned with this child's social interactions?				Yes ☐	No ☐
If YES, please describe:					
Please list some of your child's favorite interests or activities:					

Please list all family members (in or out of the house) as well as other people currently living in the home:

Name	**Age**	**Relationship**	**Occupation**	**Currently Living in Home?**

Legal History:

Parents are: Married _____	Living together _____	Divorced _____	Separated _____	Widowed _____	
Legal Custody/Guardianship:					
Involved in Juvenile Court System	Yes ☐	No ☐			
If YES, please describe:					
CHINS Petition in Place	Yes ☐	No ☐			
If YES, name of Probation Officer:					
Is DCF currently involved?	Yes ☐	No ☐			
If YES, please explain					
Access to firearms in the home?	Yes ☐	No ☐			

Child/Adolescent Developmental History

Hx of Neglect?	Yes ☐	No ☐
If YES, please explain:		
Hx of Physical Abuse?	Yes ☐	No ☐
If YES, please explain:		
Hx of Sexual Abuse?	Yes ☐	No ☐
If YES, please explain		
Hx of Verbal/Emotional Abuse?	Yes ☐	No ☐
If YES, please explain		
Hx of Being Exposed to Domestic Violence?	Yes ☐	No ☐
If YES, please explain		

Academic History

Current School:			Grade Level:
Ever repeated a grade?	Yes ☐	No ☐	If YES, which grade level?
Target of bullying or excessive teasing?	Yes ☐	No ☐	
If YES, please describe:			
Has a CORE evaluation been completed by the school?	Yes ☐	No ☐	
Is there an Education Plan (IEP) or 504 in place?	Yes ☐	No ☐	
Ever Received special/extra help in school?	Yes ☐	No ☐	
If YES, please check types of services being received:			
☐ Occupational Therapy	☐ Speech/Language		
☐ Resource Room	☐ Other		