

Child, Adolescent and Adult Psychiatry

New Patient Information Form

(Please fill out and return at or prior to first appointment)

Patient Demographic Information:

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred contact: _____ home/work/cell _____ home/work/cell

Email address: _____ Appointment reminders: Email or text

Parent's Name (if patient is a minor) _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Preferred contact: _____

Parent's Name (if patient is a minor): _____

Address: _____ City: _____ State: _____ Zip: _____

Highest Education: _____ Preferred contact: _____

Referred By: _____

Chief Complaint: What is your primary reason for seeking psychiatric consultation?

History of Presenting Illness:

When did these symptoms begin?

Did something occur to precipitate them? _____

Have there been symptom-free periods? _____

Past Psychiatric History:

When did treatment first begin?

What kind of treatment has occurred?

1. Individual Psychotherapy? If yes, when and with whom?

2. Group or Family/Couples Psychotherapy? If yes, when and with whom?

Have you (your child) ever been psychiatrically hospitalized? If yes, when, where, and for what reason? _____

Have you (your child) ever thought of or attempted to commit suicide? If yes, when, how, and under what circumstances? _____

Have you (your child) ever hurt oneself in any way? For example, cutting or burning self. If yes, when, how, and under what circumstances? _____

Medical History:

Current and Prior Medical Problems: _____

Medical Hospitalizations/Surgeries: _____

Known Drug Allergies: _____

Primary Care Physician: _____ Last physical exam: _____

Address/Phone: _____

Immunizations current? Yes/No

Past Medications:

Name of Medication	Dose Taken	Why Taken	Who Prescribed	Comments (helpfulness / side effects)

Current Medications:

Name of Medication	Dose Taken	Why Taken	Who Prescribed	Comments (helpfulness / side effects)

Please comment on any substance abuse (drugs/alcohol).

What?	When did you start?	How much did you use?	Last use?	What did it do for you?

Please circle any that the patient has had and include dates as best you can:

- | | |
|-----------------------------------|----------------------------------|
| Head Injury/Loss of Consciousness | Heart Problems |
| Seizures/convulsions | Rheumatic fever/strep infections |
| Other neurological problems | Liver/Kidney problems |
| Ear, nose or throat problems | Skin problems |
| Dental problems | Joint/limb problems |
| Asthma | Hearing/vision problems |
| Chest problems | Growth/endocrine problems |
| Stomach or bowel problems/soiling | Gynecological/menstrual problems |
| Urinary or bladder/wetting | Childhood measles/mumps |

Family History:

1. Please give the names, ages, and relationships of people living in the home:

2. Who are other immediate family members not living in the home?

Family Psychiatric History:

Has any family member had any of the following? Please circle and indicate which family member.

Depression	ADHD/ADD
Mania/Bipolar Disorder	Learning Disability
Suicidal thoughts/urges/behaviors	Coordination Problems
Anxiety	Mental Retardation
Panic	Autism/Asperger's Disorder/PDD
Obsessions/Compulsions	Sleep Disorder
Rituals	Drug Use
Movement Disorders	Alcohol Use
Tics	Psychosis
Unusual noises/vocalizations	Legal Problems
Eating Disorder	Psychiatric Hospitalizations

Other: _____

Please elaborate on above as needed: _____

Family Medical History:

Please provide information about significant medical issues on the FATHER'S side:

Please provide information about significant medical issues on the MOTHER'S side:

Prenatal History:

Was the pregnancy healthy? Yes _____ No _____ Problems: _____

Were medications used during the pregnancy? Yes ___ No ___

If yes, what kind? _____ How Often? _____

Were drugs/alcohol used during the pregnancy? Yes _____ No ___

If yes, what kind? _____ How Often? _____
 Did the mother smoke during the pregnancy? Yes ___ No ___ If yes how much? _____
 Was the pregnancy full term? Yes ___ No ___
 Was delivery normal? Yes ___ No ___ If no, problems? _____
 Any feeding problems? _____ Gained weight well? _____
 Was there any problem in the first week? _____
 first month? _____
 first year? _____

Developmental History:

1. Describe yourself/child as an infant:

- a) active / active but calm / passive / other:
- b) cuddly / irritable / withdrawn / other:
- c) cried easily and frequently / reasonable amount / seldom
- d) soothed easily / difficult to soothe / average
- e) response to changes: severe / moderate / mild
- f) response to being held (describe):
- g) reaction to strangers: friendly / indifferent / fearful

2. Describe current eating habits: _____ Problems: _____

3. Describe current sleeping habits: _____ Problems: _____

4. Developmental Milestones (**only mark if significantly early or late**):

Motor:

rolled front/back (4 mo) _____
 sit with support (6 mo) _____
 sit alone (9-10) _____
 pull to stand (10 mo) _____
 crawling (10-12 mo) _____
 walks alone (10-18 mo) _____
 running (15-24 mo) _____
 tricycle (3 yrs) _____
 bicycle (5-7 yrs) _____

Language:

smiling (4-6 wks) _____
 cooing (3 mo) _____
 babbling (6 mo) _____
 jargon (10-14 mo) _____
 first word (12 mo) _____
 follows 1-step command (15 mo) _____
 2 word combo (22 mo) _____
 3 word sentence (3 yrs) _____
 speech problems _____

Adaptive:

mouthing (3 mo) _____
 transfers objects (6 mo) _____
 picks up raisin (11-12 mo) _____
 scribble (15 mo) _____
 drinks from cup (10 mo) _____
 uses spoon (12-15 mo) _____
 undresses _____
 bowel trained _____
 bladder trained _____

School:

Repeated Grade? Y/N If yes, which? _____

Special/resource classes? _____

Other special services? (speech/OT/PT) _____

IEP? _____ 504 Plan? _____ Academic grades received: _____

Evaluations performed:

Date _____ Type _____ Reasons _____

Results _____

Date _____ Type _____ Reasons _____

Results _____

Relationships with teachers? _____ With peers? _____

Ability to work independently?	good	average	poor
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Organize self?	good	average	poor
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Attendance?	good	average	poor
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Have you (your child) ever had truancy proceedings? Y/N

Have you (your child) had any other legal proceedings? Y/N If yes, please describe.

Describe your (your child's) activities, interests, hobbies, skills, strengths:

Please use the remaining space to describe any other concerns:

Problem Behavior Checklist: Do you/your child have any of the following problems?

	In Past	Occasionally	Often	Very Often
Short Attention Span	_____	_____	_____	_____
Impulsivity (acts before thinking)	_____	_____	_____	_____
Won't follow rules/directions	_____	_____	_____	_____
Irritable, poor frustration tolerance	_____	_____	_____	_____
Easily riled up	_____	_____	_____	_____
Picks on others, bullies	_____	_____	_____	_____
Feels picked on	_____	_____	_____	_____
Teases others unmercifully	_____	_____	_____	_____
Deliberately tries to annoy people	_____	_____	_____	_____
Easily angered, bad temper	_____	_____	_____	_____
Frequent accidents	_____	_____	_____	_____
Gets out of control	_____	_____	_____	_____
Gets violent and aggressive	_____	_____	_____	_____
Cruel to animals	_____	_____	_____	_____
Fire Setting	_____	_____	_____	_____
Steals	_____	_____	_____	_____
Cries easily	_____	_____	_____	_____
Gets giddy and silly	_____	_____	_____	_____
Tiredness/listlessness	_____	_____	_____	_____
Lack of interest in activities	_____	_____	_____	_____
Isolates self from others	_____	_____	_____	_____
Sadness	_____	_____	_____	_____
Poor appetite	_____	_____	_____	_____
Problems getting to sleep	_____	_____	_____	_____
Early morning awakening	_____	_____	_____	_____
Self-injurious/abusive behaviors	_____	_____	_____	_____
Excessive sleepiness	_____	_____	_____	_____
Weight gain/loss	_____	_____	_____	_____
Worries a lot	_____	_____	_____	_____
Fear of the dark	_____	_____	_____	_____
Other specific fears (heights, etc)	_____	_____	_____	_____
Catastrophic fears	_____	_____	_____	_____
Reluctance to go to school	_____	_____	_____	_____
Repeated unwanted thoughts	_____	_____	_____	_____
Compulsive behaviors	_____	_____	_____	_____
Rituals (has to repeat same action)	_____	_____	_____	_____
Hair pulling	_____	_____	_____	_____
Excessive concerns: body defects	_____	_____	_____	_____