



PRE-APPOINTMENT INFORMATION FORM

Full Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Today's Date: _____

Person Completing This Form (if not patient): _____

Primary Care Doctor: _____ Therapist: _____

What are your concerns leading to this evaluation: (please be as specific as possible)

Patient's symptoms or behaviors engaged in or displayed (check all that apply):

- Feels sad/depressed for no reason
- Feels anxious, worries, or is scared
- Feels hopeless or worthless
- Has lost interest in enjoyable activities
- Loses temper easily
- Is disorganized
- Has difficulty completing tasks
- Is forgetful
- Is easily distracted
- Frequently interrupts during conversation
- Has difficulty breaking routines
- Has difficulty making friends
- Rocks, spins, or other activities to calm them down
- Strongly dislikes certain textures of food or clothing
- Makes very little eye contact
- Gets nervous or scared frequently
- Gets very shy around new people
- Complains about feeling sick repeatedly
- Engages in counting or lining up objects
- Frequent hand washing or other rituals
- Has nightmares
- Voices thoughts of hurting self
- Cuts self
- Have periods of time with changes in sleep or appetite
- Has heard or seen things that are not there
- Has obsessed over food or weight
- Has made self vomit
- Isolates self

Patient's Psychiatric History

Has the patient taken psychiatric medication (i.e. depression, ADHD, anxiety, etc.)?
If so, which ones and at what dosage?

Has the patient ever been psychiatrically hospitalized?
If so, when, where, and for what reason(s)?

Does the patient have a previous therapist?

Alcohol and Drug Use History

Alcohol: Describe consumption history:

Have there been legal, medical, or school/work-related problems as a result?

Illicit substances:

Has the patient used or experimented with marijuana, cocaine, prescription medications, or other drugs? If so, please describe.

Have there been legal, medical, or school/work-related problems as a result?

Patient's Medical History

Has the patient ever been diagnosed with the following (circle all that apply):

- | | | | | |
|--------------|-------------------------|---------------------|----------------------------|----------|
| Asthma | Diabetes | High Blood Pressure | High Cholesterol | Seizures |
| HIV | Thyroid
Hypoglycemia | Hearing Problems | Vision Problems | |
| Birth Defect | Cancer | Genetic Syndrome | Head Trauma/Concussion/TBI | |

Other medical problems not listed above OR explanation of any of the above:

What surgeries has the patient had?

Past significant hospitalizations (medical):

List of Medications

Name of Medication	Dose and How often receives	Reason
1.		
2.		
3.		
4.		
5.		
6.		

Family Mental Health History

Has any immediate or extended family member been diagnosed of the following (circle all that apply)?

- | | | | |
|-----------------------|------------------|----------------|-------------------------|
| Depression | Bipolar | OCD | PTSD |
| Anxiety | PTSD | Panic Attacks | Learning Disorders |
| Psychosis
Disorder | Schizophrenia | ADHD | Autism/Asperger's |
| Dementia | Suicide Attempts | Hallucinations | Intellectual Disability |

Alcohol Related Problems

Drug Related Problems

Has anyone been diagnosed with another mental health problem or personality disorder not listed above?

Which family members have been diagnosed or has had any of these problems?

Has anyone received mental health medications? If so, who and which medications?

Has anyone been hospitalized for mental health reasons?

Family Medical History

Does anyone in the family have any of the following medical problems (circle all that apply)?

- | | | | | |
|--------------|-------------------------|---------------------|----------------------------|----------|
| Asthma | Diabetes | High Blood Pressure | High Cholesterol | Seizures |
| HIV | Thyroid
Hypoglycemia | Hearing Problems | Vision Problems | |
| Birth Defect | Cancer | Genetic Syndrome | Head Trauma/Concussion/TBI | |

Which family members have been diagnosed or has had any of these problems?

Social History

Has the patient ever been a victim of or exposed to:

- Sexual abuse/molestation:
- Physical abuse:
- Emotional abuse:
- Domestic Violence:
- Other:

Sleep and Appetite (child patients)

What time does your child go to bed? School nights: _____ Weekends: _____
What time does your child get up? School nights: _____ Weekends: _____

Does your child sleepwalk or talk in his/her sleep?

What types of sleep disturbances does your child have? How often?

Is there a television, computer, or video game system in your child's bedroom?

How is your child's appetite? _____

What foods are his/her favorite? _____

What foods do they dislike? _____

Parents', Step-Parents', Grandparents', Nannies', and other caregivers' information

	Name	Relationship	Phone number	Time spent with child
1.				
2.				
3.				
4.				
5.				
6.				

What does each of the parents/step-parents do for a living?

Are the birth parents married, divorced, remarried, or never married?

Has your child ever been in foster care or DSS care/custody?

Siblings

Name	Age	Grade in School/Name of School
1.		
2.		
3.		
4.		
5.		

Who lives in your home (including pets)?

Developmental History

Place of Birth:

Birth Weight:

Full Term: Yes/No

APGAR scores: (if known):

Problems with conception/pregnancy/labor/delivery (including illnesses):

Breast or bottle fed?

Early infant difficulties (eating, colic, sleeping):

Milestones (list the age at which the child did each of these):

Smile _____ "Coo" _____ Crawl _____ Walk _____

First Word _____ Use 2-3 word sentences _____ Potty Trained _____

Were there any developmental delays that concerned you or healthcare providers?

Does your child have difficulties with wetting or soiling themselves overnight or at school?

School History

School:

Grade Level:

Extracurricular activities:

How much time, on average, does your child spend watching TV, playing video games, or with electronics (i.e. on computer, tablet, Facebook, youtube)?

Has your child ever failed a grade or been held back? If so, which grade(s)?

Has your child ever been in special education, self-contained, or resource classes: If so, for what reason was he/she referred?

Suspensions (# of times and reasons):

Expulsions (from what school, when, and reason):

Patient's relationship history

Has your child had difficulties making friends? If so, describe:

Did your child ever have difficulty separating from you?

Has your child ever had a boyfriend or girlfriend?

To your knowledge, has your child ever been sexually active?

Behavioral management

What methods of rewards or punishments have you tried with your child? How successful were each?