Southern Psychiatry

PRE-APPOINTMENT INFORMATION FORM (CHILD/ADOLESCENT)

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)

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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

List of Medications

	Name of Medication	Dose and frequency	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medication Allergies

Patient's Psychiatric History

Previous diagnoses and/or testing:

Past medications, dose, and reason:

Past hospitalizations:

Previous therapists:

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	Hearing Problems	Vision Problems	Hypoglycemia
Birth Defect	Cancer	Genetic Syndrome	Head Trauma/Concussion/TBI	

Other:

Past surgeries:

Past significant hospitalizations (medical):

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?

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

Depression	Bipolar	OCD	Personality Disorder
Anxiety	PTSD	Panic Attacks	Learning Disorders
Psychosis	Schizophrenia	ADHD	Autism/Asperger's Disorder
Dementia	Suicide Attempts	Hallucinations	Intellectual Disability
Alcohol Related Problems		Drug Related Problems	

Other:

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	Hearing Problems	Vision Problems	Cancer
Birth Defect	Genetic Syndrome	Hypoglycemia	Head Trauma/Concussion/TBI	

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

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/stepparents 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?

Has the patient ever been a victim of or exposed to sexual abuse/molestation, physical abuse, emotional abuse, or domestic violence?

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 you 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?