NEW PATIENT INFORMATION & HISTORY (CHILD)

PATIENT NAME:_____DATE:_____

BIRTH DATE: _____ AGE: _____

Please tell me your child's MOST SIGNIFICANT problems or symptoms in order of importance,

1. _____
2. _____
3. _____
4. _____
5. _____

Briefly describe when and how the problems started?

_____

_____

_____

_____

_____

Please CIRCLE all symptoms that your child experiences FREQUENTLY.

Agitation	Sleep disturbances	Appetite Disturbances
Angry Outbursts	Insomnia	Eating Too Much or Too Often
Crying Spells	Excessive Sleeping	Lack of Appetite
Low Self-Esteem	Frequent Awakening	Other _____
	Nightmares	

Suicide Attempt: No Yes If Yes: how many: _____ When: _____

Why: _____

How: _____

Patient Name_____

Has your child hurt others: No Yes If Yes: Who: _____When:_____

Why: _____

_____

Problems with boyfriend/girlfriend? No Yes N/A
Hearing Voices? No Yes Describe: _____

Seeing things that are not there? No Yes Describe: _____

HISTORY OF PSYCHIATRIC TREATMENT

Outpatient: No Yes Since when: _____How often: _____

Therapist and or Psychiatrist Name/Phone/Fax #/Email: _____
_____

Medications prescribed? No Yes If yes, list names: _____

_____

_____

Inpatient No Yes If yes: First time_____ Last time_____

Total number _____

Medications prescribed? No Yes if yes, list names: _____

_____

_____

PERSONAL HISTORY

Born where: _____Grade completed in school: _____

History of child abuse No Yes who and when: _____

Brothers: No Yes Names /age_____

Sisters: No Yes Names/age_____

Are any family members under psychiatric treatment? No Yes Who/Diagnosis:_____
_____

_____
Is there extended family members with psychiatric disorders? No Yes Who/diagnosis: :_____

_____

_____

Patient Name_____

Relevant History:

Developmental History (list problems):_____

_____

_____

School History (overall grades, problems/successes)_____

_____

_____

Social Skills/Relationship (problems/successes):_____

_____

_____

Family Relations (problems/successes):_____

_____

_____

Problems with the law:

Have you been in jail: No Yes Number of Times:_____

Prison: No Yes Total time incarcerated:_____

Reasons: Theft, Armed Robbery, B&E, Assault

Domestic Violence, DUI, Fraud, Drug Related

Are you currently on probation? No Yes If yes, for what_____

Drug Use/Abuse History:

Check all that been have used:	Date Last Used	Frequency of Current Use	Amount of Current Use
___ Alcohol			
___ Cocaine			
___ Crack			
___ Marijuana			

Patient Name_____

MEDICAL HISTORY

Please list all serious illnesses, injuries and surgeries with the dates:

1. _____
2. _____
3. _____
4. _____

Who is your child's family doctor or Primary Care Physician (PCP)?_____

Name/Phone/Fax #/Email:_____

Address: _____

When was your child's last doctor's appointment?_____