Neogen Psychiatry, P.A.

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
Seizures/convulsions
Other neurological problems
Ear, nose or throat problems
Dental problems
Asthma
Chest problems
Stomach or bowel problems/soiling
Urinary or bladder/wetting
Heart Problems
Rheumatic fever/strep infections
Liver/Kidney problems
Skin problems
Joint/limb problems
Hearing/vision problems
Growth/endocrine problems
Gynecological/menstrual problems
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:	Language:	Adaptive:
rolled front/back (4 mo) _____	smiling (4-6 wks) _____	mouthing (3 mo) _____
sit with support (6 mo) _____	cooing (3 mo) _____	transfers objects (6 mo) _____
sit alone (9-10) _____	babbling (6 mo) _____	picks up raisin (11-12 mo) _____
pull to stand (10 mo) _____	jargon (10-14 mo) _____	scribble (15 mo) _____
crawling (10-12 mo) _____	first word (12 mo) _____	drinks from cup (10 mo) _____
walks alone (10-18 mo) _____	follows 1-step command (15 mo) ___	uses spoon (12-15 mo) _____
running (15-24 mo) _____	2 word combo (22 mo) _____	undresses _____
tricycle (3 yrs) _____	3 word sentence (3 yrs) _____	bowel trained _____
bicycle (5-7 yrs) _____	speech problems _____	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
Organize self?	good	average	poor
Attendance?	good	average	poor

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				