Child Patient Health Information

Patient: _____DOB: _____Date of Service:_____
Grade in School: _____ Special Education? _____
Provider you are seeing today? _____

Person completing this form: _____

Main reasons and problems for which you are now seeking services for your child? _____
_____
_____

Please list diagnoses that your child was previously given and the treatment that your child received:
_____
_____

Primary Care Physician (PCP) name: _____
PCP Address: _____
City: _____State: _____Zip Code: _____
Phone Number: _____Fax Number: _____Email: _____

Who referred your child to us? _____

***Do we have your permission to communicate with your child's primary care physician?**
Yes____ No____

Name of your Pharmacy: _____Phone: _____

1. Please indicate below the medical conditions that your child has had:

❒ None
❒ Arthritis
❒ Bronchial Asthma
❒ Cerebrovascular Accident
❒ Coronary Artery Disease
❒ Diabetes
❒ Acid Reflux or other stomach problems
❒ Head Trauma
❒ Hepatic Disease
❒ HIV/AIDS
❒ Hypertension
❒ Kidney Disease
❒ Seizures
❒ Chronic Pain/Injuries
❒ Crohn's Disease
❒ Multiple Sclerosis
❒ Heart Condition or Heart Attack
❒ Migraines
❒ Other: _____
_____
❒ Note: _____
_____

2. Past Surgeries Relevant to the Current Services that you are seeking for your child?
   - ❒ None
   - ❒ Details of relevant surgeries: _____

3. Mark below, the behavioral health conditions that your child's close biological family members have been diagnosed or have been suspected of having?
   - ❒ ADHD
   - ❒ Addictions
   - ❒ Alzheimer's
   - ❒ Anxiety
   - ❒ Bipolar
   - ❒ Depression
   - ❒ Eating Disorders
   - ❒ OCD
   - ❒ Positive in biological relatives
   - ❒ Schizophrenia
   - ❒ Other: _____

4. What medications and dosages does your child currently take for behavioral health reasons (i.e. anxiety; depression; bipolar disorder): _____

5. What medications and dosages does your child take for physical health reasons? _____

6. Which medications have you or your family members taken for similar conditions for which you are seeking services for your child and have they been effective? _____

7. Is your child allergic to any medications, substances or foods? Which? _____

8. Does your child use tobacco or alcohol or drugs that are not prescribed? What and how often? _____

9. What are your child's recent grades? _____

10. Has school attendance been a problem for your child? _____

11. <u>Developmental Symptoms</u>:
   - ❒ None
   - ❒ Tics
   - ❒ Participated in special programs at school
   - ❒ Learning Disorder
   - ❒ Developmental Disorder
   - ❒ Mental Retardation
   - ❒ Note: _____

12. Developmental History: Did your child have problems in health or development during birth, infancy, childhood?

- ❒ Normal, Unremarkable
- ❒ Not Relevant
- ❒ Relevant
- ❒ Note: _____

13. Please indicate your child's current Social Support:

- ❒ Family/Friends local
- ❒ Family out of area are/involved
- ❒ Minimal Family/Friends contact
- ❒ Note: _____

14. Please note a little about your child's family, education, religion, etc. or life events which your child has experienced that you believe are important for your child's provider to know: _____

_____

15. Please list what you believe to be your child's Strengths/Abilities:

- ❒ Average or above intelligence
- ❒ Supportive family and/or friends
- ❒ Motivation for treatment/growth
- ❒ Capable of independent living
- ❒ Work skills
- ❒ Religious affiliation
- ❒ Active sense of humor
- ❒ Ability for insight
- ❒ Communication skills
- ❒ Financial means
- ❒ Special hobby/interest

16. Please list your child's Weaknesses/Challenges which may hinder your child's progress:

- ❒ Loss (deaths; other)
- ❒ Legal issues
- ❒ Family conflict
- ❒ Traumatic event
- ❒ Educational concerns
- ❒ Substance abuse
- ❒ Medication change or non-compliance
- ❒ Health problems

Survey of Mental Illness Symptoms Related to Diagnostic Categories.

Please mark your child's current symptoms with a checkmark.

17. Depression Symptoms:

- ❒ None
- ❒ Depressed Mood
- ❒ Appetite Disturbance
- ❒ Insomnia (can't sleep)
- ❒ Hypersomnia (sleeps too much)
- ❒ Fatigue
- ❒ Decreased Concentration
- ❒ Loss of Interest in Usual Activities
- ❒ Significant Weight Loss or Gain
- ❒ Restlessness/ Psychomotor
- ❒ Agitation
- ❒ Sluggishness
- ❒ Feelings of Worthlessness or Guilt
- ❒ Thoughts of Death or Suicidal Ideation (*Complete Risk Assessment*)
- ❒ Irritability
- ❒ Note: _____

18. Suicide Risk Assessment: To the best of my knowledge, my child

- ❒ None
- ❒ Has attempted suicide in the past
- ❒ Has does not had suicidal thoughts
- ❒ Has suicidal thoughts but would not act on them and has no plan.
- ❒ Has suicidal thoughts and thinks about ways to commit suicide and often has intent.
- ❒ I agree to contact a Crisis Line, relatives or 911, if my child's suicidal intent activates.
- ❒ Note: _____

19. Mania Symptoms:

- ❒ None
- ❒ Elevated, expansive, or irritable mood
- ❒ Talkative or pressure to keep talking
- ❒ Distractibility
- ❒ Can't stop an activity or my agitation
- ❒ Can't stop thinking about grand plans
- ❒ Racing thoughts
- ❒ Excessive involvement-pleasurable activities
- ❒ Become unaware of my behavior and circumstances

20. Anxiety Symptoms:

- ❒ None
- ❒ Worry about the same things again and again/ruminations
- ❒ Repetitive behaviors
- ❒ Rapid heartbeat, sweats, shakes, or chest pains
- ❒ Shortness of breath, nausea, dizziness, derealization
- ❒ Fear of dying or losing control, depersonalization
- ❒ Anxiety about being in a place where exiting is difficult
- ❒ Avoidance of such places
- ❒ Fear of animals, nature, blood, injections

21. Obsessive Compulsive Disorder:

- ❒ None
- ❒ Recurrent and persistent thoughts; urges
- ❒ Major effort to suppress thoughts and urges
- ❒ Repetitive behaviors; handwashing, counting. etc.
- ❒ Above patterns engaged in to reduce distress

22. Conduct Disorder Symptoms:

- ❒ None
- ❒ Aggression to people or animals
- ❒ Deceitfulness; theft
- ❒ Destruction of Property in fine Setting
- ❒ Serious violation of rules (truant, running)

23. Trauma/PTSD Symptoms:

- ❒ None
- ❒ Avoids events that remind of trauma, unable to recall event, detachment
- ❒ Deja-vu
- ❒ Distressing recollections or dreams
- ❒ Distress/fear related to an event
- ❒ Repeated thoughts about traumatic event
- ❒ Trouble with sleep, irritable, hypervigilance
- ❒ Experienced traumatic event(s)
- ❒ Repeat exposure to traumatic events, learned about trauma with loved ones
- ❒ Hyperarousal: Aggressive behavior, irritability, reckless behavior
- ❒ Negative distortions in cognitions, thoughts, moods, or feelings
- ❒ Dissociative symptoms: Amnesia/memory gaps, derealization, depersonalization
- ❒ Re-exposure trauma or intrusion symptoms: dreams, nightmares, flashbacks
- ❒ Avoidance: Efforts to avoid thoughts, feelings or events

24. Schizo-Affective Symptoms:

- ❒ None
- ❒ See things that others don't
- ❒ Hear things that others don't
- ❒ Delusions
- ❒ Grandiose Ideas that others think impossible
- ❒ Persecutory: Feel like people or agencies are out to do me wrong
- ❒ Disorganized speech
- ❒ Isolated, no friends.
- ❒ Loss of ability to speak/ mutism
- ❒ With postpartum onset
- ❒ Note: _____ _____

25. Cognition Symptoms:

- ❒ None
- ❒ Impaired Thinking and Planning
- ❒ Disturbance of sight or balance or perception
- ❒ Disturbance fluctuates or develops over short period of time
- ❒ Memory Impairment
- ❒ Aphasia: Can't comprehend or find words or phrases to speak
- ❒ Can't coordinate my physical body movements
- ❒ Disturbance in ability to plan and organize
- ❒ Note: _____ _____

26. Substance Abuse Symptoms and/or Concerns:

- ❒ None
- ❒ Substance abuse or alcohol abuse/addictions are a concern
- ❒ Note: _____ _____ _____

27. ADHD Symptoms:

- ❒ None
- ❒ Planning problems

❒ Hyperactivity
❒ Distractibility
❒ Poor concentration
❒ Impulsivity
❒ Follow through problems
❒ Eating Disorder Symptoms:_____
_____
_____
❒ Conduct/Behavior Symptoms: _____
_____
_____

28. Please write about what you believe to be important regarding your child's symptoms and possible treatment: _____
_____
_____

If you would like us to communicate results or progress to another agency, professional, or person, please request a RELEASE OF INFORMATION from and complete it. Thanks.

Signature of Responsible Party:

_____ Date: _____