PEDIATRIC PSYCHIATRY NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire as thoroughly as possible. If you have any questions, ask our office staff.

Patient's name: _____ DOB: _____
Person completing form: _____ Date: _____
Relationship to patient: _____

What is the main reason for the appointment? _____
_____
_____
_____

Do you have concerns about the patient having any of the following problems?

No	Yes		No	Yes	
		Aggressive behavior			Illegal behavior
		Anger			Impulsive behavior
		Anxiety			Irritable moods
		Autism spectrum			Missing school
		Dangerous behavior			Obsessions
		Defiance			Odd behavior
		Depression			Running away
		Drug or alcohol use			Self-harm
		Eating problems			Sexual behavior (inappropriate/risky)
		Elevated moods			Sleep problems
		Focus problems			Suicidal thoughts
		Hallucinations			Trauma-related symptoms
		Hyperactivity			Violent thoughts

Is the patient currently seeing a counselor, therapist, or psychologist?
☐ No ☐ Yes (name/location/phone): _____

Current medications (names and doses of all prescription and over-the-counter medications):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Does the patient have any medication allergies? ☐ No ☐ Yes (list medications and allergic reaction to each):
_____
_____
_____

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Primary Pharmacy (name/location/phone): _____
Secondary Pharmacy (name/location/phone): _____

Has the patient taken psychiatric medications in the past? ☐ None
(If you need more room or cannot recall medication names, please ask for our medication checklist page)
☐ ADHD medications: _____
☐ Anxiety medications: _____
☐ Antidepressant medications: _____
☐ Mood stabilizing medications: _____
☐ Sleep medications: _____
☐ Antipsychotic medications: _____
☐ Other psychiatric medications: _____

Has the patient had previous psychiatric, behavioral, or mental health treatment? ☐ None

- Outpatient (when/whom): _____
  _____
- Inpatient (when/where): _____
- Residential (when/where): _____
- IOP (when/where): _____

Please list all non-psychiatric doctors, nurse practitioners, or other medical providers that the patient is currently seeing.
Primary Care Provider: _____
Medical Specialists: _____
_____
_____

Does the patient receive any of the following therapies? ☐ No ☐ Yes (please list name/location of provider)
☐ Speech/language therapy: _____
☐ Occupational therapy: _____
☐ Physical therapy: _____
☐ Other specialized therapy: _____

Was the patient born at full term (37 - 41 weeks gestation)? ☐ Yes ☐ No: _____ weeks gestation
What did the patient weigh at birth? _____ lbs _____ oz OR _____ g
Were there any problems during the pregnancy or delivery? ☐ No ☐ Yes (please describe): _____
_____
_____
Did the mother take any medications, drugs, or alcohol during the pregnancy? ☐ No ☐ Yes (please describe):
_____
_____

Did the patient meet developmental milestones on time?
☐ Yes ☐ No Gross motor skills (crawling, walking): _____
☐ Yes ☐ No Fine motor skills (grasp, feeding): _____
☐ Yes ☐ No Speech/language (words, sentences): _____

Does the patient have any medical conditions? (Please list any condition for which the patient sees a doctor more than once a year, sees a specialist, or takes any medication, including over-the-counter medication.)

☐ Allergies
☐ Asthma
☐ Anemia
☐ Epilepsy/seizure disorder
☐ Chronic headaches/migraines
☐ Diabetes
☐ Genetic condition
☐ Heart condition
☐ Kidney condition
☐ Stomach/intestinal problems
☐ Bowel/bladder problems
☐ Thyroid condition
☐ Other: _____

Has the patient ever had a concussion, brain injury, or serious head injury? ☐ No ☐ Yes (please give details):

_____

_____

Has the patient ever had any surgery? ☐ None
☐ Myringotomy/tympanostomy tubes
☐ Tonsillectomy/adenoidectomy
☐ Wisdom teeth or other dental extractions
☐ Other: _____

Do any of these conditions run in the family (among blood relatives)?

No	Yes	Type of Condition	Who has it?
		Allergies/Asthma	
		Anemia	
		Epilepsy/seizure disorder	
		Chronic headaches/migraines	
		Alcoholism/Addiction	
		ADHD	
		Autism/Asperger sydrome	
		Anxiety	
		Depression	
		Bipolar disorder	
		Schizophrenia	
		Diabetes	
		High blood pressure	
		Heart condition	
		Kidney condition	
		Stomach/intestinal problems	
		Bowel/bladder problems	
		Thyroid condition	
		Autoimmune condition	
		Genetic condition	
		Other:	

With whom does the patient live? (Mark all that apply)
☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandmother ☐ Grandfather
☐ Other adult(s): _____
☐ Siblings (ages/genders): _____
☐ Other children/youth: _____

What grade is the patient in (or entering)? _____ At which school? _____
Does the patient have: ☐ an IEP ☐ a 504 plan ☐ Neither. If yes, please describe: _____
_____
_____
_____

Please describe the patient's hobbies, interests, and activities (including sports, music, arts, clubs, etc):
_____
_____
_____
_____

Please describe the patient's media use habits, including topics/genres/specific titles, estimated time spent, and parental limits or supervision in place:
☐ Television: _____
☐ Movies: _____
☐ Music: _____
☐ Reading: _____
☐ Video games: _____
☐ Internet: _____
☐ Social media: _____

Has the patient ever experienced or witnessed: ☐ neglect ☐ physical abuse ☐ sexual abuse ☐ verbal abuse ☐ violent or sudden death (including accidents or medical emergencies)? ☐ None of the above
If yes, please describe as best you are able/comfortable: _____
_____
_____
_____

Is there a gun or firearm in the home? ☐ No ☐ Yes ☐ Unknown
If yes, has the patient taken a gun safety course? ☐ Yes ☐ No

If the patient is 12 or more years old, PLEASE HAVE THE PATIENT COMPLETE THE FOLLOWING:

Do you have any history of: ☐ truancy charges ☐ legal charges ☐ arrest ☐ detention or incarceration
☐ probation ☐ juvenile court involvement ☐ other legal involvement ☐ None of the above
If yes, please describe: _____

_____

_____

_____

Have you ever tried (even in small amounts):
Nicotine (vapes, cigarettes, cigars, etc)? ☐ No ☐ Yes (please give details): _____

_____

Alcohol (beer, wine, liquor, mixed drinks)? ☐ No ☐ Yes (please give details): _____

_____

Cannabis/marijuana (smoke or edible)? ☐ No ☐ Yes (please give details): _____

_____

Any other substances to get high? ☐ No ☐ Yes (please give details): _____

_____

_____

_____

With what gender do you identify? ☐ Female ☐ Male ☐ Non-binary ☐ Genderfluid/other: _____
How do you describe your sexual orientation? ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Asexual
☐ Other/unsure (describe if you wish): _____

_____

Have you ever engaged in sexual activity (any contact between you and another person that involved one or both people's genitals, including oral sex)? ☐ Yes ☐ No ☐ Prefer not to answer
If yes, are you currently sexually active? ☐ Yes ☐ No ☐ Prefer not to answer
What method(s) of birth control do you use? ☐ Condoms ☐ Oral contraceptive pill ☐ IUD ☐ Depo-Provera
☐ Birth control implant (such as Nexplanon) ☐ Other: _____

Are there any concerns you wish to share with your provider confidentially (without informing your parents)?

_____

_____

_____

_____

(Please be aware that your provider will have to tell your parents or another adult about anything that involves abuse or neglect of a minor, or an immediate threat to someone's life.)

ADDITIONAL MEDICAL HISTORY

Previous psychiatric treatment:

Type of Treatment	Dates	Location / Provider	Reason(s)	Comments
Outpatient (Psychiatrists, NP's, psychologists, therapists or counselors)				
Inpatient (hospitalization)				
Residential				
Intensive Outpatient (IOP)				

Medical Specialists that the patient is currently seeing:

Name	Specialty	Contact information (phone, fax, email, address)

PLEASE COMPLETE ALL PAGES