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):
____
____
____

PLEASE COMPLETE ALL PAGES

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)