

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): _____

PLEASE COMPLETE ALL PAGES

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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
- Other: _____
- Genetic condition
- Heart condition
- Kidney condition
- Stomach/intestinal problems
- Bowel/bladder problems
- Thyroid condition

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 syndrome	
		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:	

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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

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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)