SOUTHERN BEHAVIORAL HEALTHCARE, P.C.

**QUESTIONNAIRE FOR NEW CHILD PATIENT**

**PATIENT NAME:** **DATE:** **DOB:** **SEX:** M/F

**PREF. LANG:** English/Spanish/Other **RELIGION:** Christian/Islam/Judaism/No Rel./ Other

**RACE:** Caucasian/Afri. American/Hispanic/Asian/Other **ETHNICITY:** Cau./AA/Hisp/Asian/Other

**PARENT/CAREGIVER/INFORMANT NAME:**

Was your child referred to us? NO YES If yes, who referred your child?

**What problems does your child have?**

**School Problems:** Behavior Issues Academic and Learning Difficulties, Poor Grades, Suspension, Peer problems, Problem with Teachers, Tardiness, Skipping Classes/School, Others:

**Emotional/Behavioral Problems:** Anger, Attention, Attention and hyperactivity, Defiance, Depression, Anxiety, Mood swings, Poor Social skills, Social withdrawal, Low Self Esteem, Temper Tantrums, Self-Injury, Psychosis, Sleep Problems, Appetite Problems, Weight Issues, Drug and Alcohol use, Others:

**Family/Social Problems:** Discipline Issues, Parenting Issues, Sibling Problems, Parental Problems, Foster Care Placement, Parental Absence, Housing Problems, Financial Problems, Legal Problems, Others:

**Has your child ever made any suicide threat or attempt(s)?** NO YES, if yes, explain

**Has your child ever been abused in the past?** NO YES
If yes, What type? When?
Offender? Effect on child?

Was it reported? NO YES, if yes what was the outcome?

**PATIENT NAME:** **QUESTIONNAIRE FOR NEW CHILD PATIENT**

**Has your child ever abused drugs or alcohol?** NO YES
If yes, what type? First time? Last use?
Effect on child: Circle the one that applies: School, Family, Social, Legal, Others:

**List Current Medical and Psychiatric Medications:**

**List Previous Medical and Psychiatric Medications:**

**Names of Current and Past Psychiatrists:**

**Names of Current and Past Therapists:**

**Has your Child ever been hospitalized? (Medical and Psychiatric)** NO YES,
If yes, Name of Hospital Reason(s)
When Outcome

Name of Hospital Reason(s)
When Outcome

**Does any member of your family have any Psychiatric problems?** NO YES
Circle the one that applies: Depression, Anxiety, Schizophrenia, Bipolar, ADHD, Substance Abuse, Alcohol Abuse, Dementia, OCD, PTSD, Panic Disorder, Autistic Spectrum Disorders, Mental Retardation, Suicide Attempt, Others:

**Does any member of your family have any medical problems?** NO YES
Circle the one that applies: Asthma Seizures Head Injury Diabetes Hypertension stroke Seasonal Allergies GERD COPD High Cholesterol Migraines Chronic Headaches Cardiac Problems Liver problems Kidney Problems Thyroid Problems Chronic Back Pain Chronic Pain Arthritis Cancer Pancreas Problems Others—

**PREGNANCY AND DEVELOPMENTAL HISTORY:** Information not available

**Prenatal care received:** Yes No, If no, Why

**Any problem during pregnancy:** NO YES
Circle the one that applies: Morning Sickness, Bleeding, Physical Injury, Hypertension, Diabetes, Drug and Alcohol use, Infection, Seizures, Premature Labor, Emotional Problems, Hospitalization, Surgery in pregnancy, Recommended Bed Rest, Others:

**Pregnancy Duration:** WKS

**PATIENT NAME:** **QUESTIONNAIRE FOR NEW CHILD PATIENT**

**Delivery Type:** Normal **IF assisted,** C-section Use of forceps Use of vacuum, **WHY?**

**Any problem during delivery:** NO YES
Cord round the neck Blue at birth Breathing problem Slow heart rate Aspiration of meconium Breech delivery Others:

**Birth weight:** Unknown Pounds Ounces

**Developmental Milestones:** Were they age appropriate: Yes No
If delayed, circle the one that applies: Speech Bowel training Urinary training Walking
Others:

**Temperamental Characteristics as an infant:** Easy child Difficult child

**FAMILY AND SOCIAL HISTORY:**

Where was patient born?

Mother: Name Current Age Occupation

Father: Name Current Age Occupation

Siblings: Names Ages

**PAST MEDICAL HISTORY:** Does your child have any medical problems? NO YES
Circle the one that applies: Asthma Seizures Head Injury Seasonal Allergies GERD Diabetes Cardiac Problems Chronic Headaches Migraines High Cholesterol Hypertension Cerebral Palsy Others--

Name of Pediatrician: Tel #

**PAST SURGICAL HISTORY:** Has your child ever had any surgery? NO YES
If yes, what was the problem?
What type of surgery? When?
Where? What was the outcome?
Any complications?

**ALLERGY HISTORY:** Does your child have any drug allergies: NO YES

If yes, name of medications: Type of reaction:

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**EDUCATIONAL HISTORY:** Name of school

Grade: Are Grades: average below Average above Average

Has your child ever been retained? NO YES, what grade

Any school suspension? NO YES, for what reason(s)?

Is your child receiving any special educational services: NO YES, what type of services?

Has your child ever attended alternative school: NO YES, for what reason(s)?

**SMOKING HISTORY:** NO YES, How long? How much?

**SEXUAL HISTORY:** NO YES, Do you practice safe sex: YES NO

**EMPLOYMENT HISTORY:** Does your child have a job: NO YES, what type?

**LEGAL HISTORY:** Has your child ever been involved with the Department of Juvenile Justice:

NO YES, explain?

Has your child ever been incarcerated: NO YES, explain?

Has your child ever been placed on probation or currently on probation: NO YES, explain?

**POTENTIAL TREATMENT BARRIERS:** Language: YES NO Cognitive: YES NO Cultural: YES NO

Religious: YES NO

**SUPPORT SYSTEM:** YES NO

**What is your treatment goal for your child?**

Revised 2/2016