Patient History Form

Demographic Information

Patient Name

Patient Date of Birth

Date form is being filled out

Who is filling out this form? *

Parent/Guardian Name *

Currently living with - please list names, ages and relationships of all household members

Please list contact information for patient and guardian(s) including mobile phone numbers and emails. *

Who can we thank for referring you to our office?

If patient is currently in school please tell me where and what grade. If patient is working please tell me where and what position. *

Psychiatric History

Please tell me why you are seeking evaluation at this time for you or your child. What are your concerns? *

What do you see as the patient's - you or your child's - areas of strength? Successes?

If the patient (you or your child) has been evaluated or treated by other psychiatrists, psychologists, therapists, neurologists or developmental specialists please list names and dates *

Please list you or your child's current medications and doses including over the counter, vitamins/supplements and alternative remedies: *

Please tell me about previous medications taken by the patient - please list the medicines, how long they were taken and why they were stopped. *

Please list any previous psychiatric hospitalizations - inpatient or partial - or residential programs. Also please list any prior intensive outpatient programs.

Developmental History

Were there any health concerns during the pregnancy regarding mother or child? Did mother take any medications or supplements during pregnancy? Did mother smoke tobacco, drink alcohol, or use any other substances during pregnancy? *

Was delivery on time? Was it vaginal or C-Section and, if known, why. How much did the baby weigh? Did the baby require medical care at or right after birth? *

What was the baby's temperament like? Easy going? Difficult? *

How old was the child when they first talked? Were there any concerns about speech or language development? Were there any concerns about social communications or interactions with others? Did they ever receive speech therapy? ABA therapy? *

How old was the child when they first walked? Were there any concerns regarding muscle tone or balance? Gross or fine motor skill development? Did they receive any physical therapy? *

Were there any concerns regarding toilet training? Any ongoing concerns about accidents?

Do you have concerns about your child's activities of daily living such as hygiene, getting dressed, asking for help, doing chores or tasks that you ask them to do?

Any concerns about difficulties with sensory input such as touch, sound or light? Please describe *

Stressor and Trauma History

Has the patient – you or your child – experienced any known traumatic events or losses? Major illness in themselves or loved ones? Victim of or witness to violent verbal or physical behaviors? Victim of bullying? Major events such as flood or fire? Other? *

Health and Medical History/Review of Systems

Any concerns about about sleep now? Have there ever been problems with sleeping in the past? Please decribe. *

Any concerns about about eating and appetite currently or in the past? Any concerns about growth? Loss of or increased appetite? Weight loss or weight gain? Concerns with food restriction, binging or purging? *

Does the patient - you or your child - participate in physical activity such as walking, dance, sports, hiking, running, yoga, martial arts, etc? Please describe.

Tell me about any current significant health concerns? Any past medical problems? *

Any medication allergies? Any other significant allergies such as nuts or wheat? *

Any history of hospitalizations or surgeries - if so please list

Any history of seizures? Head Injuries? Headaches? Fainting? Motor or vocal tics? *

Any history of problems with heart structure or valves? Presence of a heart murmur? Concerns about rhythm problems? Any family history of sudden death in people under 50 years of age? Any family history of cardiac arrythmias or other heart problems in people under 50? *

Any problems with fatigue? Joint pain? Gastrointestinal problems such as frequent belly pain, diarrhea or constipation? Any respiratory or breathing problems? Any skin concerns such as eczema? *

For female patients - have periods started? Any concerns about menstrual cycles? Pain or irregularity? Any pregnancies? Have you started or completed menopause? Any other GYN health concerns?

Please tell me about use of alcohol? Does the patient (you/your child) use alcohol? If so how much/how often? Any problems related to alcohol in school or work or home settings? Any legal problems such as DWI? *

Does the patient (you/your child) smoke marijuana or use marijuana for medical purposes? How often? Any other drugs – including cocaine, Ecstasy/Molly, misuse of prescription medication such as narcotics or tranquilizers? Any legal problems related to drug use? *

Work and School

Tell me about any concerns at school or work? What problems, if any, are occurring there?

Are there any support services in place at school or work? If so please describe. Does the patient receive disability benefits? *

Family History

Is there any family history of depression? Bipolar Disorder? Suicide? Anxiety or OCD? Schizophrenia? Autism? Intellectual disability? Genetic disorders? ADHD? Language or learning problems? School problems? Any

significant family medical history outside of mental health? *

Social and Interests/Activities

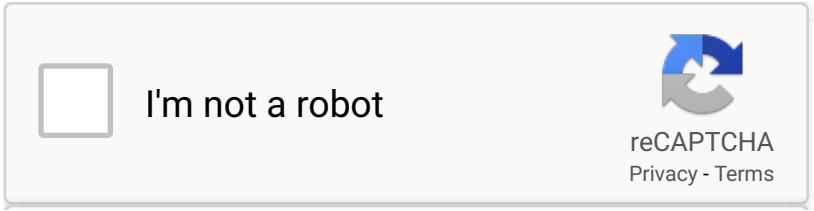
Are you satisfied with you/your child's social connections and support? Please describe any concerns *

Please describe you/the patient's (you or your child's) interests and activities outside of school and work

Additional information

Is there anything else you think it is important for me to know about you/your child or your current concerns?

CAPTCHA



Send