Name of Patient: _____

CHILD AND ADOLESCENT PATIENT QUESTIONNAIRE

Who referred your child?_____

What was their concern?_____

_____

What is your primary concern?_____

_____

What is the school's primary concern?_____

_____

When did you first become aware of concerns?_____

_____

Name of Child:_____ _____ _____
First Middle Last

Date of Birth:_____Place of Birth:_____

Who has legal custody or guardianship of child?_____

FAMILY DATA

Father:
Name:_____DOB:_____

Address:_____

Home Phone: ( )_____ Work Phone: ( )_____

Place of Employment:_____Title:_____

Highest Level of Education:_____Religious Affiliation:_____

Mother:
Name:_____DOB:_____

Address:_____

Home Phone: ( )_____ Work Phone: ( )_____

Place of Employment:_____Title:_____

Highest Level of Education:_____Religious Affiliation:_____

Stepmother:
Name:_____DOB:_____

Address:_____

Home Phone: ( )_____ Work Phone: ( )_____

Place of Employment:_____Title:_____

Highest Level of Education:_____Religious Affiliation:_____

Stepfather:
Name:_____DOB:_____

Address:_____

Home Phone: ( )_____ Work Phone: ( )_____

Place of Employment:_____Title:_____

Highest Level of Education:_____Religious Affiliation:_____

Please identify marital status including dates of all marriages, divorces and remarriages, for both natural and stepparents:

_____

_____

List on this page in chronological order the names of all children including the applicant, Stepbrothers and sisters, half brothers and sisters.

Name	Relationship to your child	Gender	Age	Education and/or occupation

List other children or adults who have lived or are now living in the home and their relationship to the applicant.

_____

_____

_____

List dates or moves and for what reason:

_____

_____

_____

DEVELOPMENTAL INFORMATION

Length of Pregnancy: _____Birth Weight: _____

Planned or unplanned Pregnancy: _____

Was the pregnancy complicated or involved with drugs or alcohol?_____

Nature of delivery: _____Natural _____ Caesarian _____Breech

Condition of child at time of birth:_____

If child is adopted, from where?_____

At what age was child adopted?_____

Age of parents at time of birth or adoption: Father: _____ Mother:_____

Please give age your child: Crawled:_____ Walked: _____ Talked:_____ Toilet Trained: _____

What have the significant stressors or traumas been to the family or child?

_____

_____

_____

EDUCATIONAL HISTORY

Where is child attending school now?_____

What grade?_____

If it is an ungraded class, state approximate grade achieved:_____
If child is not enrolled, name last school attended, grade achieved, date withdrawn.

_____

List in order of attendance, all school enrollments child has had; also name of tutors, if any, give name and address. Indicate if it was a public or private school and the grade attended:

School	Address	Public/Private	Average Grade Made

Have any grades been repeated?_____

Has your child been identified for special education, learning support or emotional support? Please state year identification and provisions made.

_____

_____

Please check those items that pertain to your child:

_____ Often fails to finish things he or she starts
_____ Easily distracted
_____ has difficulty concentrating
_____ Shifts excessively from one activity to another
_____ Frequently is disruptive in class
_____ Has difficulty awaiting his/her turn (i.e. games)
_____ Has difficulty sitting still
_____ Impulsive or acts without thinking
_____ Abusive to animals
_____ Physically violent towards property (i.e. vandalism, destructive)
_____ Physically abusive to self (scratches self, suicidal attempts)
_____ Fire setting
_____ Stealing, Shoplifting, Breaking and Entering
_____ Runaway
_____ Lying
_____ Chronic violation of parental limits
_____ Drug Abuse (what kind?)_____
_____ Alcohol abuse (what kind?)_____
_____ Any involvement with juvenile court
_____ Unrealistic fears (explain)_____
_____ Acts too young for his/her age
_____ Clings to adults or too dependent
_____ Feels no one loves him/her
_____ Gets teased a lot
_____ Complains of loneliness
_____ Demands a lot of attention
_____ Easily made jealous
_____ Refusal to attend school
_____ Avoidance of being left alone
_____ Excessive need for reassurance
_____ Very self-conscious or easily embarrassed.
_____ Often appears tense and unable to relax

_____ Frequent physical complaints (i.e. headaches, stomachaches, nausea)
_____ Overly concerned with future events
_____ Nervous mannerisms (i.e. nail biting, thumb sucking, rocking)
_____ Feelings of inadequacy
_____ Panic – feelings of intense fear/discomfort with palpitations, shortness of breath, choking feeling, etc.
_____ Obsessions – unwanted ideas, images, or impulses that intrude on thinking against your wishes and efforts to resist them. (Fear of contamination, recurring doubts about danger, extreme concern with other symmetry or exactness.)
_____ Can't get his/her mind off certain thoughts
_____ Fears he/she may do something bad
_____ Fears she/he has to be prefect
_____ Strange thoughts or ideas (Explain)_____
_____ Hallucinations – visual or auditory (Describe)_____
_____ Inappropriate expression of feelings (i.e. laughing at something sad)
_____ Concern that people are out to get him/her
_____ Severe mood changes (i.e. very sad to very happy)
_____ Often appears sad
_____ confused or seems to be in a fog
_____Day dreams or gets lost in his/her thoughts
_____ Doesn't seem to have much energy
_____ Social withdrawal
_____ Overtired
_____ Pessimistic outlook toward the future
_____ Excessive tearfulness or crying
_____ Recurrent thoughts about death or preoccupation with death
_____ Suicidal thoughts or verbalized intentions
_____ Inappropriate sexual behavior (Explain)_____
_____ Poor relationship with parents
_____ Sibling rivalry
_____ Negative peer associates – hangs with others that get in trouble
_____ Argues a lot, bragging, boasting
_____Mean to others
_____ Has difficulty making or keeping friends
_____ Does not associate with people his or her own age
_____ Avoids unfamiliar social situations
_____ Is easily led by others
_____ Has difficulty participating in organized activities (sports)
_____ Avoids competitive situations
_____ Sleep difficulties (i.e. sleepwalking, restless, inability to fall asleep or sleeps too much)
_____ Eating difficulties (i.e. has difficulty keeping food down, overeats, does not have much of an appetite, fears of trying new foods, tremendous concern about weight
_____ Poor personal hygiene (does not keep self clean or take any interest in appearance)
_____ Enuretic (urinates during the day or night on self)
_____ Encopretic (soils self)
_____ Deliberately harms self
_____ Tics (sudden rapid, recurrent motor movements or vocalizations)

Medications your child has been on in the past for mood or behavior: _____

_____

What medication(s) is your child taking now?:_____

_____

List any allergic reactions to medications:_____

_____

If your child has ever been **hospitalized** please explain when and for what reason:

Name of hospital	Date	Diagnosis

Has this child ever been exposed to abuse? Please state whether it is/was physical, emotional or sexual and whether he was the object of the abuse of exposed to it.

_____

_____

_____

Please check if any of the following pertain to your child and explain (se back of page if necessary)

____Heart disease	____Nausea or vomiting	____Concussions
____Lung disease	____Drug or alcohol abuse	____Nervous disorders
____Liver disease	____Diarrhea (frequently)	____Neurologic testing
____Jaundice	____Diabetes	____High fever
____Seizures	____Tonsillectomy	____Injuries or broken bones
____Fainting	____Orthodontia	____Accident prone
____Asthma	____Skin disease	____Activity limitations
____Dietary problems	____Irregular sleep pattern	____Speech problems
____Hearing problems	____Visual problems	____Other
____Urinary problems	____Bowel elimination problems	

Gynecology

____Menstrual problems ____ Birth control: (if so, what type)_____

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Please check which, if any, of the following conditions/problems apply to your child's blood relatives. If other significant mental/psychiatric problems are present among blood relatives, please list those in the space provided below.

	Child's Mother	Child's Father	Child's Brother	Child's Sister	Child's Grandp(s)	Other
Childhood opposition/defiant						
Problems with aggression						
Attentional problems						
Learning disability						
Failed high school						

Mental retardation						
Psychosis/schizophrenia						
Depression (greater than 2 weeks)						
Anxiety or adjustment disorder						
Panic disorder						
Other mental disorders (describe below)						
Tic disorder or Tourettes						
Alcohol abuse						
Substance abuse						
Antisocial behavior (assault/thefts)						
Arrests/incarcerations						
Physical abuse (victim)						
Physical abuse (perpetrator)						
Sexual abuse (victim)						
Sexual abuse (perpetrator)						

Name of person completing this form:_____

Relationship to applicant:_____

I do certify that all the foregoing information is true and complete.

NAME_____DATE_____

Parent/Legal Guardians, please complete if there is a custody agreement.

Patient Name: _____DOB: _____

In order to provide psychiatric services to your minor child, we **require** consent from any parent or legal guardian not attending the appointment when there is a legal custody agreement in place.

Please provide the requested information below:
Current Custody Arrangement: (check the box that applies):

1___ I have sole legal custody – I have attached a letter from my attorney or a copy of the legal custody agreement verifying that I am the sole legal custodian who has the right to make mental health decisions for the minor named above.

2a___I have joint or shared legal custody – **I am the other parent or legal guardian and I give permission for the minor named above to receive psychiatric treatment** at Reading Pediatrics 40 Berkshire Court Wyomissing, PA 19610.
Relationship: _____ Phone: _____

Printed signature: _____

OR

2b ___I am the caregiver for this minor child and other parent is currently unreachable and cannot provide or sign any documentation giving consent for treatment, due to _____. I am aware that the absent parent can choose to limit treatment interactions or to terminate treatment at this office because I do not have sole legal custody. I also am aware that if custody issues interfere with the Doctor/Patient relationship, this could result in the termination of treatment at this office.

Relationship: _____ Phone: _____

Printed signature: _____
Signature: _____ Date:_____
Acknowledgement by Provider: _____ Date: ____