Clear Lake Kids Psychiatry

Name_____ DOB_____ Age_____
Reason for today's visit_____
Who lives in the household?_____
Any other households on a regular basis?_____
Primary caregiver(s)_____
Parent(s) occupation(s)_____
Grade in school _____Name of School _____
Daycare or after school care? Yes No Where? _____
What kind of grades does your child get? _____
Does child have a 504 or IEP? Yes No Does your child have a behavior plan? If so, explain _____
Current medications/ doses _____
Any medication allergies? _____
Previous medications _____
Any problems sleeping? Yes No explain _____
Passed hearing screen in the last year? Yes No Passed vision screen? Yes No
Wears glasses or contacts? Yes No
Chronic *medical* problems? _____
Any surgeries?_____
Has child ever had a closed head injury, ie. Concussion? Yes No when? _____
Has child ever had a seizure? Yes No when? _____
Has child ever been hospitalized for mental health concerns? Yes No
Where and when? _____
Any concerns with development? _____
Walked at what age? _____ Talked _____ Potty Trained _____
Any problems during the pregnancy or delivery? Explain _____
_____
Primary doctor _____ Specialists _____
Month of last wellness checkup _____
Has child ever been in therapy? Yes No Currently? Yes No
Name of therapist _____Any previous neuropsych testing? Yes No
Explain _____
Has your child ever been given a diagnosis? _____
Family History: Parents, Grandparents, Siblings, Aunts, Uncles and 1st cousins.
Circle positives and list family member affected by either now or previously.
Alcoholism _____Drug abuse_____
Depression _____ Anxiety _____
ADHD _____ Dyslexia _____
Tourette's _____ Bipolar _____
Suicide or attempts _____ Autism _____
Eating disorder _____ OCD _____

Family history of cardiac problems? _____