GRANGER
MEDICAL CLINIC

Michael Connolly, MD

New Child Information Packet

MRN#:_____ APPOINTMENT DATE:_____

Patient Name: _____ DOB:_____

By completing this questionnaire and **returning it prior to your appointment**, you will help make your evaluation as thorough as possible in our first visit, increasing the chance that treatment can begin immediately, if there is a question that you cannot, or do not wish to, answer just leave it blank.

Mother: _____ Phone Numbers: _____

Father: _____ Phone Numbers: _____

Step-Mother: _____ Phone Numbers: _____

Step-Father: _____ Phone Numbers: _____

Person completing this form:_____

Are the Patients parents married or divorced:_____

Who has legal custody and who can make medical decisions? _____

Who referred you to this clinic? _____

Presenting problem:_____

_____

_____

What concerns you most about your child? _____

_____

_____

When did you first notice this problem? _____

_____

How has this problem affected her/her function? _____

_____

_____

At home:_____

_____

At school: _____

_____

With friends: _____

_____

Do you have any other concerns about your child? _____

_____

_____

Have you recently worried that you child has:

YES NO **Depression** - (sad, hopeless, poor sleep, crying, etc.)
YES NO **Mood Swings** - (energetic, little sleep, pleasure seeking, racing thoughts, talkative)
YES NO **Anxiety** - (worries, restless, scared, poor sleep, etc.)
YES NO **Behavioral Problem** - (fights, anger, arguing)
YES NO **Attention/Hyperactivity Problem** - (poor attention, hyperactive, impulsive)
YES NO **Abnormal Eating Behaviors** - (too much, too little, fears of weight & body image)
YES NO **Social Anxiety** - (she and or afraid to be around others)
YES NO **Remembering Past Traumas** - (in nightmares, recurrent memories, etc.)
YES NO **Autism** - (social and language impairments, rigidity)
YES NO **Psychosis** - (hearing voices, seeing things, paranoid)
YES NO **Dissociation** - (feeling outside your body or things are not real, etc.)

Past Psychiatric History

Please list any previous psychiatric hospitalizations, residential or day treatment programs (including any alcohol and drug treatment programs):

Date	Location	Diagnosis	Helpful: YES/NO

Please list any current or prior outpatient psychiatrists and/or therapists your child has seen:

Current Psychiatric Medications:

Name	Duration	Dose	Response

Previous Psychiatric medications you have tried:

Name and Dose	Duration	Response	Reason for Stopping

Current NON-Psychiatric medication including herbals and vitamins:

Name and Dose	Duration	Response	Reason for Stopping

Has your child ever harmed themselves intentionally or attempted suicide? YES NO

If yes please explain: _____

_____

Has your child harmed anyone else? YES NO

Developmental History

Did your child achieve the following milestones early (E), Average (A) or Late (L) compared to others of her/his age?

_____ Language – (age at first words, sentences, etc.)

_____ Fine Motor Skills – (building towers with cubes, drawing circles)

_____ Gross Motor Skills – (rolling over, standing, walking)

_____ Toilet Training

Past Medical History

Who is your child's primary care provider? _____

Were there complications with pregnancy, delivery or immediately after birth? _____

Has your child ever experienced a head injury, loss of consciousness or seizure? _____

Have you recently worried that your child may have problems with? _____

YES	NO	HEART	YES	NO	LUNGS	YES	NO	KIDNEYS
YES	NO	NEUROLOGICAL	YES	NO	DIGESTION	YES	NO	HORMONES
YES	NO	BLOOD/INFECTIONS	YES	NO	OTHER _____			

Any Chronic Medical Problems? _____

_____

_____

Serious Injuries: _____

Medical Hospitalizations: _____

_____

Surgeries: _____

_____

Drug, Seasonal or Food Allergies: _____

_____

Chronic Pain (headaches, stomach aches, chest pain) _____

Social History

Is your child your biological child? YES NO

If NO, at what age was she/he adopted? _____ Is there contact with the biological parents? _____

Where was your child born? _____

Raised: _____

Has your child moved a number of times? YES NO

If YES, please list the age of move and locations. _____

_____

Parent: (Including step-mother and step-father if applicable)

Name	Occupation	Hrs./Wk.	Relationship with Child

Please list the other siblings and other members of the household.

Name	Age	Lives at Home	Relation to Child

Are you struggling with your marital relationship or parenting? YES NO

Has your child ever been involved with the following?

YES NO Child Protective Services
YES NO Youth Corrections
YES NO Juvenile Detention
YES NO Boys and Girls Club
YES NO Youth Services
YES NO Head Start

School

Where does your child attend school? _____

In what grade lever is he/she? _____

What are his/her typical grades? _____

What are your child's academic strengths? _____

Academic weaknesses? _____

Has there been a change in your child's performance at school? YES NO

If YES, please describe: _____

_____

_____

Has your child received IQ or academic testing? YES NO

What were the results? _____

_____

_____

Does or has your child participated in any of the following?

YES NO Resource
YES NO Accelerated Programs
YES NO 504 Plan
YES NO Individual Education Plan (IEP)
YES NO Home-Hospital Programming

Has your child had problems with any of the following?

YES NO Truancy
YES NO Fighting
YES NO Absenteeism
YES NO Detention
YES NO Suspension

<u>Peers</u>

Does your child have quality relationships with other children? YES NO

If NO, please explain: _____

_____

What are your child's favorite activities: _____

_____

Culture

Do you have a religious preference in the household? YES NO

If YES, what is the preference? _____

Has your child expressed any problems related to race, religion or culture? YES NO

If YES, please explain _____

_____

Teen/Youth Adult Session

Do you have any concerns regarding your adolescent's friendships?

YES	NO	Too Old	YES	NO	Too Young	YES	NO	Truant
YES	NO	Gang-bangers	YES	NO	Drug Use	YES	NO	Fringe
YES	NO	Alcohol Use	YES	NO	TOO Many	YES	NO	Alone
YES	NO	Too Few	YES	NO	Violent	YES	NO	Other

Has your adolescent had a recent change in friendships? YES NO

If YES, what changes, if any, are concerning to you? _____

_____

YES	NO	Are you concerned that your adolescent is using (or has used) drugs or alcohol?
YES	NO	Has your adolescent had use of weapons?
YES	NO	Is your adolescent currently dating?
YES	NO	Is your adolescent sexually active?
YES	NO	Has your adolescent started working?

Abuse

Has your child ever been the victim of abuse or neglect? YES NO

If YES, what was the nature of the abuse? Please circle all that apply.

Physical	Emotional	Neglect
Accidents	Disasters	Sexual
Witnessing Violence	Other	

Is there anything else you would like me to know about your child? _____

_____

_____

_____

_____

Family History

Looking at your family and all of your blood-relatives on both sides, do you think anyone has or had any of the following – be specific? List relatives by relation such as Uncle, Grandfather, Mother, Aunt, etc...

Illness	Mom's Side	Dad's Side	Brothers/Sisters
Depression			
Bipolar			
Anxiety			
ADHD			
Schizophrenia			
Alcoholism			
Drug Abuse			
Learning Disabilities			
Psychiatric Hospital			
Suicide Attempts			
Jail or Prison			
Mental Retardation			
Seizures			
Asthma			
Diabetes			
Thyroid Disease			
Migraines			
Heart Problems			
Chromosomal Disorders			
Other Problems			

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Registration Form

Today's Date:		PCP:	
Patient Information			
Last Name:	First Name:	Marital Status:	
Is this the name on your insurance card? Yes No	If not, what is the name on your insurance card?	DOB	Sex
Address:			
Home Phone:	Cell Phone:	Email	
Employer:	Work Phone:	Access to your patient portal (Circle One) Yes No	
Pharmacy Name:	Pharmacy Phone:		
Pharmacy Address:			
Please put all other children we see on the back page			

Insurance Information - Please give card, ID and Copay to Receptionist

Person responsible for bill:	DOB	Address	Phone	
Is this person a patient here?		Employer		
Primary Insurance/Auto/Industrial Name		Secondary insurance		
Primary Subscriber Name	DOB	Secondary Subcriber Name		DOB
ID Number	Group Number	ID Number	Group Number	
Patient's relationship to the subscriber:				
Name of local friend or relative not living with you		Relationship to patient	Phone Number	
Ethnicity: (Circle One) Nonhispanic Hispanic Decline				
Race: (Circle One) American Indian/Native Alaskan Asian Hispanic African American Hawaiian/Other Pacific Islander White Decline				

Release of 2-Way Communication

I give full permission to my Doctor to discuss medical information with the individual(s) listed below. I understand that placing a name below is completely voluntary and that I do not need to sign this to assure treatment from my provider. I understand I have the right to revoke this release at any time by notifying our facility.

Name_____ (Circle one or Both) RX Pick Up Verbal Communication

Name_____ (Circle one or Both) RX Pick Up Verbal Communication

Additional Children

Name	DOB	Student (Pick One) FT PT None