GRANGER
MEDICAL CLINIC

Michael Connolly, MD

# New Child Information Packet

Patient Name: _____ APPOINTMENT DATE: _____

MRN: _____ 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, simply leave it blank.

Mother: _____ Phone #(s): _____

Father: _____ Phone #(s): _____

Step-Mother: _____ Phone #(s): _____

Step-Father: _____ Phone #(s): _____

Name of person completing this form: _____

Are the patient's 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 his/her function? _____

_____

_____

At home? _____

_____

At school? _____

_____

With friends? _____

_____

Do you have any other concerns about your child? _____

_____

_____

Have you recently worried that your child has (circle Yes or No for each):

Yes No **Depression** (sad, hopeless, poor sleep, crying, etc.)
Yes No **Mood Swings** (energetic, little sleep, pleasure seeking, racing thoughts, talkative, etc.)
Yes No **Anxiety** (worries, restless, scared, poor sleep, etc.)
Yes No **Behavioral Problems** (fights, anger, arguing, etc.)
Yes No **Attention/Hyperactivity Problems** (poor attention, hyperactive, impulsive, etc.)
Yes No **Abnormal Eating Behaviors** (too much, too little, fears of weight and body image, etc.)
Yes No **Social Anxiety** (afraid to be around others)
Yes No **Remembering Past Traumas** (in nightmares, recurrent memories, etc.)
Yes No **Autism** (social and language impairments, rigidity, etc.)
Yes No **Psychosis** (hearing voices, seeing things, paranoid, etc.)
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:

_____
_____
_____

Please list any psychiatric medications your child is **currently** taking:

| Medication Name and Dosage | Duration | Response |
|---|---|---|
| | | |
| | | |
| | | |

Please list any **previous** psychiatric medications that your child has tried:

| Medication Name and Dosage | Duration | Response | Reason for Stopping |
|---|---|---|---|
| | | | |
| | | | |

Please list any NON-PSYCHIATRIC medications your child is currently taking, including herbal supplements and vitamins:

| Medication Name and Dosage | Duration | Response | Reason for Stopping (if applicable) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Has your child ever harmed themselves intentionally or attempted suicide? Yes No

If yes, please explain: _____

_____

Has your child ever 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 his/her age?

_____ Language (age at first words, sentences, etc.)
_____ Fine Motor Skills (building towers with cubes, drawing circles, etc.)
_____ Gross Motor Skills (rolling over, standing, and walking)
_____ Toilet Training

**Past Medical History**

Who is your child's primary care provider? _____

Were there complications with pregnancy, delivery, or immediately after birth? Yes No

If yes, please explain: _____

Has your child ever experienced a head injury, loss of consciousness, or seizure? Yes No

If yes, please explain: _____

Have you recently worried that your child may have problems with (circle Yes or No for each):

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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: _____ | | | |

Does your child have any chronic medical problems? _____

_____

_____

Has your child had any serious injuries? _____

_____

_____

Please list any medical hospitalizations: _____

_____

Please list any surgeries: _____

_____

Please list any medication, seasonal, or food allergies: _____

_____

Please list any chronic pain issues (headaches, stomach aches, chest pain, etc.): _____

_____

**Social History**

Is your child your biological child? Yes No

If no, at what age was he/she adopted? _____

Is there contact with the biological parents? Yes No

Where was your child born? _____

Where was your child raised? _____

Has your child moved a number of times? Yes No

If yes, please list the age and location of each move: _____

_____

Parent information (including step-mother and step-father if applicable):

| Name | Occupation | Hours/Week | Relationship with Child |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list any siblings and other members of the household:

| Name | Age | Lives at home? Yes/No | Relation to Child | Relationship with Child |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Are you struggling with your marital relationship or parenting? Yes No

Has your child ever been involved with any of the following (circle Yes or No for each):

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 level is he/she? _____
What are his/her typical grades? _____
What are your child's academic strengths? _____
What are your child's academic weaknesses? _____

Has there been a change in your child's performance at school? Yes No
If yes, please explain: _____
_____
_____

Has your child received IQ or academic testing? Yes No
If yes, what were the results? _____
_____
_____

Does, or has, your child participate(d) 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

**Peers**

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 of the following concerns regarding your adolescent's friendships (circle Yes or No for each):

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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? (circle all that apply)

| | | |
|---|---|---|
| Physical | Emotional | Neglect |
| Accidents | Disasters | Sexual |
| Witnessing violence | Other: _____ | |

Is there anything else that 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? Please be specific and list relatives by relation (e.g., mother, grandfather, aunt, uncle, etc.).

| **ILLNESS** | MOTHER'S SIDE | FATHER'S SIDE | BROTHERS/SISTERS |
|---|---|---|---|
| Depression | | | |
| Bipolar | | | |
| Anxiety | | | |
| ADHD | | | |
| Schizophrenia | | | |
| Alcoholism | | | |
| Drug Abuse | | | |
| Learning Disabilities | | | |
| Psychiatric Hospitalization | | | |
| Suicide Attempt(s) | | | |
| Jail or Prison | | | |
| Mental Retardation | | | |
| Seizures | | | |
| Asthma | | | |
| Diabetes | | | |
| Thyroid Disease | | | |
| Migraines | | | |
| Heart Problems | | | |
| Chromosomal Disorders | | | |
| Other Problems | | | |