HEIDI BRUTY, MD
CHILD, ADOLESCENT & ADULT PSYCHIATRY

NEW PATIENT INFORMATION FORM - CHILD

(Please fill out and return at or prior to first appointment)

DEMOGRAPHIC INFORMATION

Patient Legal Name	Preferred Name	Date
Date of Birth	Age	Sex ◯ Male ◯ Female
Address	City / State	Zip
Father's Name	Mother's Name	
Father's Address: ◯ Same as above	Mother's Address: ◯ Same as above	
Father's Phone ◯ Home ◯ Cell ◯ Work	Mother's Phone: ◯ Home ◯ Cell ◯ Work	
Father's Email Address:	Mother's Email Address:	
Parents: ◯ Married ◯ Divorced ◯ Separated ◯ Never Married		
Child is living with?	Appointment reminders? ◯ Email ◯ Text ◯ Both	
Referred by?	May we acknowledge the referral? ◯ Yes ◯ No	

CHIEF COMPLAINT

Briefly describe your reason for seeking treatment.

Describe main symptoms.

Please check any areas below which have been worsened due to your child's current problems.

- ◯ School/work performance
- ◯ Relationship with family
- ◯ Interest in keeping up apprearance
- ◯ Ability to control temper
- ◯ Ability to carry out usual leisure interests/hobbies
- ◯ Ability to plan for future and set goals
- ◯ Relationships with friends
- ◯ Ability to manage usual chores at home
- ◯ Ability to control behavior
- ◯ Extracurricular activities
- ◯ Relationships with teachers/school
- ◯ Relationship with legal authorities

PATIENT PSYCHIATRIC AND MEDICAL HISTORY

HISTORY OF PRESENTING ILLNESS

When did these symptoms begin?

Did something occur to precipitate them?

Have there been symptom-free periods?

PAST PSYCHIATRIC HISTORY

Has patient been treated for problem in the past?

When did treatment first begin?

What kind of treatment occurred?

Individual psychotherapy? If yes, when and with whom?

Group/Family/Couples psychotherapy? If yes, when and with whom?

Has patient ever been psychiatrially hospitalized? If yes, when how, and under what circumstances?

Has patient ever hurt himself/herself in any way? For example, cutting or burning self. If yes, when, how, and under what circumstances?

Has patient ever thought of or attempted to commit suicide? If yes, when, how, and under what circumstances?

MEDICAL HISTORY

Current and prior medical problems:

Medical hospitalizations / surgeries:

Known drug allergies:

Primary Care Physician:	Last physical exam:
Address/Phone:	Immunizations current? ⬭ Yes ⬭ No

Describe current eating habits:

Describe current sleeping habits: (How many hours per night? Wake up during night? How long does it take to fall asleep?)

Describe current exercise habits:

PAST MEDICATIONS

NAME OF MEDICATION	*DOSAGE*	*WHY PRESCRIBED*	*WHO PRESCRIBED*	*COMMENTS (HELPFULNESS/SIDE EFFECTS)*

CURRENT MEDICATIONS

NAME OF MEDICATION	*DOSAGE*	*WHY PRESCRIBED*	*WHO PRESCRIBED*	*COMMENTS (HELPFULNESS/SIDE EFFECTS)*

Please comment on any substance abuse (drugs/alcohol).

What	*When did you start*	*How much did you use*	*Last use*	*What did it do for you?*

Please mark any that the patient has or has had and include dates as best you can.

- ◯ Head injury/Loss of consciousness
- ◯ Seizures/Convulsions
- ◯ Other neurological problems
- ◯ Ear, Nose, or Throat problems
- ◯ Dental problems
- ◯ Asthma
- ◯ Chest problems
- ◯ Stomach or bowel problems/soiling
- ◯ Urinary or bladder/wetting
- ◯ Heart problems
- ◯ Rheumatic fever/strep infections
- ◯ Liver/Kidney problems
- ◯ Skin problems
- ◯ Joint/limb problems
- ◯ Hearing/vision problems
- ◯ Growth/endocrine problems
- ◯ Gynecological/menstrual problems
- ◯ Childhood measles/mumps

FAMILY HISTORY

Please give the names, ages, and relationships of people living in the home:

Who family are other immediate family members not living in the home:

FAMILY PSYCHIATRIC HISTORY

Has any family member had any of the following? <u>Please indicate which family member.</u>

- ◯ Depression
- ◯ Mania/Bipolar Disorder
- ◯ Suicidal thoughts/Urges/Behaviors
- ◯ Anxiety
- ◯ Panic
- ◯ Obsessions/Compulsions
- ◯ Rituals
- ◯ Movement Disorders
- ◯ Tics
- ◯ Unusual noises/vocalizations
- ◯ ADHD
- ◯ Eating Disorder
- ◯ Learning Disability
- ◯ Coordination problems
- ◯ Mental Retardation
- ◯ Autism/Asperger's Disorder/PDD
- ◯ Sleep Disorder
- ◯ Drug Use
- ◯ Alcohol Use
- ◯ Psychosis
- ◯ Legal Problems
- ◯ Psychiatric hospitalizations
- ◯ Other _____

Please elaborate on above as needed:

Please provide information about significant medical issues on the FATHER'S side:

Please provide information about significant medical issues on the MOTHER'S side:

PRENATAL HISTORY

Was the pregnancy healthy? ◯ Yes ◯ No	Problems:	
Were medications used during pregnancy? ◯ Yes ◯ No	If yes, what kind?	How often?
Were drugs/alcohol used during pregnancy? ◯ Yes ◯ No	If yes, what kind?	How often?
Did the mother smoke during the pregnancy? ◯ Yes ◯ No	If yes, how much?	
Was the pregnancy: ◯ Full term ◯ Preterm	If preterm, how many weeks?	Delivery: ◯ Vaginal ◯ C-section

Were there delivery problems such as: ◯ meconium ◯ forceps ◯ low oxygen ◯ other:

Were there any feeding problems? ◯ Yes ◯ No	Gained weight well?

Were there any problems in the first week?

First month?

First year?

DEVELOPMENTAL HISTORY

Describe child as an infant:

—	◯ Active	◯ Active but calm	◯ Passive	◯ Other _____
—	◯ Cuddly	◯ Irritable	◯ Withdrawn	◯ Other _____
—	◯ Cried easily/frequently	◯ Cried reasonable amount	◯ Cried seldom	◯ Other _____
—	◯ Soothed easily	◯ Difficult to soothe	◯ Average	◯ Other _____
—	*Response to changes:*	◯ Severe	◯ Moderage	◯ Mild
—	*Reaction to strangers:*	◯ Friendly	◯ Indifferent	◯ Fearful
—	*Describe response to being held:*	_____		

Developmental Milestones (MARK ONLY IF SIGNIFICANTLY DELAYED)

MOTOR	LANGUAGE	ADAPTIVE
◯ rolled front/back (4 mo)	◯ Smiling (4-6 wks)	◯ Mouthing (3 mo)
◯ sit with support (6 mo)	◯ Cooing (3 mo)	◯ Transfers objects (6 mo)
◯ sit alone (9-10 mo)	◯ Babbling (6 mo)	◯ Picks up raisin (11-12 mo)
◯ pull to stand (10 mo)	◯ Jargon (10-14 mo)	◯ Scribble (15 mo)
◯ crawling (10-12 mo)	◯ First word (12 mo)	◯ Drinks from cup (10 mo)
◯ walks alone (10-18 mo)	◯ Follows 1-step command (15 mo)	◯ Uses spoon (12-15 mo)
◯ running (15-24 mo)	◯ 2 word combo (22 mo)	◯ Undresses
◯ tricycle (3 yrs)	◯ 3 word sentence (3 yrs)	◯ Bowel trained
◯ bicycle (5-7 yrs)	◯ Speech problems	◯ Bladder trained

School:

Repeated grade? ◯ Yes ◯ No If yes, which grade? _____

Special/Resource classes? _____

Other special services? (Speech/OT/PT) _____

IEP? ◯ Yes ◯ No 504 Plan? ◯ Yes ◯ No Academic grades received: _____

Evaluations performed:

Date:		Type:	Reasons:
Results:			
Date:		Type:	Reasons:
Results:			

Relationships with teachers?	With peers?
Has your child every had truancy proceedings? ◯ Yes ◯ No	Has your child had any other legal proceedings? ◯ Yes ◯ No

If yes, please describe:

Describe your child's activities, interests, hobbies, skills, strengths:
Please use the remaining space to describe any other comments, questions, or concerns.

Problem Behavior Checklist: Does your child have any of the following problems? Please check all that apply.

	In the past	Occasionally	Often	Very Often
Short attention span				
Impulsivity (acts before thinking)				
Won't follow rules/directions				
Irritable, poor fustration tolerance				
Easily riled up				
Picks on others, bullies				
Feels picked on				
Teases others unmercifully				
Deliberately tries to annoy people				
Easily angered, bad temper				
Frequent accidents				
Gets out of control				
Gets violent and aggressive				
Cruel to animals				
Fire setting				
Steals				
Cries easily				
Gets giddy and silly				
Tiredness/listlessness				
Lack of interest in activities				
Isolates self from others				
Sadness				
Poor appetite				
Problems getting to sleep				
Early morning awakening				
Self-injurious/abusive behaviors				
Excessive sleepiness				
Weight gain/loss				
Worries a lot				
Fear of the dark				
Other specific fears (heights, etc)				
Catastrophic fears				
Reluctance to go to school/work				
Repeated unwanted thoughts				
Compulsive behaviors				
Rituals (has to repeat the same action)				
Hair pulling				
Excessive concerns: body defects				