

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Name(s) of parent/guardian accompanying patient: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Who is filling out this form? \_\_\_\_\_

**ALLERGIES to any medicines?**  No  Yes List: \_\_\_\_\_

Does your child see a **therapist** for talk therapy?  No  Yes Name \_\_\_\_\_

**How did you hear about us?** If someone referred you, who? \_\_\_\_\_

Internet  Insurance company  Friend  Therapist  Physician  Unsure/Other \_\_\_\_\_

**BACKGROUND INFORMATION**

**Tell us about your family & living situation**

**Educational, Work, Legal & Religious History**

**Names of those living in the same household and names of Siblings & Step Siblings *not* living with you:**

<u>Living with you?</u>	<u>Name</u>	<u>Age</u>	<u>Relationship to you</u>
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

Have child's parents separated or divorced?  Yes  No When: \_\_\_\_\_

Has either remarried? Name of step-parent: \_\_\_\_\_

What contact does child have with other biological parent? \_\_\_\_\_

**Education:** Current or highest grade level? \_\_\_\_\_

If in school, how are grades? \_\_\_\_\_

Has child had any history of **learning difficulties** – dyslexia, being a slow learner, etc?  No  Yes: \_\_\_\_\_

Is child in special education, or '504'?  No  Yes

**Peer Relationships** – Does child/adolescent have close friends?  Yes  No

Has the family moved recently?  No  Yes: \_\_\_\_\_

Are you concerned about influences of certain peers?  No  Yes:

**Legal** – Has the child/adolescent had any legal problems or

Are there any ongoing problems with custody issues?  No  Yes

Describe: \_\_\_\_\_

**Spiritual History**

Are your child's beliefs Christian?  No  Yes  Unsure

Other Religious beliefs? \_\_\_\_\_

How important to your child is faith in God:

Important  Somewhat Important  Not Important

Does your child meet with others in religious or spiritual community?

No  Yes

**THE PROBLEM WHICH BRINGS YOUR CHILD/TEEN HERE:**

**Why are you here and What are your problems/concerns?**

*(Briefly explain the problem that brings you here now and what stressful circumstances have contributed to it.)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## OTHER SYMPTOMS

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## FAMILY HISTORY

<b>Please indicate whether any of your (blood) relatives have had any of these concerns:</b>					
	Parents	Brothers/Sisters	Children	Grandparents	Aunts/Uncles
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autistic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SLEEP ISSUES

**IN THE LAST TWO WEEKS, if your child has trouble sleeping too much or too little, or their sleep is interrupted by awakening several times each night, please answer the following:**

What time does your child typically go to bed? \_\_\_\_\_ What time do they typically fall asleep? \_\_\_\_\_

What time do they typically wake up? \_\_\_\_\_ Do they seem to feel rested when they wake up in the morning?  Yes  No

Including naps during the day, how many hours, on average, do they sleep per 24 hour day? \_\_\_\_\_

If they awaken frequently through the night, how many times does your child awaken, and how long does it take them to go back to sleep?  
Awaken approximately \_\_\_\_\_ times. Time it takes to get back to sleep: \_\_\_\_\_

## RELATIONSHIPS AND SOCIAL SUPPORTS

### FAMILY RELATIONSHIPS

How would you rate your child's happiness in your family?  Happy  Fairly happy  Just OK  Fairly unhappy  Very unhappy

If VERY UNHAPPY, please write briefly in the space provided below what the general nature of the problems are.

\_\_\_\_\_

### SOCIAL SUPPORTS

Yes  No Does child experience a lot of loneliness?

Yes  No Does child have a close friend whom they can tell things and trust that the friend won't tell others? How often do they talk? \_\_\_\_\_

### OTHER CONFLICTUAL RELATIONSHIPS

Yes  No Is child having significant conflict or stress with anyone outside of your family, being bullied, etc? If so, who, and about what?

\_\_\_\_\_

### SCHOOL

How is child doing in school? Explain any problems, such as not passing classes, worries about grades, or conflict with people at school.

\_\_\_\_\_

## PARENTING DIFFICULTIES/OTHER ISSUES OR QUESTIONS

Describe what problems you have as you try to parent your child. For example, are there ways in which you or the child's other parent may be contributing to, or at least not helping, the problem; or things that as a parent you might need help with and would like to discuss?

If divorce has occurred, how well would you say the two of you are able to cooperate with regard to the child?

\_\_\_\_\_

## PROBLEMS WITH EMOTIONAL INSTABILITY (For teenagers only)

*Having problems with emotional instability means having unstable relationships, low self-esteem, and problems with impulsive behavior, beginning by late adolescence or early adulthood.*

Problems with emotional instability – does your teenager tend to:

- Make frantic efforts to avoid real or imagined abandonment.
- Have a pattern of difficult relationships caused by alternating between extremes of intense admiration and hatred of others.
- Have an unstable self-image or be unsure of his or her own identity.
- Act impulsively in ways that are self-damaging, such as extravagant spending, sex with many partners, substance abuse, binge eating, or reckless driving (if driving age, or driving a car without permission).
- Have recurring suicidal thoughts, make repeated suicide attempts, or cause self-injury through mutilation, such as cutting or burning oneself.
- Have frequent emotional overreactions or intense mood swings, including feeling depressed, irritable, or anxious.

These mood swings may only last a few hours at a time. In rare cases, they may last a day or two.

- Have long-term feelings of emptiness.
- Have inappropriate, fierce anger or problems controlling anger – or often display temper tantrums or get into fights.
- Have temporary episodes of feeling suspicious of others without reason (paranoia) or losing a sense of reality.

## SOCIAL INTERACTIONS AND ASPERGER'S SYMPTOMS

### I. Social Interactions and Relationships

- 1) Significant problems with nonverbal communication skills, such as understanding the meaning of eye-to-eye contact, facial expressions, or body posture.**  Yes  No

*The problems with nonverbal communication skills involve difficulty 'reading' people. For example, the child may recognize, that another person does not like something they just said or did, but they may not understand why the other person was bothered. Or, for example, when another person bumps into them accidentally, they assume it was on purpose.*

- 2) Marked difficulty in establishing or maintaining friendships with children of the same age.**  Yes  No

*Though may play well with younger children, or be able to converse with adults. Seems 'clueless' in many social situations, often saying and doing things which a child even much younger in age would intuitively know not to do. Lacks 'common sense' in relating to other people.*

- 3) Lack of interest in sharing enjoyment, interests, or achievements with other people.**  Yes  No

*On the other hand, may go on and on talking about something in which they are interested despite the fact that the person to whom they are talking is not interested and does not want to hear (example of a problem with reading body language).*

- 4) Lack of empathy. Has difficulty understanding other people's feelings and connecting to them in a personal way.**  Yes  No

*May be able sometimes to recognize what others' feelings are, but has difficulty connecting with others and apparent difficulty identifying the distress of other people and responding appropriately.*

Total YES answers \_\_\_\_\_

### II. Limited interests in activities or play

- 1) Preoccupation with certain topics**  Yes  No

*For example, may be fascinated by Star Wars, Japanese cartoon cards or characters, video games, military history, dinosaurs, maps, weapons, or other interests which are 'different' from other children the same age.*

- 2) A need for sameness and routines; or being rigid and inflexible**  Yes  No

*For example, insisting that things be done a certain way, though there is no reason why they should be done so.*

- 3) Can't 'let go' of a topic or request.**  Yes  No

*For example, repeatedly asks over and over for something they want to do or have. They won't take 'no' for an answer.*

- 4) Unusual behaviors or movements of the body**  Yes  No

*These may include body rocking and hand flapping.*

Total YES answers \_\_\_\_\_

## MEDICATIONS – CURRENT and PAST MEDICATIONS

List ALL CURRENT MEDICATIONS, VITAMINS, HERBAL, & SUPPLEMENTS that you are now taking:

Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal

List ALL PAST MEDICATIONS that you have taken:

<input checked="" type="checkbox"/> if Taking Now or Past	Medication <small>Have you ever taken any of these:</small>	dose	When & Why Stopped	When	<input checked="" type="checkbox"/> if Taking Now or Past	Medication <small>Have you ever taken any of these:</small>	dose	When & Why Stopped	When
<input type="checkbox"/> Now <input type="checkbox"/> Past	Ritalin/Methylin				<input type="checkbox"/> Now <input type="checkbox"/> Past	Abilify			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Metadate				<input type="checkbox"/> Now <input type="checkbox"/> Past	Aristada or Maintena			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Mydayis				<input type="checkbox"/> Now <input type="checkbox"/> Past	Rexulti			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Aptensio				<input type="checkbox"/> Now <input type="checkbox"/> Past	Geodon			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Concerta				<input type="checkbox"/> Now <input type="checkbox"/> Past	Risperdal/Invega			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Focalin (or XR)				<input type="checkbox"/> Now <input type="checkbox"/> Past	Zyprexa			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Daytrana				<input type="checkbox"/> Now <input type="checkbox"/> Past	Seroquel (or XR)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Adderall (or XR)				<input type="checkbox"/> Now <input type="checkbox"/> Past	Saphris			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Vyvanse				<input type="checkbox"/> Now <input type="checkbox"/> Past	Fanapt			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Other stimulant				<input type="checkbox"/> Now <input type="checkbox"/> Past	Latuda			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Strattera				<input type="checkbox"/> Now <input type="checkbox"/> Past	Vraylar			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Qelbree				<input type="checkbox"/> Now <input type="checkbox"/> Past	Caplyta			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Clonidine				<input type="checkbox"/> Now <input type="checkbox"/> Past	Clozapine			
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<input type="checkbox"/> Now <input type="checkbox"/> Past	Prozac				<input type="checkbox"/> Now <input type="checkbox"/> Past	Depakote			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Zoloft				<input type="checkbox"/> Now <input type="checkbox"/> Past	Tegretol (Carbamazepine)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Paxil				<input type="checkbox"/> Now <input type="checkbox"/> Past	Trileptal			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Luvox				<input type="checkbox"/> Now <input type="checkbox"/> Past	Lamictal (lamotrigine)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Celexa				<input type="checkbox"/> Now <input type="checkbox"/> Past	Topamax			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Lexapro				<input type="checkbox"/> Now <input type="checkbox"/> Past	Valium (Diazepam)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Effexor XR				<input type="checkbox"/> Now <input type="checkbox"/> Past	Xanax (Alprazolam)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Pristiq				<input type="checkbox"/> Now <input type="checkbox"/> Past	Ativan (Lorazepam)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Cymbalta				<input type="checkbox"/> Now <input type="checkbox"/> Past	Klonopin (Clonazepam)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Wellbutrin				<input type="checkbox"/> Now <input type="checkbox"/> Past	Lyrica			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Remeron				<input type="checkbox"/> Now <input type="checkbox"/> Past	Neurontin			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Buspirone				<input type="checkbox"/> Now <input type="checkbox"/> Past	Hydroxyzine			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Trintellix				<input type="checkbox"/> Now <input type="checkbox"/> Past	Ambien (or CR)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Vibryd				<input type="checkbox"/> Now <input type="checkbox"/> Past	Lunesta			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Fetzima				<input type="checkbox"/> Now <input type="checkbox"/> Past	Temazepam			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Nefazodone				<input type="checkbox"/> Now <input type="checkbox"/> Past	Sonata			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Amitriptyline				<input type="checkbox"/> Now <input type="checkbox"/> Past	Trazodone			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Imipramine				<input type="checkbox"/> Now <input type="checkbox"/> Past	Rozerem			
<input type="checkbox"/> Now <input type="checkbox"/> Past	EMSAM				<input type="checkbox"/> Now <input type="checkbox"/> Past	Melatonin			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Nardil				<input type="checkbox"/> Now <input type="checkbox"/> Past	Benadryl (antihistamine)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Parnate				<input type="checkbox"/> Now <input type="checkbox"/> Past	Other OTC sleep aid			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Ketamine				<input type="checkbox"/> Now <input type="checkbox"/> Past	Buprenorphine			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Provigil/Nuvigil				<input type="checkbox"/> Now <input type="checkbox"/> Past				