TTUHSC Department of Psychiatry Clinic
Child and Adolescent Psychiatry Appointment Date _____

New Patient Questionnaire

Child's Name_____Referring Doctor/Source _____

Age ___ M/F Grade ___ Name & City of School_____

Name/relationship of person filling out this form _____

☐Parent ☐Step-parent ☐Legal Guardian Other _____

Person accompanying child to the appointment must have legal medical decision making authority. If parents are divorced or separated or person accompanying child is other than the biological parent, you must bring a copy of the custody agreement or legal documentation demonstrating medical decision making authority.

Are there any current legal issues with the caretakers? Y N

In your own words why are you requesting an evaluation for your child?_____

_____

Circle all behaviors that have been problematic for your child:

Worry	Defiant Behaviors	Depressed mood/Crying
Inattention	Poor sleep	Hyperactivity
Strange thoughts	Repetitive behaviors/rituals	Difficulty in social situations

Has your child ever talked of suicide? Y N
Has your child made any suicide attempts? Y N

Has your child ever seen a mental health professional? Y N
Has your child ever been admitted to a hospital for psychiatric treatment? Y N
Is your child currently receiving counseling or other mental health services? Y N

If you answered yes to any of the above questions, please fill out a *Release of Information* specific to the mental health professional or facility so that we may obtain records. You may obtain these from our front desk when you arrive for your appointment.

If your child has had multiple inpatient stays or multiple psychiatric providers, please list names and dates of those encounters below:

Provider/Facility	Treatment Dates	Reason for Treatment

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Please answer the following questions to the best of your ability.

Was your child preterm? (<37 weeks) Y N
Where there any problems with delivery? Y N
Did your child stay in the NICU? Y N
How was the child's delivery (circle all that apply)? Vaginal Scheduled C-Section
Forceps Emergent C-Section
Vacuum
Any problem behaviors in toddlerhood? Y N
Does your child refuse to go to school? Y N
Is your child in special education (ARD/504)? Y N
Is your child sexually active? Y N
Has Child Protection ever been involved? Y N
Has your child been in Foster Care? Y N
If driving, has your child had traffic tickets? Y N
If driving, any motor vehicle accidents? Y N
Has your child been arrested? Y N
Is your child on probation? Y N
If yes, PO's name and contact number _____

Has your child been the victim of or witnessed (circle all that apply):
Sexual abuse Physical abuse Emotional abuse Natural disaster
Other Trauma _____

Has child ever had (circle all that apply):
Headaches Meningitis Encephalitis Loss of consciousness
Seizures Stroke
Other neurological problem_____

Is there any family history (blood relatives) of: psychiatric hospitalizations, depression, schizophrenia, suicide, bipolar (manic depression), anxiety, alcohol problems, drug abuse, arrests, prison, mental retardation, learning disorders, or other disorders? Please describe including children, siblings, parents, aunts, uncles, grandparents, 1st & 2nd cousins.

RELATIONSHIP TO CHILD	DIAGNOSIS/SYMPTOMS	AGE	HOSPITALIZATIONS/TREATMENTS?

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Please list your all of the child's current medications. Include vitamins, herbal remedies and over the counter medications.

MEDICATION	DOSE	DATE START	PRESCRIBING DOCTOR

Please list any psychiatric medications your child has taken in the past.

MEDICATION	HIGHEST DOSE	WAS IT HELPFUL	REASON FOR DISCONTINUING

ADDITIONAL INFORMATION YOU WANT THE DOCTOR OR NURSE TO KNOW ABOUT: