* Please complete this questionnaire and bring it for your first appointment. You will notice that it is a lengthy questionnaire. It covers many details about your child that will help better understanding of your concerns.

Child's Name: ____________________ **Sex:** __________

Date of Birth: ______________ **Ethnicity/Race:** ______________

* **Who has custody of the child (if other than biologic parent(s), what is the relationship to the child)?**

Name: ______________________________

Relationship to the child: ______________________________

* **Who is completing this form & relationship to the child (if different from the above)?**

Name: ______________________________

Relationship to the child: ______________________________

* **Mother/maternal caregiver information.**

Mother is: ☐ Biological ☐ Adoptive ☐ Foster ☐ Step ☐ Other

Mother's name: ______________________________

Address: ______________________________

Phone number best to contact: ______________________________

Occupation: ______________ Employer: ______________

Marital status: ______________ Years of education/Degree: __________

If there is a stepfather, his name: ______________________________

* **Father/paternal caregiver information.**

Father is: ☐ Biological ☐ Adoptive ☐ Foster ☐ Step ☐ Other

Father's name: ______________________________

Address: ______________________________

Phone number best to contact: ______________________________

Occupation: ____________________ Employer: _____________________________

Marital status: ____________________ Years of education/Degree: ____________

If there is a stepmother, her name: ____

*** Who currently lives in the house with the child?**

Name	Age	Sex	Relationship

*** What are the 2 issues you are the most concerned about the child? How long have they been of concern; and how have they progressed?**

1. ____

____

____

____

2. ____

____

____

____

____

*** Has there been any particular event happened that has prompted this referral?**

____

____

____

____

*** Who has recommended this referral?** ______________________________________

*** What are your goals and hope to achieve from this referral?** __________________

____

____

____

____

*** Current symptoms. Check all that apply.**

	Decreased appetite		Increased appetite
	Sleeping difficulty		Sleeping too much
	Impulsivity		Hyperactivity
	Temper/anger outbursts		Low energy/fatigue
	Self injurious behavior		Suicidal thought/comment
	Stomach upset		Headache
	Paranoia		Hallucination
	Fear/anxiety		Nervous habits
	Other:		Other:
	Other:		Other:

*** Previous psychiatric, psychological or mental health evaluation/treatment, if any.**

Provider Name	Dates	Service	Outcome	Reason for Stopping

Provider Name	Dates	Service	Outcome	Reason for Stopping

*** Previous psychiatric hospitalization or residential treatment, if any.**

Facility	Dates	Service	Outcome

*** Previous or present treatment with medications to address emotional, behavioral or mental health reasons, if any.**

Now	Past	Medication Name	Reason	Dosage	Outcome

*** Previous or present substance abuse issue.**

	How Often?	How Much?	Treatment? Legal issues?
Cigarette			

	How Often?	How Much?	Treatment? Legal issues?
Alcohol			
Other Illicit Drug (Name:)			
Other Illicit Drug (Name:)			

*** List any Allergies to Medications:** ____

*** Physical Medical/Surgical Issues.**

Now	Past	Diagnoses	Treatment	Medication	Outcome

* **Any history of head injury or seizures?** ____________________________________

____

*** Pregnancy and birth history of the child.**

Any medical complications during pregnancy? ____________________________

____

Any medications, tobacco, alcohol or street drugs taken during pregnancy? _____

____

Any complications at birth? ____

*** Early Development history.**

Age when your child: walked _______; talked _________; toilet trained _______

*** How has your child been at school?**

Grade	Academic or Social Issues, if Any
Preschool	
Kindergarten	
First	
second	
Third	
Fourth	
Fifth	
Sixth	
Seventh	
Eighth	
Ninth	
Tenth	
Eleventh	
Twelfth	

*** Does anyone of the extended family suffer from any of the following? If so, relation to your child?**

Condition	Relation to the Child
Depression	
Bipolar Disorder	

Condition	Relation to the Child
Anxiety or Panic Attacks	
Alcohol Abuse	
Drug Abuse	
Schizophrenia/Psychosis	
Mental Retardation	
Learning Disorder	
Attention Deficit Disorder	
Tics/Tourette's Disorder	
Autism	

* Thank you for taking the time to complete this questionnaire. If there are other things you think would be important, please write them out on a separate piece of paper. Please bring the following documents if available.

- IEP
- School report cards
- Teacher's notes