NYSTROM & ASSOCIATES, LTD.
PSYCHIATRIC MEDICATION PEDIATRIC PATIENT INFORMATION FORM

Today's Date: _____

Identification:
Child's Name: _____ DOB: _____ Age: _____
Home address: _____
Home Phone: _____ Cell Phone: _____ Other: _____
Emergency Contact/Relationship: _____ Phone: _____

Guardianship:
Legal Guardian #1/Relationship: _____ Phone: _____

Legal Guardian #2/Relationship: _____ Phone: _____

Legal Custody:
- ☐ Joint
- ☐ Mother
- ☐ Father
- ☐ County
- ☐ Foster Parent
- ☐ Other: _____

Physical Custody:
- ☐ Joint
- ☐ Mother
- ☐ Father
- ☐ County
- ☐ Foster Parent
- ☐ Other: _____

Additional Custody Considerations: _____
_____
_____

Current Providers:
Medical/Primary Care Provider: _____
Clinic: _____
Phone: _____ Date of last physical: _____

Home Health Nurse or PCA: _____
Company: _____ Phone: _____

Psychologist/Therapist: _____
Clinic: _____ Phone: _____

County Social Worker/Case Manager: _____
Phone: _____ Cell/Pager: _____

Probation Officer: _____
Phone: _____ Cell/Pager: _____

Presenting Information:

1. How were you referred to this clinic for medication evaluation?

_____
_____
_____

2. In your initial meeting with your provider, what do you want to accomplish the most?

_____
_____
_____

3. Does your child have a past psychiatric diagnosis (such as ADHD, depression, etc.)? If yes, please describe.

_____
_____
_____

4. Do you know of, or suspect, your child has used or is currently using tobacco, drugs, or alcohol?

_____
_____
_____

5. Has your child had legal problems related to drug or alcohol use, curfew, stealing, fighting, etc.? If yes, please describe.

_____
_____
_____

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6 – 17

Child's Name: _____ Age:____ Sex: ☐ Male ☐ Female Date:_____
Relationship with the child:_____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS**, how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS**, has your child…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS**, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

LEVEL 2—Sleep Disturbance—Parent/Guardian of Child Age 6-17*

* PROMIS—Sleep Disturbance—Short Form[1]

Child's Name: _____ Age:____ Sex: ☐ Male ☐ Female Date: _____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "problems sleeping—that is trouble falling asleep, staying asleep or waking up too early" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

						Clinician Use
Please respond to each item by choosing one option per question.						**Item Score**
In the past SEVEN (7) DAYS….	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**	
His/her sleep was restless.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
He/she was satisfied with his/her sleep.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
His/her sleep was refreshing.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
He/she had difficulty falling asleep.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
In the past SEVEN (7) DAYS….	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	
He/she had trouble staying asleep.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
He/she had trouble sleeping.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
He/she got enough sleep.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
In the past SEVEN (7) DAYS….	**Very Poor**	**Poor**	**Fair**	**Good**	**Very good**	
His/her sleep quality was…	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
					Total/Partial Raw Score:	
					Prorated Total Raw Score:	
					T-Score:	N/A[1]

[1]This measure has not been validated in children.

LEVEL 2—Somatic Symptom—Parent/Guardian of Child Age 6-17*

* Adapted from the Patient Health Questionnaire Physical Symptoms (PHQ-15)

Child's Name: _____ Age:____ Sex: ☐ Male ☐ Female Date: _____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "complaining of stomachaches, headaches, or other aches and pains" and/or "worrying about his/her health or about getting sick" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child has been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

					Clinician Use
During the past 7 days, how much has your child been bothered by any of the following problems?					**Item Score**
		Not bothered at all (0)	**Bothered a little (1)**	**Bothered a lot (2)**	
1.	Stomach pain	☐	☐	☐	
2.	Back pain	☐	☐	☐	
3.	Pain in his or her arms, legs, or joints (knees, hips, etc.)	☐	☐	☐	
4.	***FOR ADULTS***	☐	☐	☐	
5.	Headaches	☐	☐	☐	
6.	Chest pain	☐	☐	☐	
7.	Dizziness	☐	☐	☐	
8.	Fainting spells	☐	☐	☐	
9.	Feeling his or her heart pound or race	☐	☐	☐	
10.	Shortness of breath	☐	☐	☐	
11.	***FOR ADULTS***	☐	☐	☐	
12.	Constipation, loose bowels, or diarrhea	☐	☐	☐	
13.	Nausea, gas, or indigestion	☐	☐	☐	
14.	Feeling tired or having low energy	☐	☐	☐	
15.	Trouble sleeping	☐	☐	☐	
				Total/Partial Raw Score:	
				Prorated Score: (if 10 or more items answered)	

Adapted from Physical Symptoms (PHQ-15) for research and evaluation purposes.

LEVEL 2—Inattention—Parent/Guardian of Child Age 6-17*

* Swanson, Nolan, and Pelham, version IV (SNAP-IV)

Child's Name: _____ Age:____ Sex: ☐ Male ☐ Female Date: _____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game" at a slight or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

						Clinician Use
For each item, choose the response which best describes your child in the last SEVEN (7) DAYS:		**Not at All**	**Just a Little**	**Quite a Bit**	**Very Much**	**Item Score**
1.	Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.	☐ 0	☐ 1	☐ 2	☐ 3	
2.	Often has difficulty sustaining attention in tasks or play activities.	☐ 0	☐ 1	☐ 2	☐ 3	
3.	Often does not seem to listen when spoken to directly.	☐ 0	☐ 1	☐ 2	☐ 3	
4.	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties.	☐ 0	☐ 1	☐ 2	☐ 3	
5.	Often has difficulty organizing tasks and activities.	☐ 0	☐ 1	☐ 2	☐ 3	
6.	Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework).	☐ 0	☐ 1	☐ 2	☐ 3	
7.	Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools.)	☐ 0	☐ 1	☐ 2	☐ 3	
8.	Often is distracted by extraneous stimuli.	☐ 0	☐ 1	☐ 2	☐ 3	
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	
					Average Total Score	

LEVEL 2—Depression—Parent/Guardian of Child Age 6-17*

* PROMIS Emotional Distress—Depression—Parent Item Bank

Child's Name: _____ Age: ____ Sex: ☐ Male ☐ Female Date: _____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "not finding interest or pleasure in doing things" and/or "seeming down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) days, my child said he/she …							**Item Score**
		Never	**Almost Never**	**Sometimes**	**Often**	**Almost Always**	
1.	Could not stop feeling sad.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
2.	Felt alone.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
3.	Felt like he/she couldn't do anything right.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
4.	Felt lonely.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
5.	Felt sad.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
6.	Felt unhappy.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
7.	Thought that his/her life was bad.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
8.	Didn't care about anything.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
9.	Felt stressed.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
10.	Felt too sad to eat.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
11.	Wanted to be by himself/herself.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Anger—Parent/Guardian of Child Age 6-17*

* PROMIS Emotional Distress—Calibrated Anger Measure—Parent[1]

Child's Name: _____ Age: ____ Sex: ☐ Male ☐ Female Date: _____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "seeming irritated or easily annoyed" and/or "seeming angry or lost his/her temper" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) days…							Item Score
		Never	**Almost Never**	**Sometimes**	**Often**	**Almost Always**	
1.	My child felt mad.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
2.	My child was so angry he/she felt like yelling at somebody.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
3.	My child was so angry he/she felt like throwing something.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
4.	My child felt upset.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
5.	When my child got mad, he/she stayed mad.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

[1]This measure was not tested in the DSM-5 Field Trials.

LEVEL 2—Irritability—Parent/Guardian of Child Age 6-17*

* Affective Reactivity Index (ARI)

Child's Name: _____ Age: ____ Sex: ☐ Male ☐ Female Date: _____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "seeming irritated or easily annoyed" and/or "seeming angry or lost his/her temper" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

					Clinician Use
In the past SEVEN (7) days and compared to others of the same age, how well does each of the following statements describe the behavior/feelings of your child? Please try to answer all questions.					
		Not True	**Somewhat True**	**Certainly True**	**Item Score**
1.	Is easily annoyed by others.	☐ 0	☐ 1	☐ 2	
2.	Often loses his/her temper.	☐ 0	☐ 1	☐ 2	
3.	Stays angry for a long time.	☐ 0	☐ 1	☐ 2	
4.	Is angry most of the time.	☐ 0	☐ 1	☐ 2	
5.	Gets angry frequently.	☐ 0	☐ 1	☐ 2	
6.	Loses temper easily.	☐ 0	☐ 1	☐ 2	
7.	Overall irritability causes him/her problems.	☐ 0	☐ 1	☐ 2	
				Total/Partial Raw Score:	
				Prorated Total Raw Score: *(if 1 item is left unanswered)*	

LEVEL 2—Mania—Parent/Guardian of Child Age 6-17*

* Adapted from the Altman Self-Rating Mania Scale (ASRM)

Child's Name: _____ Age: ____ Sex: ☐ Male ☐ Female Date:_____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "sleeping less than usual, but still have a lot of energy" and/or "only sleeping for a short time at night" at a mild or greater level of severity. The five statement groups or questions below ask about these feelings in more detail.

1. **Please read each group of statements/question carefully.**
2. Choose the one statement in each group that best describes the way your child has been feeling for **the past week**.
3. Check the box(✓ or x)next to the number/statement selected.
4. **Please note:** The word "occasionally" when used here means once or twice; "often" means several times or more and "frequently" means most of the time.

		Clinician Use
Question 1		**Item score**
☐ 1	He/she does not feel happier or more cheerful than usual.	
☐ 2	He/she occasionally feels happier or more cheerful than usual.	
☐ 3	He/she often feels happier or more cheerful than usual.	
☐ 4	He/she feels happier or more cheerful than usual most of the time.	
☐ 5	He/she feels happier or more cheerful than usual all of the time.	
Question 2		
☐ 1	He/she does not feel more self-confident than usual.	
☐ 2	He/she occasionally feels more self-confident than usual.	
☐ 3	He/she often feels more self-confident than usual.	
☐ 4	He/she frequently feels more self-confident than usual.	
☐ 5	He/she feels extremely self-confident all of the time.	
Question 3		
☐ 1	He/she does not need less sleep than usual.	
☐ 2	He/she occasionally needs less sleep than usual.	
☐ 3	He/she often needs less sleep than usual.	
☐ 4	He/she frequently needs less sleep than usual.	
☐ 5	He/she can go all day and all night without any sleep and still not feel tired.	
Question 4		
☐ 1	He/she does not talk more than usual.	
☐ 2	He/she occasionally talks more than usual.	
☐ 3	He/she often talks more than usual.	
☐ 4	He/she frequently talks more than usual.	
☐ 5	He/she talks constantly and cannot be interrupted.	
Question 5		
☐ 1	He/she has not been more active (either socially, sexually, at work, home, or school) than usual.	
☐ 2	He/she has occasionally been more active than usual.	
☐ 3	He/she has often been more active than usual.	
☐ 4	He/she has frequently been more active than usual.	
☐ 5	He/she is constantly more active or on the go all the time.	
	Total/Partial Raw Score:	
	Prorated Total Raw Score: ***(if 1 item is left unanswered)***	

Adapted from Altman EG, Hedeker D, Peterson JL, Davis JM: The Altman Self-Rating Mania Scale. Biological Psychiatry 42:948-955, 1997

LEVEL 2—Anxiety—Parent/Guardian of Child Age 6-17*

* Adapted from PROMIS Emotional Distress—Anxiety—Parent Item Bank

Child's Name: _____ Age: ____ Sex: ☐ Male ☐ Female Date: _____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "feeling nervous, anxious, or scared", "not being able to stop worrying", and/or "couldn't do things he/she wanted to or should have done because they made him/her feel nervous" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS, my child said that he/she …							Item Score
		Never	**Almost Never**	**Sometimes**	**Often**	**Almost Always**	
1.	Felt like something awful might happen.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
2.	Felt nervous.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
3.	Felt scared.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
4.	Felt worried.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
5.	Worried about what could happen to him/her.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
6.	Worried when he/she went to bed at night.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
7.	Got scared really easy.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
8.	Was afraid of going to school.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
9.	Worried when he/she was at home.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
10.	Worried when he/she was away from home.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Substance Use—Parent/Guardian of Child Age 6-17*

* Adapted from the NIDA-Modified ASSIST

Child's Name: _____ Age: ____ Sex: ☐ Male ☐ Female Date: _____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "having an alcoholic beverage"; "smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco"; "using drugs like marijuana, cocaine or crack, club drugs, hallucinogens, heroin, inhalants or solvents, or methamphetamine"; and/or "using any medicine without a doctor's prescription." The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past two (2) weeks. Please respond to each item by marking (✓ or x) one box per row.**

								Clinician Use
Please respond to each item by choosing one option per question.		**Not at All**	**Less Than a Day or Two**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**	**Don't Know**	**Item Score**
During the past TWO (2) WEEKS, about how often did your child …								
a.	Have an alcoholic beverage (beer, wine, liquor, etc.)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
b.	Have 4 or more drinks in a single day?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
c.	Smoke a cigarette, a cigar, or pipe or used snuff or chewing tobacco?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
During the past TWO (2) WEEKS, about how often did your child use any of the following medicines without a doctor's prescription or in greater amounts or longer than prescribed?								
d.	Painkillers (like Vicodin)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
e.	Stimulants (like Ritalin, Adderall)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
f.	Sedatives or tranquilizers (like sleeping pills or Valium)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
Or drugs like:								
g.	Steroids	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
h.	Other medicines	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
i.	Marijuana	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
j.	Cocaine or crack	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
k.	Club drugs (like ecstasy)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
l.	Hallucinogens (like LSD)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
m.	Heroin	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
n.	Inhalants or solvents (like glue)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	
o.	Methamphetamine (like speed)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐	

Courtesy of National Institute on Drug Abuse.

Current Medications:

Please list **ALL current medications**, including over-the-counter & vitamins:

Medication	Dose	Directions	Date/Time of Last Dose

Does patient have any known allergies to medications of any kind (circle)? YES NO

If yes, please list medication and reaction:

_____

_____

Previous Medications:

Please list all past trials of Psychiatric Medications, dose, length of use, and reason for discontinuing:

Medication	Dose	Length of Use	Reason for Discontinuing

Family History:

1. Has anyone in the child's biological family been diagnosed or treated for a mental health problem? If yes, please describe:

   _____

   _____

   _____

2. Has anyone in the child's family attempted or completed suicide? If yes, please describe:

   _____

   _____

   _____

Social History:

1. Has there been any divorce/separation/remarriage/adoption/foster placement in the family? If yes, please describe:

   _____

   _____

   _____

Family Members	Age	Sex	Occupation	Education (Highest Level)	Religion	Living in home?
Parent/Guardian						
Parent/Guardian						
Siblings 1.						
2.						
3.						
4.						
5.						
6.						
Step-Parent(s) 1.						
2.						
Other Family						

Please indicate below if you know of, or suspect, your child has been the victim of any kind of abuse or trauma.

☐ Physical Abuse ☐ Emotional Abuse ☐ Verbal Abuse

☐ Sexual Abuse ☐ Bullying ☐ Other Trauma

Developmental/Medical History

1. Describe any known or suspected prescription medication use, alcohol use, or drug use during pregnancy:

   _____

   _____

2. Were there any complications with labor/delivery or a significant period of bed rest?

   _____

   _____

3. Please complete the table below regarding developmental milestones:

Gross Motor Development (crawling, walking)	☐ Early	☐ Average	☐ Late
Fine Motor Development (fingers/hands)	☐ Early	☐ Average	☐ Late
Communication Development	☐ Early	☐ Average	☐ Late
Self-Care	☐ Early	☐ Average	☐ Late
Social Skills	☐ Early	☐ Average	☐ Late
Education (alphabet, numbers)	☐ Early	☐ Average	☐ Late
Toilet Training	☐ Early	☐ Average	☐ Late

4. Please indicate if the child has a history of any of the following:

   ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Sensory Issues

5. Please indicate below if the child has a chronic medical problem:

   ☐ Diabetes ☐ Cancer ☐ Seizure Disorder

   ☐ Heart Condition ☐ Asthma ☐ Kidney or Liver Problems

   ☐ Other: _____

6. Has the child ever had surgery? If yes, please describe:

   _____
   _____

7. Has the child ever been treated for a head injury, serious accident, or lead poisoning? If yes, please describe:

   _____
   _____

School Information:

Current School: _____ Grade: _____
Address/City: _____
Contact/Title: _____
Phone: _____ Fax: _____

Please describe past and present academic work:

_____
_____
_____
_____

Does your child have an IEP/504 Plan (circle)? YES NO

Has your child ever repeated a grade? If yes, please describe:

_____
_____

Does your child have a learning disability? If yes, please describe:

_____
_____

Does your child have a history of truancy, suspension, expulsion, or detention? If yes, please describe:

_____
_____