

Working with children and adolescents creates special challenges for doctors. Completing these questions about your child and your family will be very helpful in making an accurate diagnosis and providing the best care to your child. Please complete the questionnaire as best you can before arriving for your appointment. We will have an opportunity to discuss your answers at the time of your child's appointment. Every family's situation is unique. If the questionnaire does not provide an area for you to best describe your child's situation, there is room to provide input on the last page or feel free to include additional information.

Child's Name _____

Birth date _____ Age _____ Gender: Male / Female

Person Completing Form: _____ Your relationship to child: _____

Who is your pediatrician/physician? _____ Phone: _____

Have you notified your child's pediatrician/physician of this appointment? Yes No

What is the primary reason for this referral? _____

Has your family experienced recent stresses? Abuse or neglect _____

Divorce or Separation Moving Birth of another child Death of a family member or close friend

Legal Problems Parent fired or laid off Legal Problems Illness in family Other _____

Family History: What is the present marital status of this child's parents?

Mother: Married to child's father Married Separated Divorced Other _____

Father: Married to child's mother Married Separated Divorced Other _____

Housing: Lives with parents Lives with grandparents Other _____

Siblings:

Name _____ Age _____ Gender: Male / Female Lives at home? Yes No

Name _____ Age _____ Gender: Male / Female Lives at home? Yes No

Name _____ Age _____ Gender: Male / Female Lives at home? Yes No

Name _____ Age _____ Gender: Male / Female Lives at home? Yes No

Name _____ Age _____ Gender: Male / Female Lives at home? Yes No

Does anyone else live in the home? _____

Child Name: _____

EPA.Physician.Child Assessment

Mother's History:

Mother's Name _____ Birth date _____ Age _____

Mother's place of birth _____ Highest Grade completed _____ Degree _____

Was this child's mother in any special education classes or treatment programs? Please explain _____

In general, what sort of grades did child's mother make? A/B B/C C/D D/F

Has this child's mother ever thought they might have attention deficit or be hyperactive? Yes No

Has this child's mother experienced: Depression Anxiety Panic Disorder Bipolar Disorder

Schizophrenia Anorexia Bulimia Alcohol Abuse Drug Abuse Other _____

Has this mother's siblings or her own parents experienced any of these issues? _____

Father's History:

Father's Name _____ Birth date _____ Age _____

Father's place of birth _____ Highest Grade completed _____ Degree _____

Was this child's father in any special education classes or treatment programs? Please explain _____

In general, what sort of grades did child's father make? A/B B/C C/D D/F

Has this child's father ever thought they might have attention deficit or be hyperactive? Yes No

Has this child's father experienced: Depression Anxiety Panic Disorder Bipolar Disorder

Schizophrenia Anorexia Bulimia Alcohol Abuse Drug Abuse Other _____

Has this father's siblings or his own parents experienced any of these issues? _____

Child's History:

Pregnancy: What was the length of pregnancy for this child? _____

Were there any known complications of pregnancy/birth? _____

Did child's mother smoke cigarettes, use alcohol +/- or drugs during pregnancy? Yes No

Number of days that child stayed in hospital after birth? _____

Child Name: _____

Childhood Diseases: Please check all that apply.

- Asthma Anemia Lead Poisoning Meningitis Encephalitis Seizures
 Epilepsy Jaundice Hydrocephalus Cerebral Palsy Heart Problems Mental Retardation
 Vision Problems Hearing Problems Emotional Difficulties Other _____

Current Health: Poor Fair Good Excellent Present Weight: _____ pounds

Is the child in any way physically ill or handicapped at this time? Yes No Please explain how your child is being treated for this illness/situation _____

Is your child presently taking any medication? _____

Has your child ever been placed on medication for emotional or behavioral problems? Yes No Please explain.

Medication	Dosage	Start Date	End Date	No Effect	Slight Effect	Improvement

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Please explain any side effects or other problems you have had with these medications

Please check all that apply:

Please leave this area blank for the doctor's use:

Does your child have trouble paying attention? Yes No

Does your child ever seem: Distrustful of others? Yes No

To express strange thoughts? Yes No

To blame others? Yes No

Does your child have trouble at school with: Grades? Yes No

Behavior? Yes No Skipping classes? Yes No

Child Name: _____

Do you have concerns about your child's: Eating? Yes No

Sleep? Yes No Weight? Yes No

Does your child often complain of "not feeling well"? Yes No

Does your child have trouble making or keeping friends? Yes No

Does your child ever seem: Nervous or Afraid? Yes No

Sad? Yes No Angry? Yes No

Does your child show any of these behaviors? Smoking

Use of Alcohol Use of Drugs Being sexually active

Setting Fires Lying Stealing Destroying Property

Hurting animals or younger/smaller children

Where does this child attend school? _____

In general, what sort of grades did child's father make? A/B B/C C/D D/F

Where did child attend school previously (if anywhere)? _____

Do you have any other input from friends, family or teachers that you feel that the doctor needs to know about?

Signature _____ Date _____

Child Name: _____