Anne Arundel Medical Group
Mental Health Specialists

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CHILD AND ADOLESCENT INITIAL PSYCHIATRIC VISIT QUESTIONNAIRE

Child's name: _____ Child's DOB: _____
Respondent's name: _____ Relationship to child: _____

Please check and answer or explain where indicated

1. **What is the purpose of your visit? (Check all that apply)**
   ☐Evaluation ☐Second opinion ☐Consultation
   ☐Medication management ☐Therapy ☐ Other: _____

2. **Who referred you?**
   ☐Self ☐Primary therapist ☐Psychiatrist ☐Pediatrician ☐School ☐Other: _____
   Name: _____
   Contact Number: (____) ____ - _____

3. **Legal Guardianship: Are you the patient's legal guardian?** ☐Yes ☐No
   If there are any legal documents relating to guardianship, custody or decision making, the documents must be provided before or at registration when you arrive for the patient's first appointment or the patient cannot be seen.

4. **Is the patient your biological (birth) child?** ☐Yes ☐No
   If no, please explain:
   _____

5. **What is your preferred pharmacy information?**
   Name:_____
   Contact Number: (____) ____ - _____
   Address: _____

What are your main concerns?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

OFFICE USE ONLY

❑ NEW REFERRAL ❑ AAMC REFERRAL ❑ PATHWAYS REFERRAL ❑ Commercial ❑ Medicare/Medicaid ❑ Self-Pay

CURRENT SYMPTOMS:

Please check any of the symptoms below that identify/describe your child:

DEPRESSION

- ☐ Depressed mood
- ☐ Irritability
- ☐ Crying for no reason
- ☐ Guilt ("it's all my fault")
- ☐ Hopelessness ("nobody can help me")
- ☐ Worthlessness
- ☐ Anhedonia (no energy, loss of interest in things he/she used to enjoy)
- ☐ Suicidal thinking
- ☐ Self-injurious behavior (cutting/hitting)
- ☐ Increased sleep

ATTENTION

- ☐ Inattentive
- ☐ Difficulty concentrating
- ☐ Easily distracted
- ☐ Can't follow multiple-step directions
- ☐ Hyperactive/difficulty remaining still
- ☐ Impulsive
- ☐ Interrupts often/can't wait turn
- ☐ Risk taker

OPPOSITIONALITY

- ☐ Oppositional/defiant
- ☐ Argumentative
- ☐ Purposefully annoys others
- ☐ Easily angered
- ☐ Disruptive

PSYCHOSIS

- ☐ Hallucinations (hearing voices or seeing things)
- ☐ Delusions (bizarre thinking)
- ☐ Paranoia (suspicious)
- ☐ Disorganized thinking

MANIA

- ☐ Decreased need for sleep
- ☐ Elevated mood/grandiosity
- ☐ Appetite changes
- ☐ Inappropriate sexual behavior
- ☐ Too much energy
- ☐ Pressured speech
- ☐ Increase in goal-directed activities

ANXIETY

- ☐ Excessive worry
- ☐ Somatic complaints (body)
- ☐ Nightmares
- ☐ Social anxiety/avoidance
- ☐ Difficulty separating from mom/dad
- ☐ Phobias
- ☐ Obsessions/compulsions
- ☐ School refusal

CONDUCT DISORDER

- ☐ Truancy from school
- ☐ Destruction of property
- ☐ Stealing
- ☐ Lying
- ☐ Aggressive towards adults/kids
- ☐ Sets fires
- ☐ Violate curfew
- ☐ Runs away
- ☐ Cruel towards animals
- ☐ Bullies others/initiates fights

AUTISM/PERVASIVE DEVELOPMENTAL DISORDER

- ☐ Problems with speech
- ☐ Problems with social skills/interactions
- ☐ Limited or obsessive interests
- ☐ Repetitive behaviors (flapping hands, rocking, pacing, humming, etc.)

PSYCHIATRIC HISTORY

6. **Has the patient received any *previous* outpatient mental health treatment?** ☐Yes ☐No

If yes, please list all outpatient treatment providers and specialty (therapy/medication):

Name	Therapy or Medication	Diagnosis Given	Phone
1.			
2.			
3.			
4.			
5.			

7. **Has the patient received any *previous* inpatient mental health treatment?** ☐Yes ☐No

If yes, please complete the following information:

Name of Hospital	Date of inpatient admission	Reason	Diagnosis Given
1.			
2.			
3.			
4.			
5.			

8. **Please list all *current* psychiatric medications the patient is prescribed**

Medication	Dosage	Frequency	Prescribed by:
1.			
2.			
3.			
4.			
5.			

9. **Please list all psychiatric medications the patient *no longer* is prescribed and the reason**

Medication	Reason the medication was discontinued
1.	
2.	
3.	
4.	
5.	

MEDICAL HISTORY

10. Check all that apply to the patient

☐History of Seizures ☐Cerebral palsy ☐Ear Infections ☐ Surgery: _____
☐Heart conditions ☐Downs syndrome ☐Head injury ☐Last menstrual period _____
☐Chronic medical issues ☐Spina bifida ☐Muscular dystrophy ☐Specific syndromes: _____
☐High blood pressure ☐Tourette's ☐Appetite issues ☐ Loss of consciousness, fainting
☐Allergies ☐Rett syndrome ☐Feeding disorder ☐Spinal cord injury ☐Asthma
☐Other (please explain): _____

11. Does the patient have problems with sleep or appetite? ☐Yes ☐No
If yes, please explain:
_____

12. Please list any allergies and the reaction

Medication or Substance	Reaction
1.	
2.	
3.	

13. Please list the name and contact number for your current pediatrician:

Name: _____ Phone Number: (_____) _____ - _____

14. Date of the patient's last physical exam: _____

15. Is your pediatrician aware of this referral? ☐Yes ☐No

16. Are the patient's immunizations up to date? ☐Yes ☐No

17. Please list all other healthcare professionals *currently* involved in the patient's care (e.g. neurologists, therapists, psychiatrists, occupational therapists, speech therapists, etc.)**:**

Name	Specialty	Phone
1.		
2.		
3.		

18. Please list any other medication being taken (herbal, over the counter, etc.)

Medication	Reason
1.	
2.	
3.	
4.	
5.	

FAMILY HISTORY

19. **Is there a biological family history (blood relatives of the patient: mom, dad, siblings, cousins, aunts, uncles, grandparents) of mental health issues, learning problems or developmental disabilities?**
    ☐Yes ☐No
    If yes, please explain:

    _____

    _____

    Is there a biological family history (blood relatives of the patient) of medical problems (heart problems, cancer, sudden death of unknown cause, lupus, dementia, Alzheimer's Parkinson's, diabetes, deafness)?
    ☐Yes ☐No
    If yes, please explain:

    _____

    _____

DEVELOPMENTAL HISTORY

20. **Did the patient's mother have alcohol, substances, or medications while pregnant with the patient?**
    ☐Yes ☐No
    If yes, explain: _____

21. **Were there any problems during pregnancy?**
    ☐Preeclampsia (high blood pressure) ☐gestational diabetes (high sugar) ☐exposure to substances
    ☐Other: _____

22. **Were there any problems shortly after birth?**
    ☐Jaundice ☐NICU stay: _____ ☐Other: _____

23. **Delivery:**
    ☐C-section ☐Vaginal delivery ☐Forceps/Vacuum suction

24. **What was the patient's birth weight?** _____

25. **At how many weeks of pregnancy was the patient born?** _____ ☐early ☐late

26. **Please indicate the age at which the patient achieved the following milestones:**

MOTOR MILESTONES	LANGUAGE MILESTONES	SOCIAL MILESTONES
Sat up: ___ months Crawled: ___ months Walked w/out support: __ months/years	First word: ___ months 2 word phrases: ___ months Spoke in sentences: __months/years	Toilet trained: ___ months Rode a bike w/out training wheels: ___ months/years

27. **Has the patient had any of the following testing/evaluations? (If yes, please bring copies of the results)**
    ☐IQ (intelligence) ☐Speech/Language Therapy ☐Occupational Therapy ☐Physical therapy
    ☐Educational ☐Eye exam ☐Hearing ☐Sleep study
    ☐Genetic testing ☐EEG (brain wave) ☐EKG (heart) ☐ Other specialized testing:

EDUCATIONAL HISTORY

28. **What school does the patient attend?** _____

29. **In what grade is the patient enrolled?** _____

30. **Does the patient have an IEP?** ☐Yes ☐No
    Does the patient have a 504 plan? ☐Yes ☐No
    If yes to either of the above, please check the accommodations your child receives:
    ☐ One on one aide ☐ Pull-out services ☐ Frequent breaks
    ☐ Speech therapy ☐ Small class size ☐ Preferential seating
    ☐Occupational therapy ☐ School counselor ☐ Social skills group
    ☐ Extra test time ☐ Shortened assignments ☐ Other: _____

31. **Has the patient repeated a year?** ☐Yes ☐No If yes, what grade? _____

32. **What typical grade marks does the patient receive?** (A's, B's, C's, other)
    _____

33. **Does the patient have any behavioral issues at school?** ☐Yes ☐No
    If yes, please explain:
    _____
    _____

34. **Has the patient ever been suspended, expelled, or put in alternate placement?** ☐Yes ☐No
    If yes, please explain:
    _____
    _____

SOCIAL HISTORY

35. **Does the patient have friends his/her own age?**
    ☐Yes ☐No

36. **Does the patient participate in activities outside of school?** ☐Yes ☐No
    If yes, please explain:
    _____

37. **Has the patient ever been arrested/charged with a crime/put on probation?** ☐Yes ☐No
    If yes, please explain:
    _____

Signatures:
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.
I authorize the disclosure of my protected health information to the persons or entities named under sections 2, 14 and 18 above.

_____ _____
Signature of Patient, Guardian or Personal Representative **Date**