UF UNIVERSITY of FLORIDA
COLLEGE OF MEDICINE – *Jacksonville*
Department of Psychiatry
Child & Adolescent

6266 Dupont Station Ct
Jacksonville, Fl 32217
Phone 904-383-1038
Fax 904-383-1660

Date of Appointment: ______________________
Chronologic Age: ______________________

Today's Date: ______________________

Child & Adolescent Patient History Questionnaire

Child's Name:
Nickname?
Date of Birth:

Mother's Name:
Relationship: (step, adoptive, foster, etc)
Address:
Home and/or Cell Phone:

Father's Name:
Relationship: (step, adoptive, foster, etc)
Address:
Home and/or Cell Phone:

Referred By:

What Are Your Concerns About Your Child?
When Did You Begin To Notice These Concerns?
Additional Concerns:

Past Psychiatric History

Has your child ever seen a psychiatrist? If so, please provide information about providers, dates, and treatment rendered.

____

____

____

Has your child ever seen a psychologist?______________________________________

____

____

____

Has your child ever seen a therapist?____

____

____

____

Has your child ever been hospitalized for psychiatric reasons? If so, where and when?

____

____

____

____

Please circle the behaviors below that pertain to your child.

Nervous	Hyperactive	Temper tantrums	Poor sleep
Short attention span	Cries easily	Behavior problems	Destroys property
Easily frustrated	Excessive fears	Motor tics	Bite nails
Pulls hair	Frequent headaches	Frequent stomachaches	Fatigue/easily tired
Harms self (ie. cutting)	Hurts others (hits, bites, kicks)	Overweight	Perfectionist
Shy	Does not follow rules	Worries a lot	Overly talkative
Low self esteem	Likes self	Withdrawn/sullen	Slow learner
Demands attention	Plays well with peers	Irritable	Trouble making friends
Prefers to play alone	Depressed/sad	Legal problems	Weird ideas/bizarre thoughts
Running away from home	Vision problems	Hearing problems	Speech problems
Sexually active	Alcohol use	Drug use	Tobacco use
Legal Problems	Head Injury		

Medications: Please list all medications or supplements taken by your child.
Include psychiatric and medical medications.

Medication	**Dose** *(mg, units,mL, etc)*	**Doses per day** *(AM, twice daily, at bedtime, etc)*
1.		
2.		
3.		
4.		

5.		
6.		
7.		
8.		
9.		
10.		

Past Medical History:

Primary Care Physician:
Clinic Name, Address, and Phone #:

Current Medical Diagnoses *i.e. asthma, diabetes, seizures, etc*	Treatment?
1.	
2.	
3.	
4.	

Previous Surgeries	Approximate Date	Location/Hospital
1.		
2.		
3.		

Previous Hospitalizations	Approximate Date	Location/Hospital
1.		
2.		
3.		

Medication Allergies:
Food Allergies:
Are Immunizations Up-to-Date?

Developmental History:

Pregnancy:

Mother's Age During Pregnancy:	Prenatal Care Began in Which Trimester? 1st 2nd 3rd
How many total pregnancies for mother?	Which pregnancy was this one?
Any complications during the pregnancy? *ie. pre-term labor, high blood pressure, gestational diabetes*	Maternal drug, alcohol, or tobacco use during pregnancy?

Labor and Delivery:

Due Date:	Birth Date:
Hospital:	City, State:
Vaginal or C-Section?	Forceps or Vacuum Assisted?
Anesthesia? Epidural, Spinal, General, IV, None	Length of Labor?
APGAR Scores?	Birth Weight?
Complications During Delivery?	

Neonatal History:

Was your baby in the NICU?	How long did your baby stay in the hospital?
Did your baby have any nursery complications? Jaundice? Feeding problems? Infections?	Did your baby require resuscitation or oxygen?

Milestones: Please provide the age (in months) when your child attained the following milestone.

Sit unassisted	Hand-knee crawl
Walk independently	Pedal a trike
Finger feed	Toilet trained
Use "mama/dada" only for parent	First word
Point to indicate needs/wants	Used 10-15 words
Used 50 words	Put two words together

Family/Social History:

Who lives in the child's home?____

Does the child have a second home where they spend part of the week?__________________________________

Are parents married/partnered/separated/divorced?____

How long have parents been married (*if applicable*)?____

Mother	**Father**
Name:	Name:
DOB:	DOB:
Education Level:	Education Level:
Occupation/Employment:	Occupation/Employment:
Medical History:	Medical History:
Psychiatric History:	Psychiatric History:

Step-Mother *(if applicable)*	**Step-Father** *(if applicable)*

Name:	Name:
DOB:	DOB:
Education Level:	Education Level:
Occupation/Employment:	Occupation/Employment:
Medical History:	Medical History:
Psychiatric History:	Psychiatric History:

Siblings					
Name	DOB & Age	Relationship *(full,1/2,step,etc)*	Grade	Medical Problems?	Psychiatric Problems?

Family History: Please indicate if there is a family history of the following conditions and who is affected with the condition.

Anxiety	Heart disease
Depression	Sudden cardiac death
Bipolar disorder	Cancer
ADHD	Alcoholism
Autism	Drug abuse
Eating Disorders	Thyroid problems
Learning disabilities	Seizures
Other psychiatric conditions?	Other medical conditions?

Educational History:

Current School:	County/School District:
Address:	Phone Number:
Grade:	Type of Class: *Regular, Inclusion, Self-Contained, etc?*
Does your child have an IEP or 504 Plan?	Is your child in Exceptional Student Education (ESE)?
Does your child receive Speech Therapy at school?	Exceptionalities: *SLD, Autism, OHI, etc?*
Does your child receive Occupational Therapy at school?	Does your child receive Physical Therapy at school?
Has your child ever been suspended from school?	Has your child ever been expelled from school?

Please list the previous schools that your child has attended:

Years	Grades	School Name	Type of Class	Any problems? *Suspensions, Expulsions, etc*

Legal History:

Arrest(s):	Date(s):

Substance Abuse History *please include age of first use and frequency if known***:**

Alcohol First Used: Frequency:	**Marijuana (weed)** First Used: Frequency:
Cocaine (crack, coke) First Used: Frequency:	**Tobacco** First Used: Frequency:
Opiates (heroin, pain killers, methadone) First Used: Frequency:	**Benzodiazepines (Xanax, Klonopin, Ativan, Valium)** First Used: Frequency:
MDMA (ecstasy) First Used: Frequency:	**LSD (acid, hallucinogens)** First Used: Frequency:
Over the Counter (cough syrup, triple C's, laxatives) First Used: Frequency:	**Bath Salts, Spice, K2** First Used: Frequency:
Amphetamines (speed, Adderall, Ritalin) First Used: Frequency:	**Inhalants (dusters, whip its)** First Used: Frequency:
Other: First Used: Frequency:	**Other:** First Used: Frequency:

Any other issues not yet addressed?

Past Psychiatric Medication

Anti Depressants	**Response (Good, Fair, Poor)**	**Antipsychotic**	**Response (Good, Fair, Poor)**
Amitriptyline (Elavil)		Olanzapine (Zyprexa)	
Bupropion (Wellbutrin)		Perphenazine (Trilafon)	
Citalopram (Celexa)		Pimozide (Orap)	
Clomipramine (Anafranil)		Quetiapine (Seroquel)	
Desipramine (Norpramin)		Risperidone (Risperdal)	
Doxepin (Sinequan)		Asenapine (Saphris)	
Escitalopram (Lexapro)		Thioridazine (Mellaril)	
Fluoxetine (Prozac)		Thiothixene (Navane)	
Fluvoxamine (Luvox)		Trifluperazine (Stelazine)	
Imipramine (Tofranil)			
Mitrazapine (Remeron)		**Mood Stabilizers**	
Nefazodone (Serzone)		Carbamazepine (Tegretol)	
Nortriptyline (Pamelor)		Gabapentin (Neurontin)	
Paroxetine (Paxil)		Lamotrigine (Lamictal)	
Phenelzine (Nardil)		Lithium (Lithobid, etc)	
Dexvenlafaxine (Pristiq)		Topiramate (Topamax)	
Sertraline (Zoloft)		Valproic Acid (Depakote, etc)	
Tranylcypromine (Parnate)			
Trazodone (Desyrel)		**ADHD Medications**	
Venlafaxine (Effexor)		Amphetemine salts (Adderall, etc)	
		Clonidine (Kapvay, Catapres)	
AntiAnxiety		Dexmethylphenidate (Focalin)	
Alprazolam (Xanax)		Guanfacine (Intuniv, Tenex)	
Buspirone (Buspar)		Methylphenidate (Ritalin, Concerta, Daytrana, etc)	
Chlordiazepoxide (Librium)		Strattera (Atomoxetine)	
Clonazepam (Klonopin)		Vyvanse (Lisdexamfetamine)	
Clorazepate (Tranxene)			
Diazepam (Valium)		**Miscellaneous**	
Flurazepam (Dalmane)		Thyroid (Synthroid, Cytomel)	
Hydroxyzine (Vistaril)		Dilantin (Phenytoin)	
Lorazepam (Ativan)		Propranolol (Inderal)	
Oxazepam (Serax)		Naltrexone (Revia)	
Temazepam (Restoril)		Benztropine (Cogentin)	
Triazolam (Halcion)		Trihexyphenidyl (Artane)	
Zolpidem (Ambien)		L-Dopa	
Antipsychotic			
Aripiprazade (Abilify)		**Other Medications**	
Fluphenazine (Prolixin)			
Haloperidol (Haldol)			
Lurasidone (Latuda)			