Rothman Center for Neuropsychiatry

New Patient Information Form – Child and Adolescent

Dear Parent/Guardian, please fill out completely and to your best ability, checking with records, diaries, or other means to provide as much detail as possible. If area is unclear, the physician will go over that area with you. Thanks!

Patient's Name:_____ **Child's Age at visit:**_____ **Date:** _____

Person Filling out This Form: ☐ Mother ☐ Father ☐ Other _____

Please briefly describe the reason for your visit today:

_____

How did you hear about our clinic? Internet, doctor referral (if so, who?), etc _____

What do you hope to get out of your visit today? _____

Evaluation Process

Any information that you would like to add that you feel may be important to your child's care:

_____

Any topics of history or discussion you would prefer to discuss ***without your child*** present (please note we typically need to discuss the symptoms/reason for visit but we can discuss how we do this first):

_____

Background Information Section

Date of Birth: ☐☐ ☐☐ ☐☐☐☐ **2**. Gender: _____

Month Day Year

Ethnicity:

☐ White (non-Hispanic)
☐ African-American (non-Hispanic)
☐ Hispanic/Latin American
☐ Asian
☐ Native American
☐ Pacific Islander
☐ Middle Eastern
☐ Other (specify): _____

Living Situation

Describe your current living situation: _____

Father's highest education received

☐ less than 7 years of schooling
☐ junior high/middle school
☐ partial high school
☐ high school graduate/GED
☐ partial college/technical school
☐ standard college/university graduate (BA/BS)
☐ graduate professional training (MA/MS/PhD/MD)

Mother's highest education received

☐ less than 7 years of schooling
☐ junior high/middle school
☐ partial high school
☐ high school graduate/GED
☐ partial college/technical school
☐ standard college/university graduate (BA/BS)
☐ graduate professional training (MA/MS/PhD/MD)

Father's current occupation

_____

Father's current age: _____

Mother's current occupation

_____

Mother's current age: _____

Number of child's biological siblings (please include only biological brothers and sisters): _____

Age/sex of siblings: _____

Total number of children living with the child (include adopted and step-siblings): _____

Age of children living with the child (including step/foster/adopted):_____

Does the child live with any pets? **:** ☐ **NO** ☐ **YES** (specify type and number)_____

Pregnancy/Birth Information

Was the child born? ☐ **AT TERM (37-40 weeks)** ☐ **EARLY (<37weeks)** ☐ **LATE (>40 weeks)**

How old was the mother when baby was born? _____ Previous Pregnancies? ☐ **NO** ☐ **YES**

Were there any problems with the pregnancy? ☐ **NO** ☐ **YES** (specify):_____

Were any medications used by the mother during pregnancy? ☐ **NO** ☐ **YES** (specify):_____

Was child born by Cesarean (C-section)? ☐ **NO** ☐ **YES**

Were forceps used at delivery? ☐ **NO** ☐ **YES** ☐ **I DON'T KNOW**

Any other complications of delivery? ☐ **NO** ☐ **YES**, please check

☐ Premature ruptured membrane ☐ Twins or Triplets ☐ Version
☐ Extraction ☐ High Blood Pressure ☐ Hemorrhage

☐ Other:_____

Were the child's APGARS normal? ☐ **NO** ☐ **YES** ☐ **I DON'T KNOW**
If you remember the APGAR numbers, please list: _____

How much did the baby weigh at birth? _____ ☐ **I DON'T KNOW**

Did the baby start breathing right away? ☐ **NO** ☐ **YES** ☐ **I DON'T KNOW**

Did the baby cry? ☐ **NO** ☐ **YES** ☐ **I DON'T KNOW**

Were there any problems with the baby after she/he was born? ☐ **NO** ☐ **YES,** please check

☐ Incubator ☐ Trouble feeding (breast or bottle)
☐ Blueness or trouble breathing ☐ Other: _____
☐ Convulsions ☐ Jaundice
☐ Blood sugar problems If jaundice, did the child need bili lights? ☐ **NO** ☐ **YES**

When did the baby leave the hospital? _____ days after birth

When the baby came home, were there any problems? ☐ **NO** ☐ **YES,** please check:

☐ Colic, excessive irritability or crying ☐ Too floppy
☐ Slept too little ☐ Poor feeding
☐ Sleepiness, too quiet, lethargy ☐ Too stiff
☐ Other

Developmental Course

Do you feel that the child's developmental milestones were ☐ **EARLY** ☐ **LATE** ☐ **ON TIME**

When did the baby really smile (not "gas")? _____

When was the baby able to sit by him/herself WITHOUT PROPPING OR HELP? _____

When did the baby start to walk by him/herself WITHOUT HOLDING ON? _____

When did the baby say his/her first word? _____

When did the baby say short sentences like: "I want milk" or "go bye bye"? _____

Did the child have trouble learning to speak? ☐ **NO** ☐ **YES Please Explain**_____

Was he/she different from brothers or sisters or other children? _____

Is the child toilet trained? ☐ **NO** ☐ **YES**, how old when trained? _____

How old was the child when she/he was able to: Ride a tricycle? _____ Tie shoelaces? _____

Ride a bicycle without training wheels? _____ Get dressed by him/herself? _____

What hand does the child prefer to use? ☐ **RIGHT** ☐ **LEFT** ☐ **BOTH**

At what age did you notice this? ☐ **Before 1 year** ☐ **After 2 years** ☐ **After 4 years**

Does your child have a history of walking on his/her toes? ☐ **NO** ☐ **YES**

Anything else significant occur during the child's development years? ☐ **NO** ☐ **YES** (please specify):

_____

School Information

This child attends:

☐ Preschool/Daycare
☐ Stays at Home/Home-schooled
☐ Public school
☐ Private School
☐ Virtual School
☐ Charter School (Specify if any specialty :_____)

Current Grade: _____ or Grade entering in the Fall: _____

Current School: _____ Previous School: _____

How well does the patient do in:

Group/Peer activities	☐ excellent	☐ good	☐fair	☐ n/a
Fine motor skills	☐ excellent	☐ good	☐fair	☐ n/a
English/Language Arts/Reading	☐ excellent	☐ good	☐fair	☐ n/a
Math/Arithmetic/Numbers	☐ excellent	☐ good	☐fair	☐ n/a
Science	☐ excellent	☐ good	☐fair	☐ n/a
Music/Art	☐ excellent	☐ good	☐fair	☐ n/a

Has the child missed any days of school this school year? ☐ **NO** ☐ **YES** ☐ **N/A** how many?_____

What is the name of your child's school or daycare?_____

Has your child repeated any grades or been retained?_____

What is your child's most recent score on the Florida Standards Assessment (FSA; bring copies of scores)?

_____

Is your child receiving Response to Intervention (RTI)? ☐ **NO** ☐ **YES** ☐ **I DON'T KNOW**

If yes, check the level:

☐ Tier II (targeted group interventions, frequent monitoring)

☐ Tier III (intensive, individually based, more frequent monitoring)

What type of classes does your child participate in?

☐ Regular/General Education

☐ Gifted

☐ ESE

☐ Advanced Placement

☐ International Baccalaureate

Any Specific Magnet Program/Fundamental Program?_____

Does your child have an IFSP (Individualized Family Service Plan) or IEP (Individualized Education Plan)? ☐ **NO** ☐ **YES**

If Yes: (1) When was the last IEP review meeting? _____

(2) Under what condition is the child qualified?

☐ Specific Learning Disability (Specify if known :_____)

☐ Other Health Impairment (Specify if known :_____)

☐ Speech or language impairment ☐ Visual Impairment ☐ Deafness

☐ Hearing Impairment ☐ Intellectual Disability

☐ Traumatic Brain Injury ☐ Orthopedic Impairment

☐ Autism Spectrum Disorder ☐ Other (Specify: _____)

(3) What services or accommodations are in place?

_____

Does your child have a 504 plan? ☐ **NO** ☐ **YES** Resources and services provided if applicable_____

Has your child been suspended or expelled from school? ☐ **NO** ☐ **YES** Reason:_____

If Homeschooled/Virtual School, please state reason and for how long:_____

Social Information:

How many friends does your child have? ☐ **None** ☐ **1-2 friends** ☐ **Several friends**

How well does your child get along with his/her peers:

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐ **Terrible**

How well does your child handle changes in schedule or routine?

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐ **Terrible**

Family Information:

How well does your child get along with:

Siblings:	☐ excellent	☐ good	☐fair	☐ poor	☐ terrible	☐ n/a
Parents:	☐ excellent	☐ good	☐fair	☐ poor	☐ terrible	☐ n/a
Extended Family:	☐ excellent	☐ good	☐fair	☐ poor	☐ terrible	☐ n/a

How would you describe family life? ☐ **Stable** ☐ **Unstable, Please Explain**_____

Has the child experienced any of the difficulties listed in the table below? ☐ **NO** ☐ **YES**

If YES, mark all that apply.		Childs Age	Approximate date/length of problem
☐	Death of a parent		
☐	Death of other loved one/close friend		
☐	Separation from parent or family		
☐	Parents' separation/divorce		
☐	Loss of Home		
☐	Loss of Pet		
☐	Family moved		
☐	Family financial problems		
☐	Physical abuse		
☐	Sexual abuse		
☐	Parent with substance abuse problem		
☐	Conflicts with parents		
☐	Conflicts with spouse/significant other		
☐	Conflicts with family members		
☐	Removal of child from home		
☐	Unwanted pregnancy		
☐	Work problems		
☐	Victim of crime or violence		
☐	School problems		
☐	Teased or Bullied		
☐	Illness in self		
☐	Illness in family (specify:_____)		
☐	School change		
☐	Other: _____		

Child's Medical History

The following section has immune related questions. Please answer as completely as possible. If you think of information that may be relevant to your child's history that is not on this form or parent questionnaire, please add at the end of this form

Does your child have **any** history of the following?: ☐ **NO** ☐ **YES**

Illness/Symptoms	At what age(s)?	Currently present?	Comments
Autoimmune Diseases			
Sydenham's chorea (St. Vitus Dance)			
Chorea			
Rheumatic fever			
Rheumatic heart disease			
Lupus, Sjorgren's			

Multiple Sclerosis			
Idiopathic Thrombocytopenia Purpura (low platelets)			
Lyme disease/Tic bites			
Kawasaki's disease			
Henoch-Schonlein purpura			
Myasthenia gravis			
Heart murmur			
Thyroid disease: hypothyroid (Hashimoto's thyroiditis)			
Thyroid disease: hyperthyroid (Grave's disease)			
Diabetes Type 1			
Psoriasis			
Rheumatoid arthritis			
Crohn's disease			
Inflammatory bowel disease/colitis			
Other: _____			
Infectious Illness			
Frequent Strep/tonsillitis			
Frequent ear infections			
Pneumonia			
Bronchitis			
Sinusitis			
Scarlet Fever			
Impetigo			
Erythema marginatum			
Any Serious Infection:			
Other: _____			
Symptoms			
Dizziness or Fainting			
High Blood Pressure			
Loss of Consciousness			
Low Blood Pressure			

Sleep Problems			
Frequent urination			
Urogenital Problems (bladder, wetting)			
Nose bleeds			
Skin nodules			
Heart murmur			
Unexplained large or dilated pupils			
Joint swelling or tenderness			
Vaginal redness			
Erectile Dysfunction			
Rectal Bleeding			
Irritable Bowel Syndrome			
Chronic back pain			
Dysfunctional Uterine Bleeding			
Irregular Menses			
Pregnancy			
Fatigue			
Frequent Headaches			
Frequent Stomachaches			
Frequent diarrhea/loose stools			
Constipation			
Other symptom/illness:			
Perianal rash or vaginal strep			
Circular rash (red ring)			
Vision problems (e.g. Lazy eye)			
Other: _____			
Surgery and Other Medical History			
Head Injury			
Seizures			
Asthma			
Allergic rhinitis			

Tonsillectomy			
Adenoids removed			
POTS (postural orthostatic tachycardia syndrome)			
Other Serious Illness:			
Other Serious Injury:			
Surgical Procedure:			
Surgical Procedure:			
Other: _____			

Immunization History

Are your child's immunizations up-to-date? ☐ **NO** ☐ **YES**

if NO, please specify which one(s) and reason: _____

Has your child needed any additional booster vaccines? ☐ **NO** ☐ **YES**

if YES, please specify which one(s) and reason: _____

Has your child ever had any adverse reactions to immunizations? ☐ **NO** ☐ **YES**

if YES, please describe what happened: _____

Allergies

Does your child experience any of the following when they do not have a cold or viral infection:

Runny nose	☐ **NO**	☐ **YES**	Stuffy nose	☐ **NO**	☐ **YES**
Cough	☐ **NO**	☐ **YES**	Sore throat	☐ **NO**	☐ **YES**
Sinus drainage	☐ **NO**	☐ **YES**	Wheezing	☐ **NO**	☐ **YES**
Sneezing	☐ **NO**	☐ **YES**	Itchy eyes	☐ **NO**	☐ **YES**

Does your child have any allergy-related skin conditions such as eczema, atopic dermatitis, or frequent hives?

☐ **NO** ☐ **YES**

Has your child ever received medical evaluation and or treatment for allergies and/or related illnesses?

☐ **NO** ☐ **YES** Name of doctor:_____; condition: _____; treatment: _____

Had your child ever had a skin prick test? ☐ **NO** ☐ **YES**

To which of the following is your child allergic:

☐ My child has no allergies

Fish/shellfish	☐ **NO**	☐ **YES**	Egg protein	☐ **NO**	☐ **YES**	Grass	☐ **NO**	☐ **YES**
Fruits	☐ **NO**	☐ **YES**	Penicillin	☐ **NO**	☐ **YES**	Tree pollen	☐ **NO**	☐ **YES**
Peanuts	☐ **NO**	☐ **YES**	Latex	☐ **NO**	☐ **YES**	Weeds	☐ **NO**	☐ **YES**
Tree nuts	☐ **NO**	☐ **YES**	Dust mites	☐ **NO**	☐ **YES**	Wool	☐ **NO**	☐ **YES**
Milk	☐ **NO**	☐ **YES**	Dog dander	☐ **NO**	☐ **YES**	Bee stings	☐ **NO**	☐ **YES**
Soy	☐ **NO**	☐ **YES**	Cat dander	☐ **NO**	☐ **YES**	Wasps	☐ **NO**	☐ **YES**
Wheat	☐ **NO**	☐ **YES**	Cockroaches	☐ **NO**	☐ **YES**	Ants	☐ **NO**	☐ **YES**
☐ Other, please specify								

Does your child have allergies to any medications?: ☐ **NO** ☐ **YES**

If yes which medication and what symptoms? _____

Has a health professional prescribed an Epipen for your child?

☐ **NO** ☐ **YES** for what reason? _____

Has your child ever had an anaphylactic reaction?

☐ **NO** ☐ **YES** please list when, allergy trigger, and symptoms: _____

Has your child need to have an emergency visit for breathing problems?

☐ **NO** ☐ **YES** for what reason? _____

Family History

Please check if your child's "blood" family member has been diagnosed with any of the illnesses listed below. Define relationship: i.e., siblings, parents, grandparents, aunts, uncles, 1st cousins.

Diagnosed with	**Family Member**				
	Yes	**Maternal side**	**Paternal side**	**Relationship to child**	**When**
Frequent strep or tonsillitis	☐	☐	☐		
Sydenham's chorea (St. Vitus Dance)	☐	☐	☐		
Chorea	☐	☐	☐		
Rheumatic fever	☐	☐	☐		
Rheumatic heard disease	☐	☐	☐		
Lupus	☐	☐	☐		

Multiple sclerosis	☐	☐	☐		
Lyme disease	☐	☐	☐		
Kawasaki's disease	☐	☐	☐		
Henoch-Schonlein purpura	☐	☐	☐		
Myasthenia gravis	☐	☐	☐		
Heart murmur	☐	☐	☐		
Hypothyroid (Hashimoto's thyroiditis) (low)	☐	☐	☐		
Hyperthyroid (Grave's disease) (high)	☐	☐	☐		
Diabetes: childhood onset	☐	☐	☐		
Diabetes: adult onset	☐	☐	☐		
Psoriasis	☐	☐	☐		
Rheumatoid arthritis	☐	☐	☐		
Crohn's disease	☐	☐	☐		
Inflammatory bowel disease/colitis	☐	☐	☐		
Any movement disorder? please list _____	☐	☐	☐		
Any other immune-based disease? please list _____	☐	☐	☐		
Depression	☐	☐	☐		
Bipolar/Manic Depressive	☐	☐	☐		
Tic disorder or Tourette Syndrome	☐	☐	☐		
ADHD	☐	☐	☐		
Autism	☐	☐	☐		
Asperger's syndrome	☐	☐	☐		
Schizophrenia	☐	☐	☐		
OCD	☐	☐	☐		
Generalized Anxiety disorder	☐	☐	☐		
Social phobia	☐	☐	☐		
Panic disorder	☐	☐	☐		

Learning disability	☐	☐	☐		
Trichotillomania, or other skin picking	☐	☐	☐		
Alcohol problem	☐	☐	☐		
Drug problem	☐	☐	☐		
PTSD/Trauma	☐	☐	☐		
Anorexia Nervosa	☐	☐	☐		
Bulimia Nervosa	☐	☐	☐		
Binge Eating	☐	☐	☐		
Personality Disorder	☐	☐	☐		
Traumatic Brain Injury	☐	☐	☐		
Body Dysmorphic Disorder	☐	☐	☐		
Sleep Disorder	☐	☐	☐		
Sexual Disorder	☐	☐	☐		
Other problem	☐	☐	☐		

Psychiatric and Psychotherapy History

Has your child ever been treated for emotional/psychiatric/behavioral problems? ☐ **NO** ☐ **YES**

Please list names of clinicians that treated, problems addressed, the reason for stopping, and the response:

Dates	**Psychologist/Physician/ Therapist name**	**Problem(s) addressed/Type of therapy**	**Reason for stopping**	**Response**

Has your child ever been treated for the following conditions? ☐ **NO** ☐ **YES**

☐ **Anxiety** ☐ **Learning disorder**

☐ **ADHD** ☐ **OCD**

☐ **Autism** ☐ **Skin picking/hair pulling**

☐ **Behavior problems** ☐ **Speech concerns**

☐ **Depression** ☐ **Tics/Tourette's Disorder**

Has your child ever had a psychiatric hospitalizations? ☐ **NO** ☐ **YES**

If Yes: Date(s):_____ Facility/hospital name:_____

Reason:_____

Plan:_____

Was this a voluntary admission? ☐ **NO** ☐ **YES**

Has your child had any suicide attempts? ☐ **NO** ☐ **YES (When/Treatment?)**_____

Has your child ever intentionally self-injured his or herself (for example: cutting) ☐ **NO** ☐ **YES**

Has your child had any of the previous testing? ☐ **NO** ☐ **YES**

☐ Evaluation for learning/IQ,

☐ Psycho-educational testing,

☐ Testing for autism

☐ Testing for ADHD or other concerns,

☐ Evaluation by an Applied Behavior Analyst

Diagnoses/Findings _____

Please provide copies of report if available.

Sleep/Appetite

Does your child have problems with sleep? ☐ **NO** ☐ **YES**

If YES, please describe:_____

Does your child sleep alone in his/her own bed? ☐ **NO** ☐ **YES** Own Room? ☐ **NO** ☐ **YES**

Has there been any changes to your child's diet? ☐ **NO** ☐ **YES** if yes please explain:

_____

Has your child had any of the following? ☐ **NO** ☐ **YES**

☐ Binge-eating

☐ Vomiting

☐ Picky eating

☐ Constipation

☐ Weight loss

At what age did your child have onset of:

Symptoms (past or present)			**Age Symptom**	**Symptoms fluctuate**	**Triggers Please check any that apply**

	Symptoms never Present	Age First Aware of Symptom	Caused Problems related to Self-esteem Family Social/School	Do not fluctuate=0 Mildly fluctuate=1 Dramaticly fluctuate=2	Illness	Stress	Other (specify)
Compulsions (repetitive acts)	☐				☐	☐	
Obsessions (unreasonable fear)	☐				☐	☐	
Motor tics (rapid repetitive movements)	☐				☐	☐	
Vocal tics (rapid repetitive sounds)	☐				☐	☐	
Impulsivity	☐				☐	☐	
Hyperactivity (cannot be still)	☐				☐	☐	
Distractible (cannot pay attention)	☐				☐	☐	
Separation anxiety/clinginess	☐				☐	☐	
Sleep difficulty	☐				☐	☐	
Bedwetting/daytime accidents	☐				☐	☐	
Worsened handwriting	☐				☐	☐	
Oppositional	☐				☐	☐	
Irritability (easily angered)	☐				☐	☐	
Worsening of school performance	☐				☐	☐	
Clumsiness	☐				☐	☐	
Stuttering	☐				☐	☐	
Frequent urination	☐				☐	☐	
Social difficulties	☐				☐	☐	
Eating difficulties	☐				☐	☐	
Other (specify): _____					☐	☐	

Medication History

Please list any prescribed medications, over the counter medications, nutritional supplements, complimentary and/or alternative medications your child has taken for any medical conditions. This list may

include but is not limited to asthma/allergy medications, prophylactic antibiotics, allergy shots, vitamins, supplements, chelation, homeopathic, and over the counter medications.

In addition, please attach medication list from the pharmacy

ADHD/and or Tic Medications ☐ NO ☐ YES

If yes please enter dose/response to medication

Adderall (dextroamphetamine) _____

Aptensio XR (methylphenidate HCl) _____

Daytrana (methylphenidate) patch _____

Quillivant (methylphenidate HCl) _____

Concerta (methylphenidate) _____

Vyvanse (lisdexamfetamine) _____

Focalin (dexmethylphenidate) _____

Metadate (methylphenidate) _____

Ritalin (methylphenidate) _____

Strattera (atomoxetine) _____

Kapvay (Clonidine) _____

Tenex (guanfacine) _____

Intuniv (guanfacine) _____

Other: _____

Antidepressants ☐ NO ☐ YES

If yes please enter dose/response to medication

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Cymbalta (duloxetine) _____

Effexor (venlafaxine) _____

Pristiq (desvenlafaxine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Other: _____

Atypical Antipsychotics/Mood Stabilizers ☐ NO ☐ YES

If yes please enter dose/response to medication

Risperdal (risperidone) _____

Seroquel (quetiapine) _____

Zyprexa (olanzapine) _____

Abilify (aripiprazole) _____

Latuda (lurasidone) _____

Geodon (ziprasidone) _____

Saphris (asenapine) _____

Lithium _____

Depakote (valproic acid) _____

Trileptal (oxcarbazepine) _____

Lamictal (lamotrigine) _____

Topamax (topiramate) _____

Other: _____

Anxiolytics ☐ NO ☐ YES

If yes please enter dose/response to medication

Buspar (buspirone) _____

Xanax (alprazolam) _____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Other: _____

Allergy/Asthma/Cold Medications ☐ NO ☐ YES

If yes please enter dose/response to medication

Albuterol/inhalers _____

Allegra (fexofenadine) _____

Clarinex/Claritin (desloatadine) _____

Singulair (montelukast) _____

Zyrtex (cetirizine) _____

Sudafed (pseudoephedrine) _____

Benadryl (diphenhydramine) _____

Chlortriemton _____

Other: _____

Immune Therapies ☐ NO ☐ YES

If yes please enter dose/response to medication

IVIG _____

Plasmapherisis _____

Steroids (prednisone) _____

Other: _____

Vitamins/Other ☐ NO ☐ YES

If yes please enter dose/response to medication

Multi-vitamin _____

Omega 3 _____

Vitamin D _____

Magnesium _____

Melatonin _____

Hydroxyzine _____

Probiotic _____

Other: _____

Please list any medications not recorded above:_____

Was there ever a time where your child was treated with antibiotics for a prolonged period of time?

☐ **NO** ☐ **YES** please explain: _____

Additional Comments or Concerns_____