ASSOCIATES FOR PSYCHIATRIC SERVICES, P.C.

▪ PRE-ASSESSMENT FOR CHILDREN & ADOLESCENTS ▪

PATIENT NAME _____ DATE OF BIRTH_____

CHIEF COMPLAINT

Briefly state your child's main problem:_____

_____

Please check any of the following that your child has recently had to cope with:

- ☐ Addictive Behavior
- ☐ Anxiety
- ☐ Argue too much
- ☐ Avoid contact with others
- ☐ Can't concentrate
- ☐ Chronic pain
- ☐ Defy requests from others
- ☐ Depression
- ☐ Disorganized
- ☐ Divorce/Separation
- ☐ Doubting their abilities
- ☐ Eating problems
- ☐ Emotional abuse
- ☐ Family conflicts
- ☐ Fatigue
- ☐ Fear of gaining weight
- ☐ Fear of being alone
- ☐ Feel persecuted
- ☐ Guilt
- ☐ Hallucinations
- ☐ Headaches
- ☐ Homicidal thoughts
- ☐ Impulsiveness
- ☐ Inappropriate feelings
- ☐ Indecisive
- ☐ Insensitive to others
- ☐ Jealousy
- ☐ Lack of assertiveness
- ☐ Loneliness
- ☐ Loses temper easily
- ☐ Low self-esteem
- ☐ Low interest in usual activities
- ☐ Lying
- ☐ Need reassurances
- ☐ Nightmares
- ☐ Not resolving conflicts
- ☐ Over-dependent
- ☐ Panic attacks
- ☐ Phobic fears
- ☐ Physical abuse
- ☐ Problems initiating relationships
- ☐ Problems sleeping
- ☐ Sexual abuse
- ☐ Shame
- ☐ Shyness
- ☐ Speaking problems
- ☐ Stealing
- ☐ Substance abuse
- ☐ Suicidal ideas
- ☐ Unable to relax
- ☐ Unrealistic worrying
- ☐ Other

MEDICAL HISTORY

Does your child have any past or current medical problems? ☐ If yes, list:_____

_____

Does your child have any problems with hearing or speech articulation?_____

Does your child have any problems with gross motor coordination or fine motor coordination?_____

Has your child had any of the following childhood illnesses or injuries:

- ☐ Mumps
- ☐ Chicken Pox
- ☐ Measles
- ☐ Whooping Cough
- ☐ Encephalitis
- ☐ Otitis Media
- ☐ Lead Poisoning
- ☐ Lost Teeth
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Stomach Pumped
- ☐ Eye Injury
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sutures
- ☐ Other Diseases

Has your child ever been hospitalized overnight since birth? Yes ☐ No ☐

If yes, for what reason and how long?_____

_____

Has your child had surgery?_____ If so, what kind?_____

Please list all medications your child is currently taking:

NAME OF MEDICATION	DOSAGE & FREQUENCY	PRESCRIBING PHYSICIAN

Attach separate sheet if necessary.

Please list any drug allergies or sensitivities that your child has:_____

_____

Pharmacy Name:_____ Pharmacy Telephone No:_____

PRENATAL/DEVELOPMENTAL HISTORY

How was your health during pregnancy?_____

How old were you when your child was born?_____

Did you have any problems: Toxemia☐ Eclampsia☐ Ph factor incompatibility☐

Was your child born: On schedule☐ Overdue☐ How much?_____

Early☐ How much?_____

How many hours were you in labor?_____

Were you given any medications while you were in labor?_____What kind?_____

Were there any indications of fetal distress during labor or delivery? Yes☐ No☐ If yes, please explain:

_____

Was your delivery: Normal☐ Breech☐ Cesarean☐ Induced☐ Forceps☐

What was your child's birth weight?_____lbs._____oz.

Did your child have any health complications immediately following birth? Yes☐ No☐ If yes, please explain: _____

Did your child come home with you from the hospital?_____If no, explain:_____

_____

Did your child have any early infancy feeding problems? Yes☐ No☐ If yes, please explain:_____

_____

Did your child have colic? Yes☐ No☐

Did your child have any early infancy sleep difficulties? Yes☐ No☐ If yes, please explain:_____

_____

Were there any problems with your child's responsiveness or alertness? Yes☐ No☐ If yes, please explain:_____

Did your child experience any health problems during infancy? Yes☐ No☐ If yes, please explain:

_____

Did your child like to be held and cuddled as an infant: Yes☐ No☐

How active was your child as an infant and toddler? Extremely active☐ More active than average☐ Average☐ Less active than average☐ Not at all active☐

How insistent was your child in having his/her needs met? Very☐ Pretty much☐ Average☐ Not very☐ Not at all☐

At what age did your child walk?_____ At what age did your child crawl?_____

At what age was your child toilet trained? Bowel_____ Bladder_____

EDUCATIONAL HISTORY

Name of School_____ School Address_____

Grade_____ Teacher's Name_____

ACADEMIC PERFORMANCE	Academic	Social Adjustment
Preschool (good, fair, poor)	_____	_____
Kindergarten (good, fair, poor)	_____	_____
Grades 1 through 3 (good, fair, poor)	_____	_____
Grades 4 through 6 (good, fair, poor)	_____	_____
Grades 7 through 12 (good, fair, poor)	_____	_____

Has your child ever been in any special education program? Yes☐ No☐ If so, for what classes?_____

_____ How long?_____

Has your child ever been suspended or expelled from school? Yes☐ No☐

Has your child ever repeated a grade? Yes☐ No☐

SOCIAL HISTORY

Does your child make friends easily? Yes☐ No☐ If no, explain why:_____

_____

What does your child do for fun?_____

Do you approve of the friends your child chooses? Yes☐ No☐ If no, explain:_____

_____

Do you suspect that your child may be sexually active? Yes☐ No☐ If yes, explain:_____

_____

Has your child ever been in trouble with the law? Yes☐ No☐ If yes, explain:_____

_____

Does your child currently have any legal charges pending? _____ _____ _____

Does your child have any known history of:

Sexual abuse? Yes☐ No☐

Physical abuse? Yes☐ No☐

Verbal/Emotional abuse? Yes☐ No☐

If yes, explain:_____

_____

FAMILY HISTORY

Please circle:

Mother: ☐ alive ☐ deceased age_____
Father: ☐ alive ☐ deceased age_____

Age of brothers ____ ____ ____ ____ ____
Age of sisters ____ ____ ____ ____ ____
Age of children ____ ____ ____ ____ ____

Have any of the child's relatives had:

☐ Diabetes, thyroid or other gland disease	If so, whom_____
☐ Alcohol problems	If so, whom_____
☐ Drug problems	If so, whom_____
☐ Attention problems	If so, whom_____
☐ Mental retardation	If so, whom_____
☐ Behavioral problems	If so, whom_____
☐ History of seeing a psychiatrist or a counselor	If so, whom_____
☐ History of being in jail or prison	If so, whom_____
☐ Depression	If so, whom_____

MISCELLANEOUS

What do you see as goals for treatment for your child?_____

_____

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