POTOMAC PEDIATRICS

Patient's Name:_____ Date of Birth:_____
Last First Middle

Past Treatment or Evaluations for these Problems?
YES or NO

If YES, please describe (Provider's name, Type of Evaluation, i.e. Psychiatric vs. Psychological Testing, etc.)

_____

Developmental History:

Any problems during pregnancy or birth complications?

YES or NO

Any in utero exposure to substances, alcohol, nicotine, medications, x-rays, or caffeine?

YES or NO

If YES, please describe:_____

_____

Did your child/adolescent meet developmental milestones (*crawling, walking, talking, potty training, etc.)* on time?
YES or NO

If NO, please list delays (age):
_____

_____

Is your child/adolescent currently taking medications for psychiatric or emotional problems?
YES or NO

If YES, please list *medications* with *dosages* and *provider's name* below:
_____
_____
_____

Has your child/adolescent previously taken medications for psychiatric or emotional problems? YES or NO

If YES, please list past medications, dosages, side effects (if any) below:

_____

_____

Has your child/adolescent ever been *hospitalized* for *psychiatric* reasons?
YES or NO

If YES, please list *when, where*, and *duration* of each hospitalization:

_____

_____

_____

Has your child/adolescent been in treatment with a psychiatrist and/or therapist *previously*? YES or NO If YES, please list who he/she was seeing:

_____

Is your child/adolescent currently seeing a therapist? YES or NO
If YES, please list who he/she is seeing:

_____

Family Psychiatric History:

Has any blood relative (Parents/Grandparents/Siblings/Aunts/Uncles/Cousins) been diagnosed or treated for a psychiatric illness? *Please circle all that apply*

Depression	Obsessive Compulsive Disorder		Generalized Anxiety	Bipolar Disorder
ADHD	Schizophrenia	Alcoholism	Eating Disorders	Substance Abuse

Other _____
Is there a history of any attempted or completed suicides in the family?

If YES, Who _____

_____

Are there any medical illnesses that run in the family? Please circle all that apply

Seizures	Thyroid Problems		Diabetes	Anemia
Arrhythmias	Cancer	Migraines	Heart Attacks	Strokes

Other_____

SOCIAL HISTORY:

Who is currently living in the home (*parents, siblings, grandparents, significant others).*

Name	Gender	Age	Relationship	Nature of relationship to child/adolescent

What grade is your child/adolescent in?

_____

Does your child/adolescent have an IEP? YES or NO.

Is your child/adolescent in a Special Education Program? YES or NO.

What school does your child/adolescent attend?

_____

Academic Functioning

Child/Adolescent is performing: ___ at ___above ___below grade level
___ at ___above ___below family expectations
___ at ___above ___below patient's own expectations.

Does your child/adolescent have a specific difficulty with: ___writing ___reading ___math

Parent(s)/Guardian(s) Occupation/Education:

_____

_____

Any out of home placements (foster care, residential treatment facility, living with another relative or parent/guardian)?
YES or NO

If YES, please list *type of placement* and *dates.*

_____

Has your child/adolescent ever had any legal problems (*probation, youth corrections, etc.)*
YES or NO

If, YES, please list *charges, dates of probation*, *probation officer name if currently on probation*, and *any jail time (PYC, Spring Creek, DYC).*

_____

_____

SUBSTANCE ABUSE HISTORY:

Does your child/adolescent drink alcohol? YES NO
Does your child/adolescent currently use any illicit drugs (including marijuana)? YES NO
Has your child/adolescent previously used illicit drugs? YES NO

If you answered YES, please describe the type and amount of use:

_____

_____

Has your child/adolescent ever participated in an alcohol or drug treatment program? YES or NO

If you answered YES, please describe where and length of treatment:

_____

Is there any additional information that you feel would be important for Dr. Parr to know? Please provide:

_____
_____
_____