

Comprehensive Psychiatric Associates

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Mental Health Services for
Children, Adolescents, Adults, and Families

www.WellPsych.com

Client Name: _____

Appointment date: _____ Appointment time: _____

Clinician: _____

Dear Parent(s):

Your child has an appointment for a consultation at the date and time shown above. **Please read the following information carefully.**

For the initial consultation, it is generally most helpful and efficient if your child and at least one, preferably both, parents or guardians come for the first appointment. However, if you prefer to come for the first appointment without your child, please feel free to do so. Your child may be waiting alone in the waiting room for up to 40 minutes while the doctor is meeting with you, so you may want to bring along something with which your child can entertain himself or herself while waiting. **If your child is very young, might be uncomfortable waiting alone, or should not be left alone, you should bring along another adult or an older sibling** to sit with him or her in the waiting room while the doctor is meeting with you. Your first appointment will last approximately 50 to 80 minutes.

Enclosed please find information regarding our clinical services, fee and billing information, and some forms and questionnaires. **Please complete the enclosed *Questionnaire for Parents*.** Prior completion of this form will allow us to use our appointment time more efficiently. Since completion of this form may take some time, it is generally best not to leave it until the last minute. Please read and sign the *Financial Policies Agreement* and *Client Consent to Treatment & to Release of Information* forms. Bring all of these with you to your first appointment. If your child's school has recommended psychiatric consultation, or if your child has had any emotional, behavioral, or academic difficulties in school, please ask his or her teacher(s) or school counselor to complete the enclosed *School Questionnaire* and return it to you so that you may bring it in with you. If you have any copies of prior psychiatric evaluation reports, reports of psychological testing, or any other documentation of prior evaluation or treatment, please bring copies of these documents with you. It is not necessary to send any of these documents to us prior to the appointment.

We generally try to schedule the initial consultation with a clinician who will be appropriate to provide any ongoing treatment that is indicated, based on what you told our staff when you called to schedule the consultation. However, in some cases the clinician providing the initial consultation may recommend that a different clinician would be more well qualified to provide whatever treatment is indicated.

We will do our best to complete your child's evaluation as efficiently as possible. However, you should be aware that more than one appointment is often required to complete the evaluation and to have adequate time to discuss our impressions and treatment recommendations with you. If you need to cancel or reschedule your first appointment, please call the office to let us know as far in advance as possible, but at least 72 hours prior to the scheduled appointment. If an initial appointment is cancelled with less than 72 hours prior notice or missed without prior cancellation, we may not be able to reschedule. Please feel free to call the office if you have any questions.

QUESTIONNAIRE FOR PARENTS

The following questionnaire asks for information that will assist us in coming to a fuller understanding of the problems your child has been experiencing. Please complete the questionnaire as completely as possible before your first appointment. The questionnaire should be completed by one or both parents. If you need additional space for any item, please use the back of the page.

Child's name _____ D. O. B. _____ Age _____

Home Phone _____ Today's Date _____

Person Completing This Form / Relationship to Child _____

Address _____

City _____ ST _____ Zip _____

Father's Name _____

Phone: Home _____ Work _____ Cell _____

Mother's Name _____

Phone: Home _____ Work _____ Cell _____

Your Child's Physician _____

Address _____

Phone _____

Who referred you to us? _____

School Name _____ Grade _____

Address _____

Phone _____

Teacher's Name _____ School Counselor _____

I. Please state the reason you are bringing your child for evaluation.

What is the problem(s)?

When and how did the problem(s) begin?

What has been done so far to try to alleviate the problem(s)?

II. Substance Use

To your knowledge, does your child drink caffeinated beverages (coffee, tea, or caffeinated soft drinks)? Yes No IF YES, how many caffeinated drinks per day? _____

To your knowledge, has your child used alcohol or drugs? Yes No If YES, please describe:

III. Psychiatric Treatment History

Has your child ever been hospitalized for psychiatric treatment?

Yes No IF YES, number of hospitalizations: _____

Dates of last hospitalization: from _____ to _____. Name of hospital: _____

Reason for hospitalization: _____

Was the hospital treatment helpful?

Is your child currently seeing a therapist or counselor? Yes No IF YES, please specify:

Name of therapist: _____ Seeing since _____

What town is therapist in? _____ Telephone number _____

Has this therapy been helpful?

Is your child currently taking any medication for treatment of psychiatric, behavioral, or emotional problems? Yes No IF YES, please specify:

Name of medication	Dose and frequency	Taken when (dates)	Benefits and/or side effects

Has your child seen any other therapists or counselors in the past?

Yes No IF YES, please specify:

Name of therapist: _____ Dates of counseling: from _____ to _____ .

Was treatment helpful?

Name of therapist: _____ Dates of counseling: from _____ to _____ .

Was treatment helpful?

Has your child taken other medications in the past for treatment of psychiatric, behavioral, or emotional problems? Yes No IF YES, please specify:

Name of medication	Dose and frequency	Taken when (dates)	Benefits and/or side effects

Other comments regarding past psychiatric treatment:

IV. Medical History

Has your child suffered from any of the following medical problems?

- | | | |
|--|--|--|
| <input type="checkbox"/> allergic reactions to medications | <input type="checkbox"/> severe or recurrent headaches | <input type="checkbox"/> surgery |
| <input type="checkbox"/> other allergies | <input type="checkbox"/> hearing impairment | <input type="checkbox"/> thyroid condition |
| <input type="checkbox"/> asthma | <input type="checkbox"/> heart disease | <input type="checkbox"/> recurrent nausea or vomiting |
| <input type="checkbox"/> AIDS (or infection with HIV) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> recurrent constipation |
| <input type="checkbox"/> cancer | <input type="checkbox"/> hepatitis | <input type="checkbox"/> recurrent diarrhea |
| <input type="checkbox"/> cataract | <input type="checkbox"/> hormonal problems | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney problems | <input type="checkbox"/> hospitalization for medical illness |
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> liver problems | |
| <input type="checkbox"/> head injuries | <input type="checkbox"/> seizures | |

If you checked any of above, please provide details. If your child has had any other serious, recurrent, or prolonged medical illnesses, accidents, or injuries, please describe:

Overall, would you say your child's physical health is:

Excellent Very good Good Fair Poor

Are you concerned about your child's sleep? Yes No

IF YES Trouble falling asleep? Yes No

Frequent waking during the night? Yes No

Wake up early in the morning and can't fall back to sleep? Yes No

Does your child frequently seem fatigued, exhausted, or sleepy during the day? Yes No

Has your child lost weight or gained excessive weight in the last year? Yes No

IF YES Weight gain? How much _____ lbs Weight loss? How much _____ lbs

Is your child currently taking any medication other than the psychiatric medications listed above (include prescription medications, birth control pills, and over-the-counter medicines, such as cold or allergy preparations)? Yes No IF YES, please specify below:

Name of medication	Dose and frequency	Taken when (dates)	Why taking this medication?

Girls Only: Has child started to have menstrual periods? Yes No When? _____

Has your child had any problems related to her menstrual periods, such as irregular periods, prolonged or especially painful periods, or excessive bleeding? Yes No IF YES, please describe:

Have her symptoms (anxiety, depressions, other psychiatric symptoms) varied according to any pattern during the course of her menstrual cycle? For example, does she become more depressed, anxious, or irritable before her period? Yes No IF YES, please describe:

Has she ever been pregnant? Yes No

V. Developmental History

Was your child the product of a planned pregnancy? Yes No

Did mother have any medical problems or take any medications, or use drugs, alcohol, or cigarettes during pregnancy? Yes No IF YES, please specify:

Were there any medical complications associated with delivery (e.g., premature birth, cesarean section, forceps delivery, etc.)? Yes No IF YES, please describe:

Did your child have any medical problems as a newborn (e.g., low birth weight, yellow jaundice, breathing problems, neurological problems)? Yes No IF YES, please describe:

Your child's birth weight: _____

Was your child breast or bottle fed? Breast How long? _____ Bottle

Please describe your child's temperament as an infant:

Was your child's motor development (age at which he/she sat up, rolled over, stood, walked, etc.) normal or delayed? Normal Delayed If delayed, please describe:

Was your child's speech and language development normal or delayed?

Normal Delayed If delayed, please describe:

At what age was your child toilet trained? Bladder ____ yrs ____ mos Bowel ____ yrs ____ mos

Since being toilet trained, has your child had any problem with

wetting at night Yes No IF YES, until what age? _____

wetting during the day Yes No IF YES, until what age? _____

soiling at night Yes No IF YES, until what age? _____

soiling during the day Yes No IF YES, until what age? _____

To your knowledge, has your child ever been a victim of

physical abuse Yes No sexual abuse Yes No

emotional abuse Yes No witness to domestic violence Yes No

IF YES to any of the above, please describe:

Has the Department of Social Services ever had any involvement with your child?

Yes No IF YES, please describe:

As an infant, toddler, and preschooler, did your child

have any unusual problems with sleep? Yes No IF YES, please describe:

have any eating problems? Yes No IF YES, please describe:

have any unusual fears? Yes No IF YES, please describe:

have more temper tantrums than other children? Yes No IF YES, please describe:

have unusual problems in separating from parents? Yes No IF YES, please describe:

How well does your child get along with other children?

VI. Academic History

Has your child ever been held back in school? Yes No IF YES, when and why?

Has he/she ever skipped a grade? Yes No IF YES, when and why?

Has he/she ever had a CORE evaluation through the school? Yes No
IF YES, what was the outcome or what recommendations were made?

Has he/she ever been in special education classes? Yes No
IF YES, when, what type of class, which subjects?

What sort of grades does your child make in school?

Have teachers or others ever told you that your child had a learning disability? Yes No
IF YES, when? What were you told?

Has your child ever had special educational, cognitive, or psychological testing? Yes No
IF YES, please bring copies of test results with you to first appointment.

Has a teacher ever commented that your child is "hyperactive" or very distractible? Yes No
IF YES, when? What were you told?

Has a teacher ever commented on other behavioral or emotional problems? Yes No
IF YES, when? What were you told?

VII. Living Environment

Family Background

	Name	Current age or age at death	If not living, your child's age when he or she died	Occupation	✓ if living with child	If alive and not living with child, where does he or she live now?
Father						
Mother						
Brothers						
and						
Sisters						

Child's biological parents are

- married and living together mother deceased
 unmarried and living together father deceased
 unmarried, not living together both parents deceased
 unknown

If biological (or adoptive) parents are (or were) married, date married: _____

If biological (or adoptive) parents are separated or divorced,
 date separated: _____ date divorced: _____

Child lives with

- biological father & mother mother and step-father
 mother only father and step-mother
 father only adoptive parents
 other _____

If parents divorced or separated, what are custody and visitation arrangements?

Others living in child's household

Name	Relationship to child	Age

If child is adopted, age at adoption: _____ Does child know of adoption? Yes No

Do any family/household members currently suffer from significant physical health problems?

Yes No IF YES, please describe:

Do any family/household members currently suffer from significant mental/emotional health problems?

Yes No IF YES, please describe:

Have any family/household members suffered from significant problems with alcohol or drug abuse?

Yes No IF YES, please describe:

Are there any other significant stresses currently affecting your family life (e.g., financial concerns, health problems, extended family concerns or conflicts, job problems, etc.)?

Yes No IF YES, please describe:

Father's education (check highest level obtained):

- | | |
|---|--|
| <input type="checkbox"/> high school graduate or less | <input type="checkbox"/> college graduate |
| <input type="checkbox"/> some college or associate degree | <input type="checkbox"/> advanced college degree |

Father's occupation _____

Mother's education (check highest level obtained):

- | | |
|---|--|
| <input type="checkbox"/> high school graduate or less | <input type="checkbox"/> college graduate |
| <input type="checkbox"/> some college or associate degree | <input type="checkbox"/> advanced college degree |

Mother's occupation _____

Step-father's education (check highest level obtained):

- | | |
|---|--|
| <input type="checkbox"/> high school graduate or less | <input type="checkbox"/> college graduate |
| <input type="checkbox"/> some college or associate degree | <input type="checkbox"/> advanced college degree |

Step-father's occupation _____

Step-mother's education (check highest level obtained):

- | | |
|---|--|
| <input type="checkbox"/> high school graduate or less | <input type="checkbox"/> college graduate |
| <input type="checkbox"/> some college or associate degree | <input type="checkbox"/> advanced college degree |

Step-mother's occupation _____

Are there currently or have there been any significant marital problems?

Yes No IF YES, please describe:

VIII. Family History

Has your child's biological father or have any of his family members had any of the following problems?

	Father	Father's mother	Father's father	Father's siblings	Other family
Depression					
Anxiety problems					
Alcohol abuse					
Drug abuse					
Schizophrenia					
Bipolar (manic depressive disorder)					
Hospitalized for psychiatric problem					
Learning difficulties as child					
Hyperactivity or attention problems					
Tics or twitching					
Suicide					
Other psychiatric problem					
Criminal behavior					
Unknown					

Has your child's biological mother or have any of her family members had any of the following problems?

	Mother	Mother's mother	Mother's father	Mother's siblings	Other family
Depression					
Anxiety problems					
Alcohol abuse					
Drug abuse					
Schizophrenia					
Bipolar (manic depressive disorder)					
Hospitalized for psychiatric problem					
Learning difficulties as child					
Hyperactivity or attention problems					
Tics or twitching					
Suicide					
Other psychiatric problem					
Criminal behavior					
Unknown					

Have any of your child's siblings had any of the following problems?

Sibling number	1	2	3	4	5
Age					
Sex (M or F)					
Depression					
Anxiety problems					
Alcohol abuse					
Drug abuse					
Schizophrenia					
Bipolar (manic depressive disorder)					
Hospitalized for psychiatric problem					
Learning difficulties as child					
Hyperactivity or attention problems					
Tics or twitching					
Suicide					
Other psychiatric problem					
Criminal behavior					
Unknown					

IX. Please provide any other information that you believe might be helpful in understanding the problems your child is having.

X. Parent Symptom Checklist

Directions: Listed below are items regarding children's behavior or the problems they sometimes have. Read each item carefully and decide how much you think your child has been bothered by this problem *during the past month* – NOT AT ALL, JUST A LITTLE, PRETTY MUCH, or VERY MUCH. Indicate your choice by placing a check mark (✓) in the appropriate column to the right of each item. PLEASE ANSWER ALL ITEMS as best as possible.

Observation	Not at all	Just a little	Pretty much	Very much
PROBLEMS OF EATING				
1. Picky and finicky				
2. Will not eat enough				
3. Overweight				
PROBLEMS OF SLEEPING				
4. Restless				
5. Nightmares				
6. Awakens at night				
7. Cannot fall asleep				
FEARS AND WORRIES				
8. Afraid of new situations				
9. Afraid of people				
10. Afraid of being alone				
11. Worries about illness and death				
MUSCULAR TENSION				
12. Gets stiff and rigid				
13. Twitches, jerks, etc.				
14. Shakes				
SPEECH PROBLEMS				
15. Stuttering				
16. Hard to understand				
WETTING				
17. Bed wetting				
18. Runs to bathroom constantly				
BOWEL PROBLEMS				
19. Soiling self				
20. Holds back bowel movements				
COMPLAINS OF FOLLOWING SYMPTOMS EVEN THOUGH DOCTOR CAN FIND NOTHING WRONG				
21. Headaches				
22. Stomach aches				
23. Vomiting				
24. Aches and pains				
25. Loose Bowels				

Observation	Not at all	Just a little	Pretty much	Very much
PROBLEMS OF SUCKING, CHEWING, OR PICKING				
26. Sucks thumb				
27. Bites or picks nails				
28. Chews on clothes, blankets, or other items				
29. Picks at things such as hair, clothing, etc.				
CHILDISH OR IMMATURE				
30. Does not act his age				
31. Cries easily				
32. Wants help doing things he should do alone				
33. Clings to parents or other adults				
34. Baby talk				
TROUBLE WITH FEELINGS				
35. Keeps anger to himself				
36. Lets himself get pushed around by other children				
37. Unhappy				
38. Carries a chip on his shoulder				
OVER-ASSERTS HIMSELF				
39. Bullying				
40. Bragging and boasting				
41. Sassy to grown-ups				
PROBLEMS MAKING FRIENDS				
42. Shy				
43. Afraid they do not like him				
44. Feelings easily hurt				
45. Has no friends				
PROBLEMS WITH BROTHERS AND SISTERS				
46. Feels cheated				
47. Mean				
48. Fights constantly				
PROBLEMS KEEPING FRIENDS				
49. Disturbs other children				
50. Wants to run things				
51. Picks on other children				
RESTLESS				
52. Restless or overactive				
53. Excitable, impulsive				
54. Fails to finish things he starts – short attention span				

Observation	Not at all	Just a little	Pretty much	Very much
TEMPER				
55. Temper outbursts, explosive and unpredictable behavior				
56. Throws himself around				
57. Throws and breaks things				
58. Pouts and sulks				
SEX				
59. Plays with own sex organs				
60. Involved in sex play with others				
61. Modest about his body				
PROBLEMS IN SCHOOL				
62. Is not learning				
63. Does not like to go to school				
64. Is afraid to go to school				
65. Daydreams				
66. Truancy				
67. Will not obey school rules				
LYING				
68. Denies having done wrong				
69. Blames others for his mistakes				
70. Tells stories which did not happen				
STEALING				
71. From parents				
72. At school				
73. From stores and other places				
FIRE-SETTING				
74. Sets fires				
TROUBLE WITH POLICE				
75. Gets into trouble with police				
Why?				
PERFECTIONISM				
76. Everything must be just so				
77. Things must be done same way every time				
78. Sets goals too high				
ADDITIONAL PROBLEMS				
79. Inattentive, easily distracted				
80. Constantly fidgeting				
81. Cannot be left alone				
82. Always climbing				
83. A very early riser				

Observation	Not at all	Just a little	Pretty much	Very much
84. Will run around between mouthfuls at meals				
85. Demands must be met immediately – easily frustrated				
86. Cannot stand too much excitement				
87. Laces and zippers are always open				
88. Cries often and easily				
89. Unable to stop a repetitive activity				
90. Acts as if driven by a motor				
91. Mood changes quickly and drastically				
92. Poorly aware of surroundings or time of day				
93. Still cannot tie his shoelaces				

Indicate the items you are most concerned about or those you think are the most important problems your child has by placing a circle around the number (1-93) of those items.

How serious a problem do you think your child has at this time?

- No Problem
 Minor Problem
 Serious Problem