Patient Information Form

Today's Date:_____

Patient's Name _____Date of Birth _____

Your Name _____Relationship to Child _____

Name of School _____ Grade_____

Teacher(s) _____

Please list the problems with which you want help for this child:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Has the child had previous evaluations outside of School?

___Yes ____NO

If so, where and when? Please do your best to obtain a copy of any evaluation your child may have had.

_____
_____
_____

Has the child received any special treatments outside of school? __Yes __No

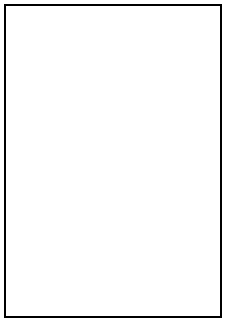
If so, please describe below:

Dates	**Types of Treatment (include name of any medicine)**

Has the child received any alternative treatments (including herbs, diets, biofeedback)??

Dates	**Types of Treatment (include name of any herb)**

Please attach a recent photograph of the child if available in the space below. It is not essential, but it is very useful to us.



Pregnancy Problems: During pregnancy were there any of these factors:

Was the baby premature? ___Yes ____No Gestational Age? _____

Did birth mother drink alcohol before she knew she was pregnant? ____Yes ____No

Drank Alcohol during pregnancy? ____Yes ____No ____Don't know

Took drugs ? ____Yes ____No ____Don't know

Had a difficult delivery? ____Yes ____No ____Don't know

Had to take medicines? ____Yes ____No ___
If so which medicines? _____

Had a Cesarean Section? ____Yes ____No ___

Other pregnancy problems?
_____

Newborn Problems: During the newborn period were there any of these factors?

	Yes	No	Unknown
Baby in the NICU?			
Baby on a Ventilator?			
Baby had a Seizure?			
Born with a Heart Defect?			
Injury during birth?			
Was a twin?			
Had an Infection?			
Baby was Blue at birth?			

Please list any other newborn problems:

1._____
2._____
3._____
4._____

Review Of Systems:

Any problems with any of the following:

Head: _____
Ears: _____
Eyes: _____
Throat: _____
Tonsils: _____
Heart : _____
Breathing :_____
Gastrointenstinal: _____
Genital Problems: _____
Bladder Problems: _____
Bone/Muscle: _____
Skin: _____
Neurological Problems: _____
Endocrine: _____
Blood: _____
Allergy/ Immune: _____

Current Medication:
_____
_____
_____

Family History:

Illnesses:
_____
_____
_____

Family History of Hyperactivity, Depression, Bipolar, Alcohol or Drug Use, Jail Time, School Problems, or other mental illness.

_____
_____
_____
_____

Biological Father's Age _____ Occupation _____
School Level Completed _____
General Health _____

Biological Mother's Age_____ Occupation _____
School Level Completed _____
General Health _____

Siblings Name and Age: _____

_____

Was the child adopted? ____Yes _____No

Are the parents divorced? _____Yes ____No

Attention	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Does not pay attention to details				
Can not sustain attention when moderately motivated				
Does not seem to listen when spoken to				
Fails to follow through on chores or homework				
Difficulty with organization				
Avoids work that requires sustained mental effort				
Loses things necessary for task or school work				
Easily distracted by extraneous stimuli				
Often forgetful in daily activities				

(6/9)

Hyperactivity/Impulsivity	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Fidgets with hands, squirms in seat				
Leaves seat in classroom				
Runs about climbs excessively (for adolescents- feels restless)				
Difficulty playing or engaging I leisure activities quietly				
Often “on the go”, Driven by a motor				
Talks excessively				
Blurts our answers				
Difficulty waiting turn				
Interrupts or intrudes on others				

(6/9)

Of the attention, hyperactivity and impulsivity signs and symptoms that applied, were most of them present before the age of seven? ___Yes ____NO

Oppositional Defiant Disorder	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Loses Temper				
Argues with Adults or Authority Figures				
Often actively refuses to comply with adult requests or rules				
Deliberately annoys others				
Blames others for his mistakes				
Touchy or easily annoyed				
Angry and resentful				
Spiteful or vindictive				

(4/8)

Anxiety	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Is fearful, anxious or worried				
Afraid to try new things, afraid of making mistakes				
Feels worthless				
Balmes self , feels guilty				
Feels lonely , unwanted				
Is sad, unhappy, depressed				
Is Self Conscious, easily embarrassed				

(3/7)

Encopresis	**Yes**	**No**
Has the child ever stuffed up the toilet with bowel movement?		
Has the child ever had a bowel accident?		
Does the child wet the bed?		

Social	definitely	somewhat	Does not	Cannot say
Does not initiate social contact				
Is very knowledgeable about a specific topic (dinosaurs?)				
Can recite TV programs word for word				
Odd use of language/toys				
Did not respond to name when younger				

Sleep	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Trouble Falling Asleep				
Often Falls asleep during a Car Ride				
Snores Loudly/Trouble breathing when sleeps				
Often appears sleepy during the day				

Vision (ask child directly)	Definitely Applies	Applies Somewhat	Does Not Apply	Cannot Say
Eyes tire easily when reading				
When reading do the words move/vibrate				
When reading do the words get blurry				
When reading is there color on the page or does the white part of the page encroach on the black				

Other Comments: