Salvador Leo Cevallos, M.D.
CENTER FOR BEHAVIORAL MEDICINE

NEW PATIENT QUESTIONNAIRE - CHILD & ADOLESCENT

Date of Visit:_____

Patient's Name:_____ **DOB:**_____**Age/Sex:**_____

Name of person completing this form: _____**Relationship to patient:**_____

1. **Purpose of Visit: What is the ONE main problem (chief complaint) which caused you to visit us? Please explain in your own words.**

   _____

   _____

   _____

2. **What other problems/concerns do you have for your child? Please list.**

_____

_____

_____

_____

3. **Allergies to Medication:**_____

4. **Current Medication/s:** ▫ **None**

Name	Dose and Times Per Day	Length of use	Compliance (G-good, P-poor, PRN-as needed)

5. **Is your child taking any Over –the-counter medicine/Vitamins/ Supplements? If yes, please list.**

   _____

   _____

6. **Is your child seeing a therapist or counselor? If yes, please write name and contact number.**_____

7. **Is your child currently receiving treatment from other providers for his behavior or emotional problems (such as chiropractic, herbal, homeopathic, acupuncture, computer-based training programs,biofeedback,etc)?**_____

_____

8. **Psychotropic Medication Trial History: Please list previous medication/s taken by your child for behavior/emotional problems.**

Name of Medicine and for what target symptom/s	**Highest Dose Given**	**Estimated date given and for how long**	**Response (none, fair, good, I do not know) and side effects, if any**	**Name of Prescriber**

9. **Birth History:**

( ) Full Term ( ) Pre/Post Term _____
( ) Normal ( ) CS
If CS, why?_____
( ) Forceps ( ) Others:_____
Complications during pregnancy:
_____
Complications during labor and delivery:
_____
NICU stay? ( ) No ( ) Yes:_____ days

Birth Weight:_____
Age of mother during pregnancy:_____
Age of father during pregnancy:_____

Any medication taken during pregnancy:
_____
Any drug or alcohol use during pregnancy:
_____
Post-partum(after pregnancy) blues/depression/psychosis:
_____
High stress/ depression during pregnancy?
_____

NEW PATIENT QUESTIONNAIRE - CHILD & ADOLESCENT

10. Developmental Milestones:

	Early	On time	Late
Social smile (smiling back at someone smiling at him/her)		**2-3 mos**	
Walk			
Toilet: Urine			
Toilet: Stool			
Speech			

11. Is your child's immunization up to date? _____

12. Does your child have any current medical problems? If so, please list.

_____

13. Does your child have a history of head trauma with loss or change in consciousness? ( ) Yes ( ) No
If yes, please provide some details about it: _____

14. Is there anybody in your family diagnosed with depression, anxiety, ADHD, Bipolar, Schizophrenia or any other psychiatric or mental health problems? If so, please list diagnosis and relationship to patient._____

_____

15. Does anyone in your immediate family have any of the following medical conditions?

- **Diabetes**
- **High blood pressure problems**
- **Obesity**
- **Heart disease**
- **Epilepsy/seizure disorder**
- **Thyroid problems**
- **Kidney disease**
- **Cholesterol problems**
- **Sudden death**

16. What is your child's current living situation? Who does your he/she live with? Please list all household members (adults and children) and include their ages and their relationship to the patient.

_____

_____

_____

17. Please describe what your child is like at home and his/her relationship to other family members:

_____

_____

18. Where does your child go to school and what is his/her current grade level?

_____

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19. Did he/she repeat any grade level? ( ) Yes ( ) No If so, what grade/s? _____

20. Does your child have an IEP (Individual Education Plan) ( ) Yes ( ) No

21. Has he/she ever received or is he/she currently receiving any special education services (such as ESE classes, speech therapy, resource, gifted, etc)? ( ) Yes ( ) No. If so, please list service/s:

_____

22. Please describe your child's academic performance in school and his/her relationship with peers and teachers:

_____

_____

23. What are your child's personal strengths and hobbies?

_____

_____

24. Do you think that your child may be using any illicit drugs or drinking alcohol? ( ) Yes ( ) No

25. Did your child experience any traumatic event/s like abuse or being in a serious accident? ( ) Yes ( ) No If yes, this will be discussed further during the visit if child and family are willing to talk about it.

26. Review of Systems: Does your child have any of the following symptoms? ( ) NONE

General:	( ) Sleep problems ( ) Excessive tiredness ( ) Poor appetite ( ) Weight loss ( ) Weight gain ( ) Fainting spells ( ) Staring spells ( ) Involuntary facial/body movements ( ) Muscle pain or stiffness ( ) Skin rash ( ) Easy bruising/bleeding ( ) Fever ( ) Frequent infections ( ) Itching
HEENT:	( ) Headaches ( ) Dizziness ( ) Blurred vision ( ) Hearing problems ( ) Ringing in the ears ( ) Vertigo ( ) Sore throat ( ) Hoarseness ( ) Difficulty swallowing ( ) Dry mouth
CV:	( ) Chest pain/discomfort ( ) Palpitations ( ) Leg swelling ( ) Gets tired easily
RESP:	( ) Difficulty breathing ( ) Cough ( ) Frequent colds
GI:	( ) Nausea ( ) Vomiting ( ) Abdominal pain ( ) Diarrhea ( ) Constipation
GU:	( ) Difficulty urinating ( ) Incontinence ( ) Bedwetting ( ) Irregular menses

27. Please write down name, address and telephone number of your PHARMACY in case medications are to be prescribed:_____