COMPREHENSIVE PSYCHIATRIC ASSOCIATES, LLC

305 NW Englewood Ct., Suite 300 • Gladstone, MO 64118
Office (816) 453-7473 • Fax (816) 453-1940

NEW PATIENT HISTORY - Child and Adolescent

NAME OF PATIENT _____ AGE _____ SEX _____

DATE OF BIRTH _____ Today's Date _____

ADDRESS _____

CITY _____ STATE _____

ZIP CODE _____ PHONE _____ (Home)

_____ (Work)

PARENTS NAMES (biological, adoptive, or foster?) _____

Has child ever been placed in DFS/SRS custody? Has child been involved with foster care?

_____

_____

Most Recent School Attended: _____

CURRENT GRADE _____

TYPE OF CLASSES: regular special education resource other _____

Does the patient have an IEP and/or 504 Plan in place? _____

When was the most recent Revision? _____

Please note if ever held back: _____ Any problems with Truancy, Suspensions? _____

Names of other children/siblings including age and relationship to patient (full or half, step, related via mom/dad)

AGE _____

AGE _____

AGE _____

Please let us know how you were referred to our clinic:

Name of referral source: _____

Relationship: _____

HAVE ANY BIOLOGICALLY RELATED RELATIVES EVER BEEN DIAGNOSED OR TREATED FOR ANY KNOWN PSYCHIATRIC DISORDERS INCLUDING ALCOHOL AND/OR DRUG ABUSE/DEPENDENCE?
If so, in the space below, please tell us who, relationship to patient, when, where, and if known...what treatment was provided?

_____

_____

_____

_____

HAS THE PATIENT EVER BEEN SEEN BY A PSYCHIATRIST, PSYCHOLOGIST, SOCIAL WORKER, OR OTHER MENTAL HEALTH PROFESSIONAL PREVIOUSLY FOR DIAGNOSIS AND/OR TREATMENT?
If so: Who? When? Where? What diagnosis was made and what treatment was provided if known? _____

_____

_____

_____

_____

PLEASE INDICATE ANY IMPORTANT ALLERGIES THE PATIENT MAY HAVE (include medications): _____

_____

_____

PLEASE LIST ANY CURRENT OR IMPORTANT PRIOR MEDICAL CONDITION(S) THE PATIENT HAS/HAD: _____

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS TAKEN BY THE PATIENT AND THE MOST RECENT DOSAGE IF KNOWN:

_____

_____

IS THERE ANY DOCUMENTED THYROID CONDITION IN ANY FAMILY MEMBER? _____
If so, what was the condition and what was the treatment? _____

_____

_____

IS THERE ANY KNOWN CARDIOVASCULAR PROBLEM IN THE PATIENT OR OTHER FAMILY MEMBERS? _____
If so, please indicate what the problems are or were: _____

_____

_____

HAS THE PATIENT EVER SUFFERED A SERIOUS HEAD INJURY WITH SOME DEGREE OF SUBSEQUENT IMPAIRMENT? _____
If so, please describe: _____

_____

_____

HAS THE PATIENT EVER HAD A SERIOUS BRAIN INFECTION SUCH AS MENINGITIS OR ENCEPHALITIS? _____
If so, when? _____ Have there been evident residual symptoms since recovery? _____

_____

_____

ARE THERE ANY IMPORTANT OR PENDING LEGAL PROBLEMS, SUCH AS ANY DIFFICULTIES WITH THE LAW, CUSTODY PROBLEMS, ETC.? _____
If so, please describe these problems: _____

_____

_____

Were there any known abnormalities/complications with the patient's pregnancy or delivery affecting either/both the patient and/or mom? _____

_____

Length of pregnancy: _____

Birth Weight: _____Apgar Score, if known: _____

Any noted complications of infant development: _____

Were any milestones unusual?

Walking
Speech and Language
Toilet training
Separation difficulties

WERE THERE ANY EVIDENT PROBLEMS IN DAY CARE, PRE-SCHOOL, OR KINDERGARTEN? _____
If so, please describe: _____

At what age did symptoms first appear and what were they? _____

_____

_____

DID ANY SYMPTOMS APPEAR TO DEVELOP AFTER IMPORTANT CHANGES IN THE FAMILY? _____
If so, what were the symptoms and describe the changes: _____

_____

PLEASE LIST AND DISCUSS ANY IMMEDIATE CONCERNS YOU HAVE: _____

_____

_____

IN THE EVENT THERE HAS BEEN ANY PRIOR TREATMENT FOR THE CONDITION(S) OF CONCERN, WE WOULD LIKE TO LEARN DETAILS ABOUT WHAT WENT RIGHT AND WHAT PROBLEMS OCCURRED: _____

_____

_____

_____

_____

IF MEDICATION HAS EVER PREVIOUSLY BEEN EMPLOYED, PLEASE INDICATE: _____
Please indicate whether generic or brand name was used. Be specific and detailed in discussing what problems arose with each medication employed: _____

_____

_____

_____

_____

HAS THE PATIENT EVER HAD COMPREHENSIVE PSYCHOLOGICAL TESTING? _____
If so, by whom? When? (We would greatly appreciate a copy of the report if available) _____

_____

_____

_____

_____

HAS THE PATIENT EVER TAKEN ANY OF THE "TESTS" FOR ADHD, SUCH AS T.O.V.A., CONNERS, VIGIL, OR GARDNER? _____
If so, we would appreciate a copy of the results. _____

_____

_____

_____

WHEN WAS THE PATIENT'S MOST RECENT PHYSICAL EXAMINATION? _____

Approximate Date: _____ By Whom? _____

Were there any significant findings? _____

_____

TO THE BEST OF YOUR KNOWLEDGE, HAS THERE BEEN ANY USE OF DRUGS AND/OR ALCOHOL? IS THIS A CURRENT PROBLEM? PLEASE LIST EXACTLY WHICH DRUGS/ALCOHOL HAVE BEEN USED, AGE AT FIRST USE OF DRUGS AND/OR ALCOHOL, AND MOST RECENT USE OF EACH. _____

_____

_____

_____

_____

IS THERE ANY ADDITIONAL INFORMATION WE MAY NOT HAVE ASKED BUT YOU WOULD LIKE FOR US TO KNOW?

_____

_____

_____

Consent For Release of Information

PLEASE LIST PATIENT'S PRIMARY CARE PHYSICIAN (include name, address, and phone number)

_____

_____

_____

_____

DOES THE PATIENT HAVE A PSYCHOLOGIST OR OTHER MENTAL HEALTH PROFESSIONAL HE/SHE FOLLOWS WITH FOR TREATMENT?
If so, please note name and address and training background (Social Worker, Psychologist, etc., and include phone number if possible):

_____

_____

_____

_____

Please sign a consent for exchange of information with the above listed professionals:

I consent to exchange information between the above listed professionals and Comprehensive Psychiatric Associates.

Signed: _____

Relationship to patient: _____ Date: _____