INTEGRATIVE MEDICAL INSTITUTE

PREVENTATIVE & FAMILY MEDICINE
CLINICAL & NEUROPSYCHOLOGY

Adolescent New Patient Paperwork (Ages 10-17)

This questionnaire is to help us understand your child and his/her life more fully. Your answers will enable us to give you greater help with the problems that brought you to us. We realize some things are harder to remember, and others are personal and even difficult to think or talk about. We will treat the information confidentially and none of it will be released to anyone unless you direct us to do so.

This questionnaire is meant to facilitate our services to you and your child. It is used as a tool, not as a final answer to anything. We will discuss this information with you during your consultation, so you'll have a chance to explain further anything you would like. You might want to check ( ) any items you especially want to discuss. Use extra paper if more space is needed for any questions. Thank you for your help.

Child's: _____ Male: ___ Female: ___ DOB: _____
First name Last name
Height: _____ Weight: _____
School name: _____ Grade: ____ Teacher's name: _____
Previous or referring doctor: _____ Date of Last Development Exam: _____
Mother's/Guardian's name: _____
First name Last name
Father's/Guardian's name: _____
First name Last name
Home phone: _____ Cell phone: _____ Work phone: _____
Street address: _____
City: _____ State: _____ ZIP code: _____
E-mail address: _____ Social Security No.: _____

Referred by: Website Doctor (please give contact information) Other (please explain)
_____
_____
_____

[ ] The email provided will be used for IMI news updates. Check box to opt-out of these emails.

Current Problems

1. What is the #1 concern causing you to seek help now? _____
   _____
2. When did the problem seem to begin? _____
   _____
3. What other changes have you noticed in your child since this problem began?
   _____
   _____
4. What was the recent "last straw" that caused you to call and make an appointment now?
   _____
   _____
5. What are you hoping I can do to help you and your family? _____
   _____
6. What things have you tried to deal with the problem? _____
   _____
   _____
7. Did you seek other professionals for help with this problem? If so, what sort of things did you like / not like about the care they provided? _____
   _____
   _____

Environmental and Family Issues

Please list all of the people living in the house with you and your child:

Name	Age	Relationship

This child has how many total: ___Older siblings ___Older half-siblings
___Younger siblings ___Younger half-siblings

Is this child adopted? Y/N
-If yes, please describe the circumstance of the adoption: _____
_____
_____

Marital Status of Biological Parents:
Biological Father:

Married, to _____, from ____ to ____
Married, to _____, from ____ to ____
Biological Mother:
Married, to _____, from ____ to ____
Married, to _____, from ____ to ____

If Biological Parents are divorced, who is the Managing Conservator?
Joint Mom Dad

How often does the child visit with the other parent? _____

Child Care:
If your child attends any child care/day care please list the following:
Name Length of Attendance
_____
_____

Discipline:
What kind of things do you do to discipline your child (please give examples):
_____
_____
Who does most of the disciplining in the house? _____
Is their disagreement about discipline? If so, please explain: _____
_____

Current Treatment

Please list the name and phone number of any therapist/counselor your child is currently seeing:
_____
Please provide the following for ANY medications (of any kind), vitamins, supplements, your child **is currently taking**:
Name Dose When Started Prescribing Physician
_____
_____
_____

Hobbies / Interests / Friends

What teams, clubs, extra curricular activities, or jobs is your child involved in?
_____
_____
What things does your child do to occupy him/herself around the house?
_____

Who does your child spend time with? _____

Educational History

Current School: _____ Phone Number: _____
Teacher: _____ Grade Level: _____
May I have permission to contact your child's teacher? Y/N
If yes, Signature: _____ Date: _____

Is homework a problem for your child? Y/N
If yes, in what way? _____
Is your child receiving any special services? Y/N
If yes, for what difficulties? _____
When was the last ARD? _____
(please bring a copy of the last ARD and any evaluations that have been done)

List previous schools, dates attended, and overall performance:

Grade	School	Date	Performance
			Poor / Fair / Good
			Poor / Fair / Good
			Poor / Fair / Good
			Poor / Fair / Good

Was your child in any special programs in the past? Y/N
If yes, what kind of program? _____
When did he/she leave the special program? _____

Please list your child's best subject: _____ worst subject: _____
Grades repeated: _____ Grades skipped: _____
If your child has ever been suspended or expelled, please tell me about this: _____
_____

Legal

Is your child involved in a lawsuit? Y/N
If yes, is mental health a factor in the case? Y/N
Have the police ever been called to your home? Y/N
If yes, when and for what reason? _____
Has your child ever been arrested? Y/N
If yes, for what reason? _____
If your child has a probation officer, please list name and phone number:
_____
Has your child ever been involved with CPS (Child Protective Services) or DHS (Department of Human Services)? Y/N

If yes, when and for what reason? _____

Has there ever been a time when you thought your child was being abused? Y/N
If yes, please explain: _____

Mental Health History

Please list any mental health professional (Psychiatrist, Psychologist, Counselor) you have seen for your child/teen in the past:
Professional's Name From…To… Problem or Concern

_____

_____

Please list any psychiatric hospital, residential treatment center, group home, day hospital, foster home, or half way house:
Name From…To… Problem or Concern

_____

_____

The following area asks about previous psychiatric medications. If your child has not taken any psychiatric medications, continue to the next page. If your child has taken medications in the past, the following ***is very important.*** Please try to recall any and all medications for it will be very important in deciding the best care in the future. Please use reverse side if more space is needed.

Drug Name	Dr.'s Name	Start/Stop	Problem	Side Effects

Developmental and Medical History

Pregnancy and Delivery (Mother's Health During Pregnancy)
Did any one of the following conditions occur *during pregnancy or delivery*?
Bleeding No/Yes
Gain>30 pounds No/Yes

Toxemia/ pre-eclampsia	No/Yes
Rh Factor incompatibility	No/Yes
Frequent nausea or vomiting	No/Yes
Serious illness or injury	No/Yes
Took prescription medication	No/Yes; if yes, name: _____
Took illegal drugs	No/Yes
Used alcoholic beverages	No/Yes; if yes, # drinks/week: _____
Smoked cigarettes	No/Yes; if yes, # cigarettes/day: _____
Medication to ease delivery pain	No/Yes; if yes, name: _____
Delivery was induced	No/Yes
Forceps used during delivery	No/Yes
Breech delivery	No/Yes
C-Section (Caesarean Delivery)	No/Yes
Other problems	No/Yes; if yes, describe: _____

Did any of the following conditions affect your child *during delivery or within the first few days after birth*?

Injured during delivery	No/Yes
Heart/Breathing distress during delivery	No/Yes
Delivered with cord around neck	No/Yes
Had trouble breathing after delivery	No/Yes
Needed oxygen	No/Yes
Was cyanotic, turned blue	No/Yes
Was jaundiced, turned yellow	No/Yes
Had an infection	No/Yes
Had seizures	No/Yes
Was given medications	No/Yes
Born with a congenital defect	No/Yes
Was in a hospital>7days	No/Yes

Infant Health and Temperament

During the first 12 months, was your child:

Difficult to feed	No/Yes
Difficult to get to sleep	No/Yes
Colicky	No/Yes
Difficult to put on a schedule	No/Yes
Alert	No/Yes
Cheerful	No/Yes
Affectionate	No/Yes
Sociable	No/Yes
Easy to comfort	No/Yes
Difficult to keep busy	No/Yes
Overactive, in constant motion	No/Yes

Very stubborn, challenging No/Yes

Early Developmental Milestones

Sitting without help	Normal / Fast / Slow / Don't Know
Crawling	Normal / Fast / Slow / Don't Know
Walking alone, without aid	Normal / Fast / Slow / Don't Know
Using single words (mama, dada)	Normal / Fast / Slow / Don't Know
Putting 2 or more words together (mama up)	Normal / Fast / Slow / Don't Know
Bowel training, day and night	Normal / Slow / Not yet
Bladder training, day and night	Normal / Slow / Not yet

Health History

Name of Child's Physician: _____
Date of last physical exam: _____; last visit: _____
Is it all right for me to contact him/her? Y/N

At any time, has your child had the following?

	Never	Past	Now
Surgery			
Hospitalization			
Appetite problems			
Weight loss or gain			
Fever or chills			
Eye or vision problems			
Chronic ear infections			
Speech or language problems			
Hearing problems			
Snoring			
Diarrhea or constipation			
Asthma			
Heart murmur			
High blood pressure			
Irregular heart beat			
Chest pain with exercise			
Fainting while exercising			
Rashes			

Birthmarks			
Hair loss			
Excessive sweating			
Sleeping problems			
Nightmares			
Sleepwalking or talking			
Head banging			
Wetting problems			
Lead poisoning			
Anemia			
Arthritis			
Broken bones			
Severe cuts requiring stitches			
Epilepsy or seizure disorder			
Meningitis / brain infection			
Head injury with loss of conscious			
Clumsiness			
Intolerant of cold or heat			
Diabetes			
Airborne allergies			
Alcohol use			
Drug abuse			
Cigarette smoking			
Medication allergies			

Family History

Many times, medical and emotional problems "*run in the family*." Knowing this can make a difference in what treatment I may recommend for your child. "*The family*" includes: Mom, Dad, brothers, sisters, Aunts, Uncles, and Grandparents. This is a list of some problems that "*run in the family*." Please **circle** any in the family.

ADD/ADHD	**Depression/Bipolar**	**Child abuse**	**Diabetes/Thyroid disease**
Repeating grades	**Suicide attempts**	**Incest**	**Heart disease**
Mental retardation	**Nervous breakdown**	**Eating disorder**	**Death < 50 y/o**
Arrests/Prison	**Alcohol / Drug abuse**	**Obsessive compulsive**	
Not graduate high school	**Schizophrenia**	**Too much worry**	

Please complete the following for your child's family. This will assist me in developing a genogram or family tree.

Biological Father's Family

	First Name	Age *(if deceased, please give age and year of death)*
Biologic Father		
His Father		
His Mother		
Older Brother/Sister		
Older Brother/Sister		
Younger Brother/Sister		
Younger Brother/Sister		
Younger Brother/Sister		

Biological Mother's Family

	First Name	Age *(if deceased, please give age and year of death)*
Biologic Mother		
Her Father		
Her Mother		
Older Brother/Sister		
Older Brother/Sister		
Younger Brother/Sister		
Younger Brother/Sister		
Younger Brother/Sister		

Patient's Brothers and Sisters

	First Name	Age *(if deceased, please give age and year of death)*
Older Brother/Sister		
Older Brother/Sister		
Older Brother/Sister		
Younger Brother/Sister		
Younger Brother/Sister		
Younger Brother/Sister		

If your child was adopted, please list at what age and any information you may know about his/her biologic family.

_____

_____

Names of person(s) completing this questionnaire:

_____ DATE: _____

_____ _____

Relationship to the child

Relationship to the child

Thank you very much for what we know is a big job in completing this questionnaire. Its completion represents an important first step in obtaining the services you are requesting!