**Pediatric Registration Questionnaire for Medication Evaluation**

Date:

**Identification**

**Child's Name:**

**4**

DOB:

Age:

Home address:

Home Phone:

Cell Phone:

Other:

Emergency Contact/Relationship:

Phone:

Legal Guardian/Relationship:

Phone:

**Insurance:**

Responsible Party:

Address: •

Phone:

Relationship to Patient:

Employer:

Insurance Coverage/Plan:

Insurance ID Number:

Group Number:

**Current Providers:**

Medical/Primary Care Provider:

Clinic:

Phone:

Date of last physical:

Home Health Nurse or PCA:

Company:..:

Phone:

Psychologist/Therapist:

Clinic:

Phone:

County Social Worker/Case Manager:

Phone:

Cell/Pager:

Probation Officer:

Phone:

Cell/Pager:

**SOCIAL SECURITY NUMBER: \_nNUNUMNUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NNUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROVIDENCE PSYCHIATRY SERVICES, LTD**

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**Presenting Information:**

1. How were you referred to this clinic for medication evaluation?

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2.

In your initial meeting with your provider, what do you want to accomplish the most?

3.

Does your child have a past psychiatric diagnosis (such as ADHD, depression, etc.)? If yes, please describe.

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4.. Do you know of, or suspect, your child has used or is currently using tobacco, drugs, or alcohol?

5. Has your child had legal problems related to drug or alcohol use, curfew, stealing, fighting, etc? If yes,

please describe:

Please check any of the following concerns:

|  |  |  |
| --- | --- | --- |
| Problem | Yes | Describe |
| Excessive or Inadequate Sleep |  |  |
| Nightmares or Sleepwalking |  |  |
| Bedwetting |  |  |
| Excessive or Inadequate Appetite |  |  |
| Weight Loss or Gain |  |  |
| Excessive Energy |  |  |
| Poor Energy |  |  |
| Low Motivation |  |  |
| Poor Concentration |  |  |
| Irritability |  |  |
| Problems enjoying activities |  |  |
| Physical complaints |  |  |
| Withdrawn/isolative |  |  |
| Crying easily |  |  |
| Low Self-Esteem |  |  |
| Self-Inflicted Injury |  |  |
| Thoughts of Suicide or Suicide Attempt(s) |  |  |
| Depressed mood |  |  |
| Anxiety/Panic |  |  |
| Impulsive Behaviors |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Medication- 3 -ALL Current Medications, including over-the-counter & vitamins:Does patient have any known allergies to medications of any kind? If yes, please list medication and reaction:**Previous Medications:**Please list all past trials of Psychiatric Medications, dose, length of use, and reason for discontinuing:**Family History:**1. Has anyone in the child's biological family been diagnosed or treated for a mental health problem?If yes, please describe:2.Has anyone in the child's family attempted or completed suicide? If yes, please describe: | Dose | Directions | Date/Time ofLast Dose |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

YES

NO

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | Length of Use | Reason for Discontinue |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

**Trauma History:**

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 **Social History:**

Has there been any divorce/separation/remarriage/adoption/foster replacement in the family: If yes,

, Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Living in**

1

Siblings

Step-Parent(s)

Other

**Developmental/Medical History:**

1. Describe any known or suspected prescription medication use, alcohol use, or drug use during

pregnancy:

2.

Were there any complications with labor/delivery or a significant period of bed rest?

3.

Did the child meet all developmental milestones on time, including crawling, walking, speech, and toilet training? If no, please describe:

4.

Has the child ever had speech or occupational therapy?

Does your child have a chronic medical problem (such as diabetes, cancer, seizure disorder,

heart conditions, asthma, or kidney or liver problems):

5.

6.

Has the child ever had surgery? If yes, please describe:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Members** | **Age** | **Sex** | **Occupation** | **Education**(highest level) | **Religion** | **the home?** |
| Mother |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |

YES

NO

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7.

Has the child ever been treated for a head injury, serious accident, or lead poisoning? If yes, please describe:

**School Information:**

Current School:

Grade:

Address/City:

Contact/Title:

Phone:

Fax:

Please describe past and present academic work:

**A**

**A**

Does your child have an IEP/504 Plan (circle):

Has your child ever repeated a grade? If yes, please describe:

Does your child have a learning disability? If yes, please describe:

Does your child have a history of truancy, suspension, expulsion, or detention? If yes, please describe:

YES

NO