Child, Adolescent, Adult
And Family Psychiatry

By Appointment

J. Patrick Ware, M.D.

P.O. Box 871149
Stone Mountain, Georgia 30087
770-806-8323
Fax: 770-806-0658
Web site: www.atlantafamilypsychiatry.com
E-mail: DRJimPat@aol.com

PATIENT/PARENT/GUARDIAN QUESTIONNAIRE

PATIENT: NAME:_____AGE:_____SEX:_____DATE:_____
DATE OF BIRTH:_____SOCIAL SECURITY NUMBER:_____
OCCUPATION:_____EDUCATION YEARS COMPLETED:_____
LEGAL CUSTODIAN: NAME:_____RELATIONSHIP (TO PATIENT):
_____QUESTIONAIRE INFORMANT: _____
RELATIONSHIP: _____ REFERRAL SOURCE: NAME: _____
PHONE:_____ HAS YOUR CHILD UNDERGONE PRIOR EVALUATION(S) FOR ACADEMIC OR OTHER DEVELOPMENTAL CONCERNS?:_____IF SO, PLEASE PROVIDE NAMES OF EXAMINERS AND DATES OF EVALUATION(S): NAME/DATES: _____
_____
HOUSEHOLD FAMILY COMPOSITION (NAME/RELATIONSHIP/AGE):_____
_____
_____
BIOLOGIC PARENTS NAMES: MOTHER: _____ AGE: _____
FATHER: _____ AGE: _____ MARITAL STATUS: _____
DATE OF MARRIAGE: _____ DATE OF DIVORCE: _____
PARENTAL REMARRIAGE DATE: MOTHER: _____ FATHER: _____
AT WHAT PATIENT AGE DID ANYONE FIRST THINK THERE MAY BE PROBLEMS?: _____
WHO THOUGHT SO?: _____ FIRST PROBLEMS NOTED: _____
_____
_____
_____
WHO SUGGESTED THIS EVALUATION?: _____
FOR WHAT PROBLEMS?: _____
_____
_____
_____
PLEASE DESCRIBE/LIST THE CURRENT PROBLEMS AND QUESTIONS: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE INDICATE BY DESCRIPTION THE NATURE/CHARACTER/QUALITY OF THE FOLLOWING: SLEEP: _____ APPETITE: _____
MOODS: _____ PEER RELATIONSHIPS: _____
GRADES: _____ PARTICIPATION IN ORGANIZED PEER ACTIVITIES: _____
WEIGHT CHANGE?: _____ OVERALL PHYSICAL HEALTH: _____
_____
CURRENT MEDICATIONS: _____
_____
PAST MEDICATIONS: _____
_____
HAS THIS PATIENT EVER REQUIRED ONGOING PHYSICIAN/MEDICAL FOLLOWUP?: _____
IF SO, DOCTOR'S NAME/DIAGNOSIS/DATES/TREATMENTS: _____
_____
_____
_____
DOES THIS PATIENT CURRENTLY OR HAS THIS PATIENT EVER HAD PROBLEMS WITH ANY OF THE FOLLOWING (PLEASE INDICATE AGE PROBLEM FIRST APPEARED AND THE LAST AGE THE PROBLEM WAS NOTED): (e.g. : WETTING: AGE 4 YRS/ 7 YRS): WETTING: _____
_____ SOILING: _____
FIREPLAY: _____ SELF INJURIOUS BEHAVIOR: _____
_____
AGGRESSIVE BEHAVIOR TOWARD OTHERS/SELF/ANIMALS: _____
_____
HEAD BANGING: _____ ROCKING: _____
SPINNING: _____ BITING: _____
UNREALISTIC FEARS: _____
EMOTIONAL IMMATURITY: _____
MOOD SWINGS: _____
DOES THIS PATIENT EVER SLEEP WITH OTHER PEOPLE?: _____ IF SO, WITH WHOM: ___
_____
ANY HISTORY OR SUSPICION OF ANY TYPE OF ABUSE OR NEGLECT: _____
(EMOTIONAL/PHYSICAL/SEXUAL): _____
_____
PRIOR OR CURRENT USE OR SUSPICION OF USE OF ALCOHOL, DRUGS, OR TOBACCO?: _____
IF SO, WHAT TYPES AND WHEN: _____
ARE THERE TIMES WHEN THIS PATIENT SHOULD BE AFRAID OF SOMETHING AND IS NOT: (e.g.: HEIGHTS/AUTOMOBILE TRAFFIC/STRANGERS)?: _____
_____
WERE THERE ANY PROBLEMS OF ANY TYPE DURING THE PREGNANCY?: _____
IF SO, WHAT TYPES AND WHEN?:_____
WERE THERE ANY PROBLEMS WITH LABOR AND DELIVERY?: _____
IF SO, WHAT TYPES: _____
DID THIS PATIENT HAVE ANY PROBLEMS IMMEDIATELY FOLLOWING BIRTH?: _____
IF SO, WHAT TYPES?: _____
_____
LENGTH OF PREGNANCY?: _____ DELIVERY: VAGINAL: _____
C-SECTION?: _____ (FOR WHAT REASONS): _____
BIRTH WEIGHT: _____ APGARS: 1 MINUTE: _____ 5 MINUTES: _____
INFANT PRIMARY CARETAKER: _____
FEEDING: BREAST/BOTTLE: (INCLUDE DURATION OF EACH):_____
_____

DURING THIS PATIENT'S FIRST 12 MONTHS, WERE THERE ANY PROBLEMS WITH: SLEEPING?: _____ FEEDING?: _____
DID THIS PATIENT CRY TO BE HELD?: (NEVER/OCCASIONALLY/ALWAYS?):_____
_____
DID THIS PATIENT REQUIRE BEING HELD IN A SPECIAL MANNER?: _____
IF SO, WHAT DID/DID NOT WORK?: _____
_____
PLEASE DESCRIBE THIS PATIENT'S PERSONALITY DURING THE FIRST 12 MONTHS: (BY MOTHER/OTHER OBSERVORS-PLEASE IDENTIFY BY WHOM):_____
_____
_____
_____
DID THIS PATIENT GO THROUGH A PERIOD EARLY ON WHEN IF YOU (PRIMARY CARETAKER) WERE HOLDING THE PATIENT, HE/SHE WOULD BE FINE, HOWEVER IF YOU WOULD HAND THE PATIENT TO ANYONE ELSE, HE/SHE WOULD BECOME FRETFUL, UPSET, AND/OR CRY?: _____ IF SO, AT WHAT AGE?: _____ AT WHAT AGE DID THIS PATIENT FIRST SIT ALONE?: _____ STAND?: _____
WALK ALONE?: _____ USE SINGLE WORDS (OTHER THAN MAMA OR DADA)?: _____ USE SHORT SENTENCES?: _____
DID THIS PATIENT GO THROUGH A PERIOD EARLY ON WHEN YOU (PRIMARY CARETAKER) NOTICED HE/SHE BECAME STUBBORN/HARD HEADED/NEGATIVISTIC/OR OPPOSITIONAL?: _____ IF SO, PLEASE GIVE AGE OF ONSET/RESOLUTION: _____
HOW OLD WAS THIS PATIENT WHEN HE/SHE FIRST SPENT TIME AWAY FROM HOME ON A REGULAR BASIS (e.g.: DAILY/WEEKLY) WITH SOMEONE THAT HE/SHE DID NOT KNOW?: (e.g.: DAY CARE/NURSERY SCHOOL/PRESCHOOL/OR KINDERGARTEN)?: _____
_____
WHAT WERE THE DESCRIPTIONS (ADJECTIVES USED) OF THIS PATIENT GIVEN TO YOU BY THESE CHILD CARE WORKERS?: _____
_____
_____
HAVE YOU OR ANYONE EXPRESSED CONCERN THAT THIS PATIENT MAY HAVE PROBLEMS WITH CONCENTRATION?: _____ IF SO, WHO?: _____
DOES THIS PATIENT HAVE PROBLEMS WITH: SELF ESTEEM?: _____
IMPULSIVE BEHAVIOR?: _____ SENSITIVITY TO SLIGHTS?: _____
KEEPING/MAKING FRIENDS?: _____ FRUSTRATION TOLERANCE?: _____
RESTLESSNESS/DIFFICULTY SITTING STILL?: _____
DIFFICULTY WITH CHANGES?: _____
DIFFICULTY COMPLETING TASKS?: _____
DIFFICULTY WITH ATTENTION?: _____ CONCENTRATION?: _____
BREATH HOLDING?: _____ TEETH GRINDING?: _____
THUMB SUCKING OR OTHER IMMATURE BEHAVIORS?: _____
_____
KNOWN OR SUSPECTED SEXUAL ACTING OUT?: _____
MASTURBATION/INAPPROPRIATE SEXUAL BEHAVIOR?: _____
BEHAVIOR PROBLEMS?: _____
_____
_____
REPETITIVE BEHAVIORS?: _____
LEARNING PROBLEMS?: _____
DIFFICULTY UNDERSTANDING THE DIFFERENCE BETWEEN REAL AND PRETEND?:_____
_____

UNUSUAL OR EXCESSIVE INTEREST IN FANTASY/PRETEND IDEAS?: _____
_____
DIFFICULTY FOLLOWING PARENTAL/ADULT REQUESTS?: _____
STEALING?: _____ LYING?: _____
UNUSUAL PREOCCUPATIONS?: _____
_____
DIFFICULTY IN MAKING OR KEEPING FRIENDS?: _____
PREFERENCE FOR YOUNGER OR OLDER FRIENDS?: _____
MANNER OF RELATING TO FAMILY MEMBERS: PARENTS?: _____
_____
BROTHERS OR SISTERS?: _____
ABSENCE OF REMORSE AFTER WRONG DOING?: _____
KNOWN OR SUSPECTED ALCOHOL/DRUG/OR TOBACCO USE?: _____
_____
SPEECH PROBLEMS?: _____
REPETITIVE SPEECH (WORDS, PHRASES, AND/OR SOUNDS)?: _____
_____
UNUSUAL USE OF WORDS, PHRASES, OR SOUNDS?: _____
_____
LETTER OR NUMBER REVERSALS?: _____
DIFFICULTY WITH PHYSICAL COORDINATION/AKWARDNESS?: _____
_____
UNUSUAL/ADVANCED ABILITIES?: _____
DIFFICULTY WAITING HIS/HER TURN?: _____
DISRUPTING CLASSROOM ACTIVITIES?: _____
DIFFICULTY ORGANIZING TIME/TASKS/OR POSSESSIONS?: _____
_____
IMPULSIVE BEHAVIORS?: _____
ABSENCE OF CONCERN FOR CONSEQUENCES FOR BEHAVIORS?: _____
ABSENCE OF AWARENESS FOR HIS/HER/OTHER'S SAFETY?: _____
DESTRUCTION OF HIS/HER OR OTHER'S PROPERTY?: _____
THREATS OF OR ACTUAL RUNAWAY BEHAVIOR?: _____
DOES THIS PATIENT EVER SPEND TIME WITH PEOPLE/PEERS NOT APPROVED BY
PARENT/GUARDIAN?: _____
DOES THIS PATIENT EVER REFUSE TO COOPERATE WITH PARENTS/ADULTS?: _____
_____
PROBLEMS SKIPPING CLASS OR SCHOOL?: _____
PROBLEMS WITH SCHOOL SUSPENSION OR EXPULSION?: _____
ANY PRIOR OR CURRENT INVOLVEMENT WITH JUVENILE COURT?: _____
IF SO, LIST AGES(S)/DATES/WHAT COURT ACTION?: _____
_____
_____
IS THIS PATIENT CURRENTLY UNDER JUVENILE COURT PROBATION/SUPERVISION?: _____
DATES/LENGTH OF PROBATION?: _____
PROBATION OFFICER'S NAME/COUNTY OF COURT?: _____
_____
PROBATION OFFICER'S CONTACT PHONE NUMBER?: _____
FIGHTING?: _____ USE OF A WEAPON IN FIGHTING?: _____
IF SO, WHAT WEAPONS?: _____
INITIATES FIGHTS?: _____ DIFFICULTY STANDING UP FOR SELF?: _____
ARGUES WITH ADULTS/AUTHORITY FIGURES?: _____

PHYSICAL AGGRESSION TOWARD OTHERS/ADULTS?: _____
PROBLEMS WITH AVOIDING OR MANIPULATING RULES?: _____
PROBLEMS WITH AWARENESS OR REGARD FOR OTHER'S FEELINGS?: _____
_____
BLAMING OF OTHERS FOR HIS/HER MISTAKES?: _____
UNNECESSARY WORRY ABOUT PARENT/OTHERS SAFETY OR WELLBEING?: _____
_____
UNUSUAL INTEREST IN DEATH OR DYING?: _____
STATEMENTS ABOUT/CONCERNING SUICIDE?: _____
STATEMENTS ABOUT/CONCERNING HOMICIDE?: _____
REFUSAL TO ATTEND SCHOOL?: _____
REFUSAL TO GO TO SLEEP WITHOUT SOMEONE NEARBY?: _____
REFUSAL/RESISTANCE IN SPENDING A NIGHT AWAY FROM HOME?: _____
AVOIDANCE OF BEING ALONE?: _____
NIGHTMARES?: _____
UNUSUAL INTEREST IN PARENT/ADULT ISSUES (e.g.: PARENT FINANCES, PHYSICAL HEALTH, OR MARITAL ISSUES)?: _____
UNUSUAL SELF-CONSCIOUSNESS?: _____
UNUSUAL NEED FOR REASSURANCE?: _____
UNUSUAL INTEREST/CONCERN ABOUT: PATIENT'S OWN BOD Y SIZE?: _____
WEIGHT GAIN/LOSS?: _____
SUSPECTED/KNOWN BINGE EATING?: _____
SELF INDUCED VOMITING?: _____
PRIOR WEIGHT CHANGE?: _____
PATIENT'S USE OF STRICT DIETING?: _____
PATIENT'S USE OF LAXATIVES?: _____ _____
PATIENT'S USE OF DIURETICS/WATER PILLS?: _____
FAILURE TO GAIN WEIGHT/GROW AS EXPECTED?: _____
UNUSUAL CONCERN ABOUT BEING MALE OR FEMALE?: _____
EXPRESSED DESIRE TO BE THE OPPOSITE SEX?: _____
OBSERVED CHARACTERISTICS MORE COMMON TO THE OPPOSITE SEX?: _____
_____
WEARING OF CLOTHING MORE CHARACTERISTIC OF THE OPPOSITE SEX?: _____
_____
PURSUIT OF INTERESTS MORE CHARACTERISTIC OF THE OPPOSITE SEX?: _____
_____
PUBERTY ONSET: FEMALES: FIRST PERIOD: (AGE):_____ LAST PERIOD?: (AGE):_____
BREAST ENLARGEMENT?: (AGE):_____ AXILLARY HAIR (AGE)?: _____
GROWTH SPURT?: (AGE): _____ MALES: (AXILLARY HAIR/GROWTH SPURT/ FACIAL HAIR)?: _____
PRESENCE OF SPEECH/MOTOR OR OTHER TICS?: _____
_____
STUTTERING?: _____ REFUSAL TO SPEAK?: _____
RAMBLING OR INCOHERENT SPEECH?: _____
PROBLEMS WITH MEMORY?: _____
BELIEF IN UNREALISTIC IDEAS?: _____
REPORTS OF SEEING OR HEARING IMAGINARY THINGS?: _____
_____
REPORTS OF/OBSERVATIONS OF DEPRESSION OR SADNESS?: _____
_____
OBSERVED OR REPORTED MOOD SWINGS?: _____
_____

WITHDRAWAL OR ISOLATION FROM OTHER PEOPLE?: _____
_____
PROBLEMS WITH KNOWING HIS/HER NAME?: _____ DATE/AGE?: _____
PROBLEMS WITH KNOWING HIS/HER GEOGRAPHIC LOCATION?: _____
PARENT/GUARDIAN'S ESTIMATE OF PATIENT'S INTELLECTUAL ABILITY?: _____
_____
WHAT PERCENTAGE OF THIS PATIENT'S INTELLECTUAL ABILITY IS THIS PATIENT USING?:
OVERALL?: _____ IN SCHOOL?: _____ AT HOME?: _____
AT PLAY OR WITH PEERS/FRIENDS?: _____ IF THIS PATIENT IS NOT PERFORMING
UP TO THEIR ABILITY, WHAT DOES THIS PATIENT NEED TO DO TO IMPROVE?: _____
_____
_____
_____
_____
HAS THIS PATIENT HAD UNREALISTIC FEARS?: _____ IF SO, PLEASE LIST: _____
_____
_____
HAS THIS PATIENT HAD PROBLEMS SHARING?: _____
DOES THIS PATIENT EXHIBIT PROBLEMS WITH: UNUSUAL COMPETITIVENESS: _____
JEALOUSY?: _____ IF SO, PLEASE DESCRIBE THE TYPE OF SITUATION OR
SETTING THESE ATTITUDES ARE OBSERVED?: _____
_____
_____
REPORTS OF/OBSERVATIONS OF FATIGUE?: _____
REPORTS OF/OBSERVATIONS OF POOR SELF ESTEEM?: _____
_____
_____
POOR IMPULSE CONTROL?: _____
REPORTS OF/OBSERVATIONS OF FEELINGS OF WORTHLESSNESS?: _____
REPORTS OF/OBSERVATIONS OF UNUSUAL FEELINGS OF GUILT?: _____
_____
REPORTS OF/OBSERVATIONS OF NERVOUSNESS OR ANXIETY?: _____
_____
DO EVENTS OR CIRCUMSTANCES SEEM TO MARKEDLY ALTER THIS PATIENT'S MOOD?: __
_____
_____
_____
DOES THIS PATIENT HAVE PERIODS OF EASY IRRITABILITY?: _____
IF SO, DESCRIBE STRESSES AND QUALITY OF MOODS PRODUCED?: _____
_____
_____
HAS THIS PATIENT DESCRIBED RECURRENT OR PERSISTENT UNUSUAL THOUGHTS?: _____
IF SO, PLEASE DESCRIBE: _____
_____
PLEASE LIST BY TYPE AND DATE ANY UNUSUAL LIFE STRESSES THIS PATIENT HAS
EXPERIENCED (e.g.: DEATH OF A PARENT, AGE 6): _____
_____
_____
_____
_____
DIFFICULTY FALLING/STAYING ASLEEP?: _____
EARLY MORNING AWAKENING?: _____

DOES THIS PATIENT RESIST: GOING TO BED?: _____ SLEEPING ALONE?: _____
IF SO, PLEASE DESCRIBE WHAT CIRCUMSTANCES ARE NECESSARY FOR THE PATIENT TO GO TO SLEEP?: _____
_____
DOES THIS PATIENT RESIST OR COOPERATE WITH MEDICATION WHEN PRESCRIBED?: ____
_____
HAS THIS PATIENT HAD AN IMAGINARY FRIEND?: _____ IF SO, AT WHAT AGE & FOR HOW LONG?: _____
WHAT ARE THIS PATIENT'S FAVORITE GAMES/ACTIVITIES?: _____ ____
_____
_____
DOES THIS PATIENT PRETEND TO BE IMAGINARY OR OTHER PEOPLE?: _____
IF SO, PLEASE DESCRIBE:?_____
_____
HAS THIS PATIENT EVER DESCRIBED UNUSUAL EXPERIENCES?: _____ IF SO, PLEASE DESCRIBE: _____
_____
_____
DOES THIS PATIENT EVER DO OR SAY THINGS WHICH THE PARENT OR GUARDIAN DOES NOT UNDERSTAND OR THAT DOES NOT MAKE SENSE?: _____ IF SO, PLEASE DESCRIBE:
_____
_____
_____
_____
HAS THIS PATIENT EVER SLEEP WALKED?: _____ IF SO, PLEASE DESCRIBE THE NATURE AND AGE(S): _____
_____
HAS THIS PATIENT EVER ATTEMPTED TO KILL HIS/HER SELF?: _____IF SO, PLEASE LIST AND DESCRIBE EACH EVENT AND AGE(S): _____
_____
_____
HAS THIS PATIENT EVER DESCRIBED THOUGHTS OR PLANS OF HOW HE/SHE MIGHT TRY TO HURT THEMSELVES OR OTHERS?: _____ IF SO, PLEASE DESCRIBE IN DETAIL EACH PLAN AND THE PATIENT'S AGE(S): _____ _____
_____
_____
_____
DOES THIS PATIENT HAVE PROBLEMS WITH ATTENTION SEEKING BEHAVIORS?: _____
IF SO, PLEASE DESCRIBE: _____
_____
_____
_____
_____
HAS THIS PATIENT EXHIBITED OVER CONCERN FOR HIS/HER PHYSICAL ATTRACTIVENESS?: _____ IF SO, PLEASE DESCRIBE: _____
_____
_____
HAS THIS PATIENT EVER DESCRIBED/REPORTED THAT ANOTHER PERSON HAS TOUCHED THEM IN THEIR PRIVATES OR IN A WAY THAT MADE THEM UNCOMFORTABLE?: _____
IF SO, PLEASE DESCRIBE EVENTS AND PATIENT'S AGE(S): _____
_____
_____
_____

HAS THIS PATIENT EXPRESSED UNUSUAL INTEREST OR CONCERN IN HIS/HER OWN PHYSICAL WELLBEING OR SAFETY (e.g.: FEAR OF DYING OR GETTING AN INCURABLE ILLNESS)?: _____ IF SO, PLEASE DESCRIBE CONCERNS AND PATIENT'S AGE(S):
_____
_____
_____

HAS THIS PATIENT EVER BEEN TREATED FOR VENEREAL DISEASE?: _____ IF SO, PLEASE DESCRIBE WITH AGE(S): _____
_____

HAS THIS PATIENT EVER BEEN KNOW OR SUSPECTED TO PARTICIPATE IN PROSTITUTION?: _____ IF SO, PLEASE DESCRIBE WITH AGE(S): _____
_____

HAS THIS PATIENT EVER EXHIBITED DIFFICULTY WITH BEING PERFECTIONISTIC?: _____ IF SO, PLEASE DESCRIBE AND GIVE AGE(S): _____
_____

PLEASE DESCRIBE IN DETAIL A TYPICAL SCHOOL AND WEEKEND DAY FROM MORNING AWAKENING TO BEDTIME: SCHOOL DAY: _____
_____
_____
_____
_____

WEEKEND DAY: _____
_____
_____
_____

NATURAL/BIOLOGIC PARENT INFORMATION: MOTHER: NAME: _____
_____ AGE: _____ MARITAL STATUS: _____
LAST YEAR OF FORMAL EDUCATION COMPLETED: _____
PROFESSION/VOCATION: _____
NUMBER OF CHILDREN (INCLUDING AGES): _____
_____
_____
_____

FATHER: NAME: _____ AGE: _____
MARITAL STATUS: _____ LAST YEAR OF FORMAL EDUCATION COMPLETED: _____ PROFESSION/VOCATION: _____
_____

NUMBER OF CHILDREN (INCLUDING AGES): _____
_____
_____

GUARDIAN/STEP-PARENT INFORMATION: NAME: _____
AGE: _____ MARITAL STATUS: _____ LAST YEAR OF FORMAL EDUCATION COMPLETED: _____ PROFESSION/VOCATION: _____
_____

NUMBER OF CHILDREN (INCLUDE AGES): _____
_____
_____

PLEASE LIST ANY KNOWN FAMILY HISTORY OF EMOTIONAL PROBLEMS: (INCLUDE FAMILY MEMBERS RELATIONSHIP TO PATIENT, AGE, NATURE OF ILLNESS AND ANY TREATMENT WHICH WAS REQUIRED): _____
_____(CONT'D)

_____
_____
_____
_____

PLEASE LIST ANY KNOWN FAMILY HISTORY OF PHYSICAL/MEDICAL PROBLEMS: (INCLUDE FAMILY MEMBERS RELATIONSHIP TO PATIENT, AGE, NATURE OF ILLNESS AND ANY TREATMEN WHICH WAS REQUIRED): _____
_____
_____
_____
_____
_____

HAS ANY MEMBER OF THE FAMILY EVER BEEN INCARCERATED?: _____ IF SO, PLEASE INDICATE WHICH FAMILY MEMBER AND THE NATURE, REASON (INCLUDING TOTAL LENGTH OF INCARCERATION) FOR THE INCARCERATION: _____
_____
_____
_____

PLEASE LIST ANY PRIOR MEDICATIONS THIS PATIENT HAS TAKEN INCLUDING ANY SIDE EFFECTS/REACTIONS: _____
_____
_____
_____
_____

IS THIS PATIENT CURRENTLY UNDER THE CARE OF A PEDIATRICIAN OR FAMILY PHYSICIAN?: _____ IF SO, PLEASE PROVIDE THE PHYSICIAN'S NAME: _____
_____

PHONE: _____ PLEASE LIST ANY MEDICAL PROBLEMS FOR WHICH THIS PATIENT IS CURRENTLY BEING TREATED: _____
_____
_____
_____

PLEASE LIST ANY PRIOR HOSPITALIZATIONS THIS PATIENT HAS REQUIRED INCLUDING THE NATURE OF THE PROBLEM AND AGE(S): _____
_____
_____
_____

PLEASE LIST ANY PRIOR SURGERY THIS PATIENT HAS REQUIRED INCLUDING TYPE/ REASON FOR SURGERY AND PATIENT'S AGE(S): _____
_____
_____
_____
_____

PLEASE LIST ANY ILLNESSES FOR WHICH OTHER FAMILY MEMBERS ARE CURRENTLY BEING TREATED (INCLUDING TYPE OF TREATMENT AND/OR MEDICATIONS): _____
_____
_____
_____
_____
_____

PLEASE LIST ANY HOSPITALIZATIONS/SURGERIES THAT OTHER FAMILY MEMBERS HAVE REQUIRED BY FAMILY MEMBER, NATURE OF ILLNESS AND/OR SURGERY AND AGE(S): ____

(CONT'D):_____
_____
_____
_____
_____
_____

PLEASE LIST ANY CURRENT MEDICATIONS THIS PATIENT IS TAKING INCLUDING DOSEAGE(S): _____
_____
_____
_____
_____
_____

HAS THIS PATIENT EVER HAD (PLEASE GIVE AGE)?: MUMPS: _____
MEASELS: _____ CHICKEN POX: _____ POLIO: _____
WHOOPING COUGH: _____ HEPATITIS: _____
HIGH FEVERS: _____ SEIZURES: _____
HEADACHES: _____ DIZZINESS: _____
LOSS OF CONSCIOUSNESS: _____ HEAD TRAUMA: _____
BLURRED VISION: _____ MENINGITIS: _____
BIRTH DEFECT: _____ RECURRENT EAR INFECTIONS: _____
EAR TUBES: _____ RECURRENT SORE THROATS, SINUSITIS, UPPER RESPIRATORY INFECTIONS, STREP THROAT, BRONCHITIS, OR ASTHMATIC ATTACKS? ____
IF SO, PLEASE INDICATE SPECIFIC ILLNESSES AND AGE(S): _____
_____
_____
_____
_____
_____

THYROID PROBLEMS?: _____ ALLERGIES?: _____
HEART MURMUR?: _____ OTHER HEART PROBLEMS (PLEASE DESCRIBE):_____
_____
_____

RECURRENT ABDOMINAL PAIN?: _____
DIARRHEA?: _____ CONSTIPATION?: _____
BLOODY STOOLS?: _____ VOMITING?: _____
FOOD INTOLERANCE?: _____ SPECIAL DIETARY REQUIREMENTS?: _
_____
_____

URINARY TRACT INFECTIONS?: _____
SUSPECTED/KNOWN SEXUAL ACTIVITY?: _____
USE OF BIRTH CONTROL?: _____
FEMALES?: LAST MENSTRUAL PERIOD?: _____ REGULAR?: _____
CYCLIC LENGTH?: _____ PREVIOUS FRACTURES (PLEASE GIVE BONE, PATIENT AGE(S), AND TYPE OF TREATMENT REQUIRED: _____
_____
_____

SKIN PROBLEMS?: _____
BLEEDING/BLOOD PROBLEMS?: _____
HAS ANYONE IN THIS PATIENT'S FAMILY EVER HAD: NERVE PROBLEMS?: _____
(CONT'D)

SEIZURES: _____ BLOOD/BLEEDING PROBLEMS: _____
THYROID PROBLEMS: _____ HIGH BLOOD PRESSURE: _____
DIABETES: _____ HIGH/ABNORMAL CHOLESTEROL: _____
OR TRIGLYCERIDES: _____ CYSTIC FIBROSIS: _____
KIDNEY DISEASE: _____ ASTHMA: _____
ALLERGY: _____ HEART DISEASE: _____
BIRTH DEFECTS: _____ CANCER: _____
OTHER: _____ IS THIS PATIENT RIGHT/LEFT HANDED: _____
PHYSICAL COMPLAINTS: _____
HEARING PROBLEMS: _____
VISION PROBLEMS: _____
WHEN WAS THIS PATIENT'S LAST PHYSICAL EXAM?: _____
NAME OF PHYSICIAN?: _____ PHONE: _____
WHEN WAS THIS PATIENT'S LAST EVALUATION OF: HEARING?: ___ _____
VISION?: _____ PLEASE LIST ANY KNOWN PATIENT ALLERGIES (INCLUDE MEDICATIONS): _____
_____
_____
DATE/TYPE OF PATIENT'S LAST IMMUNIZATIONS(S):
_____
_____
_____
_____
ARE THIS PATIENT'S IMM UNIZATIONS CURRENT?: _____ (PLEASE PROVIDE A COPY OF THIS PATIENT'S IMMUNIZATION RECORD)
PLEASE LIST ANY CONCERNS NOT ADDRESSED IN THIS QUESTIONNAIRE: _____
_____
_____
_____
_____
_____
_____
_____
_____
PLEASE LIST DISCIPLINE TECHNIQUES THAT "WORK": _____
_____
_____
PLEASE LIST DISCIPLINE TECHNIQUES THAT "DO NOT WORK": _____
_____

THIS QUESTIONNAIRE WAS COMPLETED BY: _____
RELATIONSHIP TO PATIENT:_____

_____
SIGNATURE

_____
PLEASE PRINT/TYPE NAME

_____
DATE