Columbus Childrens Behavioral Health Clinic

Please complete the following information prior to your child's first appointment with Dr. Collin Dean, PsyD.

PATIENT INFORMATION

Patient Name:_____

Nickname:_____

Date of Birth: ___/___/___ Age: _____

Sex: Male Female

Email Address:_____

Home Address:_____

_____

Phone: _____

Cell Phone/Work Phone: _____

Ethnicity (circle all that apply): African-American Asian-American Hispanic Native American White/Caucasian Other:_____

Religious preference: _____

REFERRAL INFORMATION

Patient's Physician_____ Who referred patient to the clinic_____

Is it okay to have reports mailed to the Physician? Yes No Unsure

Reason for Referral / Primary Concerns: _____

_____

FAMILY INFORMATION / PATIENT BACKGROUND INFORMATION

Biological parents are: Married _____ Divorced _____ Separated _____ Never Married
Date Date Date

Patient resides with: Mother
Biological Adoptive Foster Step Other _____

Father
Biological Adoptive Foster Step Other _____

Mother's Name _____
(circle one) Biological Adoptive Step Foster/Guardian

Age _____ Occupation _____

Employer _____

Work Schedule _____

Father's Name _____
(circle one) Biological Adoptive Step Foster/Guardian

Age _____ Occupation _____

Employer _____

Work Schedule _____

Other Members of the Household (for example, siblings, step-siblings, foster children):

Name	*Age*	*Sex*	*Relationship to patient*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Regularly Involved Adults (for example, grandparents, non-custodial parents/step-parents):

Name	*How often*	*Relationship to patient*
_____	_____	_____
_____	_____	_____

Please list previous residences (city & state) and length of time lived there:

_____

Any problems/stressors in the family in the last year? (for example, death in the family, move, parental/marital conflict, financial stressors, accidents/traumatic events) _____

MEDICAL / DEVELOPMENTAL INFORMATION (please circle answers)

Were there any problems with pregnancy or delivery? NO YES, explain: _____

Were there any concerns with drug/alcohol abuse, cigarette use, high blood pressure during pregnancy? NO YES

What is your general impression of your child's infant development? GOOD FAIR POOR

Note the month in which your child achieved the following activities:

Sat alone _____ Crawled _____ Walked _____ Fed Self _____ Spoke Words _____ Toilet Trained _____

(Normal development: Sit 6-8 mos; Crawl 9 mos; Walk 12-18 mos; Feed 10-12 mos; Speak 10 mos; Toilet 24-36 mos)

Any problems with the patient's vision?	NORMAL	ABNORMAL	CORRECTED
Any problems with the patient's hearing?	NORMAL	ABNORMAL	CORRECTED
Any problems with the patient's speech?	NORMAL	ABNORMAL	CORRECTED
Any problems with the patient's motor skills?	NORMAL	ABNORMAL	CORRECTED

Circle all conditions in which this child has had or currently has:

ALLERGIES ASTHMA CANCER DIABETES GENETIC CONDITION SEIZURES

Other medical conditions/health concerns: _____

Current Medications

Medication Name	*Dosage*	*Purpose*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the patient ever received medications, counseling/psychotherapy for behavioral/emotional concerns? NO YES

If yes, describe problems, medications, therapist, and dates: _____

Family Health History

Has either parent or other family members received medication, counseling/psychotherapy? NO YES

Has anyone in the patient's family (including parents, siblings, grandparents, uncles, aunts) ever been diagnosed with any of the following problems? (circle all that apply)

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD) LEARNING PROBLEMS DEPRESSION

ANXIETY MANIC DEPRESSION/ BIPOLAR ALCHOHOL/ DRUG ABUSE SCHIZOPHRENIA

OBSESSIVE- COMPULSIVE DISORDER (OCD) NONE OTHER: _____

SCHOOL INFORMATION

Child attends daycare? NO YES (name of daycare/child care provider) _____

Child attends school? NO YES (grade) _____ (If summer, what grade will child be entering).

School _____ Teacher's Name _____

Child's current grades are: _____ Grades last semester were: _____

Has the patient ever been suspended, expelled, or retained in a grade? NO YES (when)_____

Have you had special conferences or extra meetings with teachers or school administrators for your child's behavior or learning problems? NO YES (when) _____

Has the patient ever had an IEP, 504 Plan, or other Special Education Services? NO YES

(for example, learning disability, behavioral/emotional disorder class, speech/language services, resource room)

BEHAVIORAL HEALTH INFORMATION

Describe the best things about your child? _____

_____

List the clubs/groups and favorite activities of your child: _____

_____

Does your child have a bedtime routine? NO YES

What time does your child typically go to bed? _____ What time does he/she typically fall asleep? _____

What time does he/she wake up in the morning? _____ Does the patient snore loudly? NO YES

Does the patient typically wake up in the middle of the night? NO YES

Does the patient typically take a nap each day? NO YES (how long) _____

Which of the following <u>have recently been</u> or <u>currently are</u> problems with your child?

	Never	Some	Often	Always		Never	Some	Often	Always
Won't mind	_____	_____	_____	_____	Suicidal thoughts	_____	_____	_____	_____
Too active	_____	_____	_____	_____	Nervous	_____	_____	_____	_____
Anger/Temper	_____	_____	_____	_____	Cries a lot	_____	_____	_____	_____
Clumsy	_____	_____	_____	_____	Harms self	_____	_____	_____	_____
Destructive	_____	_____	_____	_____	Very shy	_____	_____	_____	_____
Easily upset	_____	_____	_____	_____	Clings to parent(s)	_____	_____	_____	_____
Toileting problems	_____	_____	_____	_____	Nightmares	_____	_____	_____	_____
Impulsive	_____	_____	_____	_____	Aggressive to others	_____	_____	_____	_____

What concerns you most about your child? _____

_____

Please provide any other information you would like to discuss during your child's upcoming appointment.

_____

Has your child been the a victim of any physical, emotional or sexual abuse?_____

_____