

Please return to:
SCH Psychiatry Clinic,
PO Box 5371, W3636
Seattle, WA 98105-0371

SEATTLE CHILDREN'S HOSPITAL
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL MEDICINE

PATIENT AND FAMILY INFORMATION FORM FOR AGES 0-5

IDENTIFYING INFORMATION

Child's Name: _____ Date Completed: _____
 Person answering questions: _____ DOB: _____
 Relationship: _____

REASONS FOR EVALUATION

Who referred you to Children's Hospital? _____
 What are your primary concerns about your child? _____

At what approximate age did your child start having this problem? _____
 When it first started, was the problem the same or different than it is now? _____

Where does this problem primarily occur (check all that apply)? home school daycare public settings

What services are you interested in receiving at our clinic (please check all that apply)?
 Evaluation Only Medication Therapy Comments: _____

What specific questions would you like answered by this evaluation?
 1. _____
 2. _____

PATIENT PSYCHIATRIC/ MEDICATION TREATMENT HISTORY

Patient Psychiatric Treatment History: no prior treatment

Please list all mental health services (inpatient or outpatient) that your child is receiving now or has received in the past:

Provider name and type (MD, PhD, Counselor)	Approximate Dates	Results of treatment	Status in treatment
			<input type="checkbox"/> Past <input type="checkbox"/> Current
			<input type="checkbox"/> Past <input type="checkbox"/> Current
			<input type="checkbox"/> Past <input type="checkbox"/> Current

Psychiatric Medication History: None reported

Name of medication	Status of medication	Prescribing provider	Results (including side effects)
	<input type="checkbox"/> Past <input type="checkbox"/> Current		
	<input type="checkbox"/> Past <input type="checkbox"/> Current		

CHILD'S MEDICAL/PHYSICAL HISTORY

Who is the child's primary doctor? _____ Phone #: _____

Who is the child's primary dentist? _____ Phone #: _____

When was your child last seen by a physician? _____

For what reason? _____

Any serious, acute, and/or chronic illness now (or in past)? Yes No

Details: _____

Has your child had any history of medical hospitalizations or surgeries? Yes No

Details: _____

Is your child having any sleep problems (e.g. too much/too little)? Yes No

Details: _____

Does your child snore or have sleep disordered breathing? Yes No

Details: _____

Has child had any history of seizures, head injury, concussion, serious injuries, or loss of consciousness Yes No

Details: _____

Have you started toilet training? Yes No Please describe any toilet training concerns: _____

Do you have any concerns about gender-inappropriate behavior? Yes No If yes, explain: _____

Does your child have any pain issues or concerns? Yes No

Details: _____

Is your child currently taking any non-psychiatric medication (including homeopathic, naturopathic, or alternative medicines) for physical health conditions? Yes No If yes, please provide information below.

Name of medication	Prescribing provider	Results (including side effects)

BIRTH AND EARLY INFANCY HISTORY

No information available about biological parents' history

The following information should be provided as it relates to the biological parents of the child, if known.

Was the pregnancy planned? Yes No Unknown

How many pregnancies did the biological mother have? _____

How many prior liveborn children did the biological mother have? _____

Did the biological mother receive any prenatal care? Yes Limited None Unknown

Was the mother exposed to any of the following while pregnant: None Unknown

TYPE	LIST SPECIFIC SUBSTANCES	AMOUNT	BEFORE PREGNANCY	DURING MONTH(S) OF PREGNANCY
DRUGS			<input type="checkbox"/> Yes <input type="checkbox"/> No	
ALCOHOL			<input type="checkbox"/> Yes <input type="checkbox"/> No	
TOBACCO			<input type="checkbox"/> Yes <input type="checkbox"/> No	
MEDICATIONS			<input type="checkbox"/> Yes <input type="checkbox"/> No	
X-RAYS			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Did the mother experience any significant illnesses during pregnancy? Yes No Unknown

Details: _____

Length of pregnancy: _____ (wks) Child's birth weight: _____ Age of mother: _____

Were there any labor or delivery problems? Yes No Unknown

Details: _____

Were there any problems while the baby was still in the hospital? Yes No Unknown

Jaundice Need for incubator/oxygen infection feeding problems convulsions

Other: _____

Was the child in Neonatal Intensive Care Unit? Yes No

Were there any difficulties during the baby's infancy? Yes No Unknown

attachment problems excessive crying health problems recurrent vomiting colic

feeding problems low weight gain Other: _____

Did parents have trouble adjusting to the new baby (e.g. post partum depression, anxiety)? _____

How would you describe this child's temperament? _____

DEVELOPMENTAL HISTORY

Has your child had formal developmental testing or received any early intervention services? Yes No

Details: _____

Has your child received any Headstart or other early intervention services? Yes No Details: _____

At what age (in months) did your child first perform the following skills:

- Smile at parent _____ months Not yet doing this unknown
- Play peek-a-boo _____ months Not yet doing this unknown
- Point to show something _____ months Not yet doing this unknown
- Make good eye contact _____ months Not yet doing this unknown
- Sit alone _____ months Not yet doing this unknown
- Crawl _____ months Not yet doing this unknown
- Stand alone _____ months Not yet doing this unknown
- Walk with assistance _____ months Not yet doing this unknown
- Walk alone _____ months Not yet doing this unknown
- Make consonant-vowel sound (e.g. "ba-ba") _____ months Not yet doing this unknown
- Use simple command such as "no" _____ months Not yet doing this unknown
- Speak 2 to 3 word phrases _____ months Not yet doing this unknown
- Speak full sentences _____ months Not yet doing this unknown
- Drink from a cup _____ months Not yet doing this unknown
- Eat with utensils _____ months Not yet doing this unknown
- Respond to his/her name _____ months Not yet doing this unknown
- Understand names of objects _____ months Not yet doing this unknown
- Obey verbal commands (e.g. "come here") _____ months Not yet doing this unknown
- Get dressed by him/herself _____ months Not yet doing this unknown
- Tie shoelaces _____ months Not yet doing this unknown
- Ride a 2-wheeled bike without training wheels _____ months Not yet doing this unknown
- Daytime toilet trained (bladder) _____ months Not yet doing this unknown
- Daytime toilet trained (bowel) _____ months Not yet doing this unknown
- Nighttime toilet trained (bladder) _____ months Not yet doing this unknown
- Nighttime toilet trained (bowel) _____ months Not yet doing this unknown

Does your child have a predictable sleep schedule? Yes No

For children ages 2 and older: Usual bedtime _____ Usual wake time _____

Describe any sleep concerns: _____

Describe sleeping arrangements in the family: _____

CHILD AND FAMILY SOCIAL-BEHAVIORAL HISTORY

My child currently lives with: home with biological or adoptive family or relative foster care
 group care setting residential treatment facility other; if so, where _____

With whom does this child live currently (list all adult and child members of household):

Name	Gender	Age	Relationship
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		

Does your child have thoughts of harming him/herself or other people? Yes No

Details: _____

...

Has your child been experienced any of the following: exposure to domestic violence exposure to other violence or traumatic death death of parent/psychological parent none of these experiences

Details: _____

...

Has child had history of physical abuse sexual abuse persistent inadequate parenting or neglect?

If yes, has abuse/neglect been documented by CPS/Legal System? Yes No

Details: _____

Does your child participate in any community activities (e.g. sports, boys & girls, church)? Yes No

If yes, please list the activities/groups: _____

Please describe forms of discipline which have been used in the home and their effectiveness: _____

Please list those qualities about your child that you consider to be strong positive points. _____

Does your child have any attachment difficulties with a history of disrupted parenting before age 5? Yes No

Details: _____

FAMILY MEDICAL HISTORY

Information about family medical history can be very helpful in understanding current emotional and behavioral issues for children seen in our clinic. Please indicate if anyone in your family has the following conditions. Check all that apply, past or present:

Condition/Circumstance	Child	Mother	Father	Sibling	Mother's Family	Father's Family
Intellectual Disability						
Learning Disorder						
Attention Deficit						
Hyperactivity						
Seizures/Epilepsy						
Other Neurological Disorders						
Alcohol Abuse						
Drug Abuse						
Physical/Emotional Abuse						
Sexual Abuse						
Depression						
Bipolar Disorder						
Suicide Attempts						
Anxiety Disorders						
Specific Fears or Phobias						
Obsessive-Compulsive Disorder						
Panic Attacks						
Schizophrenia or Psychosis						
Visual Disability/Problems						
Deaf/Hard of Hearing						
Tics/Tourette's Syndrome						
Chronic or Serious Medical Illnesses (e.g. Cancer , Asthma, Diabetes, Heart Disease)						
Juvenile Delinquency						
Arrests/Incarceration						
Harassment by peers						
Homelessness						
Teen pregnancy						
School suspension/expulsion						
Special Education						
Birth Defects						
Miscarriages						

