Date of Appointment: ______________

Children's Behavioral Health
Patient Information Form

This form is to be completed by the parent/legal guardian of the child to be seen at Children's Behavioral Health. If you have questions about any part of this form, please call 205-638-9193.

This form completed by ____ on this date __________________

____

Name(s) of legal guardian(s) **(write on above line)** Relationship to patient

____

Street address City State Zip County

(____)_________________(____)____________________(____)_________________(____)________________

Home phone Cell phone Work phone Other phone

____(___)_________________________________

Name of emergency contact other than immediate family Phone Relationship to patient

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____

Child/Patient name Goes by Date of birth Patient age

Sex: ☐Male ☐ Female Race: ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Biracial ☐ Other _________

____

Address (if different from legal guardian) City State Zip County

____

Insurance

____(____)_____________

Name of person/Doctor/Therapist outside of CBH who referred you for treatment Phone

Please provide information about your reasons for seeking treatment: You may use the back of this form for additional space.

Patient's Problems as You See Them (please do not leave blank)	**When did Problem Begin**
Example: *My child is aggressive and gets into fights about weekly at school. He has been suspended 4 times for fighting at school this year.*	*Two years ago*
1.	
2.	
3.	
4.	

Problem List

Check any boxes that apply to your child. *Current* means behavior problems presently occurring regardless of whether or not your child is on medication. **Please do not write in the shaded areas:**

Current / Past

Current	Past	Problem	Clinician use only. **Do not write in this space.**
☐	☐	Can't concentrate / pay attention	
☐	☐	Restless or hyperactive	Duration:
☐	☐	Talks too much / talks out of turn	Settings: Home / School
☐	☐	Impulsive or acts without thinking	Teacher complaints since:
☐	☐	Trouble staying seated	Attention span estimate:
☐	☐	Makes careless mistakes	
☐	☐	Fails to finish things he/she starts	
☐	☐	Daydreams / Gets lost in thought	
☐	☐	Inattentive / Easily distracted	
☐	☐	Has trouble following directions	
☐	☐	Forgetful / Often loses things	

Current / Past

Current	Past	Problem	Clinician use only. **Do not write in this space.**
☐	☐	Angry / Resentful	
☐	☐	Does not mind / Argues	Duration:
☐	☐	Annoys others purposely	Settings: Home / School
☐	☐	Bullies / Threatens / Intimidates others	☐ Homicidal ideations
☐	☐	Fights / Aggressive	
☐	☐	Destroys property	
☐	☐	Temper tantrums / Loses temper easily	
☐	☐	Lies / Blames others for own misbehavior	
☐	☐	Cruel to animals	
☐	☐	Has set fires	
☐	☐	Violates curfew / Has run away	
☐	☐	Suspected smoking / alcohol / drug use	
☐	☐	Inappropriate sexual behaviors	
☐	☐	Suspected sexual activity	
☐	☐	School suspensions / alternative school	
☐	☐	Legal problems	

Current / Past

Current	Past	Problem	Clinician use only. **Do not write in this space.**
☐	☐	Frequent sadness or irritability	
☐	☐	Tearful / Cries easily	Duration:
☐	☐	Low energy level	Mood:
☐	☐	Suicidal thoughts, threats, or actions	☐ Suicidal ideations
☐	☐	Low self-esteem or guilt	☐ Passive suicidal ideations
☐	☐	Cuts, burns or intentionally causes harm to self	☐ Self-injurious behaviors
☐	☐	Loss of interest in favorite activities	
☐	☐	Has trouble making and keeping friends	
☐	☐	Feelings hurt easily	
☐	☐	Change in appetite	
☐	☐	Change in sleeping patterns	
☐	☐	Frequent body aches, headaches, or stomachaches	
☐	☐	Severe changes in mood when compared to peers	
☐	☐	Can go with little to no sleep for days	
☐	☐	Talks too much, too fast, changes topics quickly, cannot be interrupted	
☐	☐	Thoughts racing	
☐	☐	Increased goal-directed activities	

☐	☐	Unrealistic highs in self-esteem	
☐	☐	Worries about safety of self or others	
☐	☐	Unusual worries or fears	
☐	☐	Panic attacks	Avoidance of triggers / palpitations / trembling or shaking / sweating / sensation of smothering / chest pain / shortness of breath / nausea / feeling lightheaded or dizzy / fainting / paresthesias / hot or cold flashes / feelings of impending doom
☐	☐	Panics or tantrums when separated from parent	
☐	☐	Obsessive thoughts	
☐	☐	Unusual behaviors that must be performed , such as dressing, bathing, mealtime, or counting rituals	
☐	☐	Nervous tics or other repetitive, abrupt nervous movements or vocal noises	

Current / Past

☐	☐	Sees or hears things that are not real	Clinician use only. **Do not write in this space.**
☐	☐	Confused thinking or beliefs	☐ Auditory /visual / tactile / olfactory hallucinations
☐	☐	Feels people are "out to get" him or her	
☐	☐	Unable to care for hygiene, nutrition, or basic needs	
☐	☐	Odd or bizarre thoughts or behavior	

Current / Past

☐	☐	Behaves like a younger child	Clinician use only. **Do not write in this space.**
☐	☐	Has trouble communicating	
☐	☐	Avoids or seems obsessed with certain things	
☐	☐	Makes repetitive sounds or body movements	
☐	☐	Fascinated with odd objects or parts of toys	
☐	☐	Uses people as objects	
☐	☐	Lack of imaginary or pretend play	
☐	☐	Does not seek to share interests	
☐	☐	Does not make friends / in his or her "own world"	
☐	☐	Does not keep eye contact	
☐	☐	Has rituals or routines that must be followed	
☐	☐	Problems with wetting or soiling self	

Please describe any stressful event or circumstance that may have triggered these problems:
____
____
____

Has your child ever witnessed or been exposed to domestic violence? ☐ No ☐ Yes If yes, please explain:____
____

What are you child's strengths? ____
____

Clinician use only. Do not write in this space.____
____
____
____

Legal/Agency Information

Are there any current custody issues? ☐ No ☐ Yes If yes, please explain_________________
____
____

Has this child been the victim of: Neglect ☐ No ☐ Yes
Physical Abuse ☐ No ☐ Yes
Sexual Abuse ☐ No ☐ Yes
If so, was this reported to the Dept. of Human Resources (DHR)? ☐ No ☐ Yes

Have others in the immediate family been a victim or perpetrator of:
Neglect ☐ No ☐ Yes____
Physical Abuse ☐ No ☐ Yes____
Sexual Abuse ☐ No ☐ Yes____

Has DHR ever been involved with this child or family? ☐ No ☐Yes
If yes, please list any situation requiring DHR, Family Court, or Juvenile Probation involvement:
Social worker / case worker:____________________________Phone:(___)__________________
Dates of involvement:________________________ Reason for involvement:________________
____
____

Have legal authorities ever been involved with this child now or in the past? ☐ No ☐ Yes
Dates of involvement:________________________ Reason for involvement:________________
____

Clinician use only. Do not write in this space.
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Family Data

Please list **ALL** individuals living in the child's household:

Name	Age	Relationship	Known to child as	Occupation
Example: *Jane Dow*	*52*	*Grandmother*	*"Mommy"*	*homemaker*

Please list all OTHER significant family/caregivers **NOT** currently residing with the patient (this would include biological parents, step parents, siblings, step siblings, etc.)

Name	Age	Relationship	Known to child as	Occupation
Example: *Ashley Smith*	*30*	*Biological Mother*	*"Mama Ashley"*	*sales*

Last Grade Completed: Mother________ Father________ Stepmother________ Stepfather_________
Guardian (if someone other than persons listed above)_____________________

Marital status of biological parents:

- ☐ Married/ Remarried
- ☐ Divorced
- ☐ Living Together
- ☐ Single/Never Married
- ☐ Legally Separated
- ☐ Widow

Biological mother's maiden name:____ DOB:________

If parents are separated or divorced, how old was patient at time of separation?______________

Housing/Living Situation:

☐ Adequate for needs ☐ Inadequate (i.e. living in a shelter, living with relatives/friends)

☐ Moved more than 2 times in past 12 months ☐ Moved more than 3 times in past 12 months

Are there transportation problems that may make it difficult to keep appointments? ☐ Yes ☐ No
If so, please explain ____

Please describe any information regarding family that may contribute to stress for the child including visitations, step parents, foster care, adoption, custody issues, financial stress or unemployment:____
____
____
____
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Clinician use only. Do not write in this space. ____
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Developmental History

Biological mother's age at child's birth_____ If child was adopted, child's age at adoption____
If not a biological child of parent, is the child aware of this? ☐ Yes ☐ No
Planned Pregnancy: ☐ Yes ☐ No ____

Check the corresponding box if the biological mother used the following during pregnancy:

☐ Alcohol
☐ Cigarettes, tobacco products
☐ Exposure to 2nd hand smoke
☐ Recreational/Street drugs (Ex.: cocaine, marijuana, heroin etc.)______________________________
☐ Prescription Medicines____
☐ Antibiotics____
☐ Over-the-counter medications____
☐ Other/ herbal____
☐ None____

Please list any problems experienced by the mother during pregnancy: (Examples: high blood pressure, Diabetes, bed rest ordered etc. ____
____

Were there any complications at birth? ☐ No ☐ Yes If yes, please specify:________________
____
____

Was the baby premature? ☐ No ☐ Yes If yes, how early was the baby? __________________

What was your child's birth weight? ______________

What was your child's personality from age 0 to 1 year:
1) Easy going 2) Slow to warm up to others 3) Demanding and difficult to please
Other ____

At what age did your child first do the following:

Sit up _________________________	Say single words ___________________________
Crawl _________________________	Say 2 or more words together ________________
Walk _________________________	Become toilet trained _______________________

Clinician use only. Do not write in this space. ____
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Medical History

Who is your child's pediatrician? ______________________________Phone (___)____________
When was your child's last complete physical exam? _____________________________________
Where was the exam completed? ____
When was your child's last hearing screening? _______________Normal? ☐ No ☐ Yes
When was your child's last vision screening? ________________Normal? ☐ No ☐ Yes
Are your child's immunizations up to date? ☐ No ☐ Yes

Has your child ever had any of the following? If so, please list dates of problems/procedures.

- ☐ Broken Bones____
- ☐ Speech problems____
- ☐ Lead Exposure____
- ☐ Seizures or convulsions____
- ☐ Head Injury ____
- ☐ Hospitalization____
- ☐ Surgery____
- ☐ EKG or EEG____
- ☐ MRI or CT____
- ☐ Heart Problems____

List any **current** health problems and child's age when diagnosed (Ex: Asthma, Diabetes, etc.):

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

List any **past** health problems and age when they occurred:

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

List any **current** medications and the doctor who prescribes them:

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

Does your child have any allergies to foods, medications, or latex? ☐ No ☐ Yes
If yes, please list with reaction: ____
____
____

Clinician use only. Do not write in this space. ____
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Please note if your child has ever taken any of the following medications:

Medication / Dose	Beneficial Effects	Side Effects	Duration	Reason Stopped
Example: Abilify -*20 mg at bedtime*	*Helps him to not hear voices*	*Headaches*	*7/03 - Present*	*Didn't work*
Abilify / Abilify discmelt / Abilify injection (aripiprazole)				
Adderall / Adderall XR (amphetamine salts)				
Anafranil (clomipramine)				
Atarax (hydroxyzine)				
Ativan (lorazepam)				
BuSpar (buspirone)				
Benadryl (diphenhydramine)				
Catapres (clonidine) tablets / patches				
Celexa (citalopram)				
Cogentin (benztropine)				
Concerta (methylphenidate)				
Cymbalta (Duloxetine)				
DDAVP (desmopresin)				
Daytrana Patch (Methylphenidate)				
Depakene (valproic acid)				
Depakote / Depakote ER (divalproex sodium)				
Desyrel (trazodone)				
Dexedrine, Dextrostat (dextroamphetamine)				
Effexor / Effexor XR (venlafaxine)				
Elavil (amitriptyline)				
Equetro (dibenzazepine)				
Eskalith (lithium carbonate)				
Focalin (dexmethylphenidate)				
Geodon (ziprasidone)				
Haldol (haloperidol)				
Inderal (propranolol)				

Medication / Dose	Beneficial Effects	Side Effects	Duration	Reason Stopped
Invega (paliperidone)				
Klonopin (clonazepam)				
Lamictal (lamotrigine)				
Lexapro (escitalopram)				
Librium (benzodiazepine)				
Lithobid, Lithonate, Lithotabs (lithium)				
Luvox / Luvox CR (fluvoxamine)				
Mellaril (piperidine phenothiazine)				
Metadate ER / Metadate CD (methylphenidate)				
Methylin / Methylin ER (methylphenidate)				
Norpramin (desipramine)				
Pamelor (nortriptyline)				
Paxil / Paxil CR (paroxetine)				
Pristiq (desvenlafaxine)				
Provigil (modafinil)				
Prozac (fluoxetine) / Prozac weekly				
Remeron / Remeron Soltab (mirtazapine)				
Risperdal / Risperdal M-tab / Risperdal Consta (risperidone)				
Ritalin / Ritalin LA (methylphenidate)				
Sapharis (asenapine)				
Sarafem (fluoxetine)				
Seroquel / Seroquel XR (quetiapine)				
Serzone (nefazodone)				
Sinequan (doxepin)				
Stelazine(trifluoperazine)				
Strattera (atomoxetine)				
Symbyax (thienobenzodiazepine)				
Tegretol (carbamazepine)				
Tenex (guanfacine)				

Medication / Dose	Beneficial Effects	Side Effects	Duration	Reason Stopped
Thorazine (chlorpromazine)				
Tofranil (imipramine)				
Topamax (topiramate)				
Trileptal (dibenzazepine)				
Valium (diazepam)				
Vivactil (protriptyline)				
Vistaril, Atarax (hydroxyzine)				
Vyvanse (lisdexamfetamine)				
Wellbutrin SR / Wellbutrin XL (bupropion)				
Xanax / Xanax XR (alprazolam)				
Zoloft (sertraline)				
Zyprexa / Zyprexa Zydis / Zyprexa IM (olanzapine)				
Other:				

Clinician use only. Do not write in this space.

Past Psychiatric History

If your child has had prior counseling, psychiatric care, psychiatric hospitalizations, or testing please list:

Hospital or doctor's name	Phone #	Dates seen	Reason for treatment

Does your child have any previous psychiatric or mental health diagnoses? ☐ No ☐ Yes
If yes, please list: ____
____
____
____

Clinician use only. Do not write in this space.

Biological Family Medical / Psychiatric History

Please write which family member of the patient had these problems if appropriate:

Past or Present diagnosis or symptoms	Biological siblings	Biological Mother	Biological Father	Biological mother's family	Biological father's family	Others living in the home
1. ADHD						
2. Oppositional/Defiant						
3. Obsessive/Compulsive Disorder						
4. Learning disability / Special Education						
5. Mental Retardation / Intellectual Disability						
6. Autism /Asperger's Disorder / PDD						
7. Psychosis / Schizophrenia						
8. Bipolar Disorder / Manic Depression						
9. Depression						
10. Suicide or suicide attempts						
12. Anxiety / Phobias						
11. Eating Disorders						
12. Tics/Tourette' s Syndrome						
13. Aggression or behavior problems						
14. Murdered or attempted to kill others						
15. Been arrested or spent time in jail						
16. Alcohol abuse						
17. Drug abuse						
17. Other psychiatric problem						
18. Heart Problems or heart attack at early age						
19. Seizures/Epilepsy						
20. Other medical problem						
21. Outpatient therapy						
22. Hospitalizations						

Clinician use only. Do not write in this space.____

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____

Educational History

Name of current school:____ Grade:___________________

Teachers:____

Current Placement: □ Regular □ Alternative school □ Special education :
□ for behavior only □ for learning difficulties □ Both □ Other:_________________________________
□ 504 Plan □ IEP

How many schools has your child attended this school year? □ One (current) □ 2-3 □ 3 or more

Any prolonged absences from school? □ No □ Yes When_________ How long_____________________
Reason____

Has your child repeated any grades? □ No □ Yes Which one(s)___________________________________

Please describe any behavioral problems that your child is having at school_________________________
____

Has your child been suspended **this school year**? □ No □ Yes How many times?_________ Please list reason for suspension:____

Has your child been tested for special education placement by the school? □ No □ Yes
When?________________________ **Please bring copies of testing / IEP / 504 plan if available**.

Specific educational difficulties: □ Spelling □ Math □ Reading □ All Subjects
□ Speech/Language □ Occupational Therapy □ Autism □ Developmental Delay
□ Other:_ ____

Current Academic Performance: □ A's □ B's □ C's □ D's □ F's

Past Academic Performance: □ A's □ B's □ C's □ D's □ F's

Peer relationships: □ Aggressive/Fights a lot □ Very Friendly
□ Has no friends □ Teased/Bullied by others

Work History if applicable (attendance, relationship with boss):

Clinician use only. Do not write in this area____
____
____
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____
____
____
____
____