DEPARTMENT OF PSYCHIATRY

Division of Child and Adolescent Psychiatry

4197 NW 86th Terrace
Gainesville, FL 32606

Phone: 352-265-4357
Fax: 352-627-4163

Welcome and thank you for choosing University of Florida Physicians!

Dear Parent/Guardian, the information you provide here will help your provider in identifying your child's needs and how to best serve your family.

Please be prepared to arrive **30 minutes early** to complete clinic paperwork upon arrival.

If you cannot keep this appointment, please call to cancel as soon as possible. If you fail to do so, you may not be allowed to reschedule your appointment.

Please complete the attached assessment forms prior to your appointment.

Please bring your completed paperwork, updated insurance information and any current medications in their original bottle to your appointment.

The Child and Adolescent Psychiatry Clinic is located at 8491 NW 39th Ave. If you have any questions or need to reschedule, please call (352) 265-4357

Thank you for choosing UF Health for your healthcare needs and we look forward to serving you!

PARENT OR GUARDIAN: PLEASE COMPLETE AND BRING THIS FORM TO CLINIC

Who referred you to our clinic?_____

DEMOGRAPHICS:

Name of the person completing this form:

_____

Relationship to the child:

_____

Child's Full Legal Name: _____

Is there another name the child prefers being called? _____

Child's Date of Birth: _____ / _____ / _____

Age: _____

Gender: _____

Race: _____

Religion: _____

Is the child adopted? No Yes
If yes, are they aware? No Yes

Who lives in the same household as the child?

Name	Sex	Age	Relationship to Child

Parent(s) occupation:

_____

What are the main concerns that you have about your child?

How long have you had these concerns?

What are your goals for treatment of your child?

Please circle all of the following symptoms that apply to your child:

Sad or depressed mood
Withdrawn from family or friends
Loss of interest in activities or hobbies
Feelings of guilt or worthlessness
Feeling hopeless about the future
Sleep disturbance
Change in appetite
Low energy or fatigue
Trouble focusing or concentrating
Thoughts of hurting self
Thoughts of suicide
Thoughts of hurting or killing others

Drastic mood swings
Episodes of decreased *need* for sleep
Extreme hyperactivity
Racing thoughts
Talking so fast it's hard to understand
Overly happy or euphoric
Overly confident

Hearing voices that other people cannot hear
Seeing things other people cannot see
Feeling paranoid
Odd thinking or beliefs

Irritability
Severe angry outbursts (verbal or physical)

Worrying too much
Feeling or acting restless
Muscle tension
Panic or anxiety attacks
Fear of looking stupid or being embarrassed
Fear of offending others
Any other fears or phobias

Thoughts, feelings or pictures that come into the child's mind even if he/she does not want them to?
Habits the child feels they must do even if he/she knows it does not make sense (for example excessive cleaning, checking, repeating, counting, organizing or hoarding things)?

Poor body image
Trying to lose weight even though he/she is not overweight
Intentionally throwing up after eating

Easily loses temper
Easily annoyed
Defiant
Argues with authority figures
Annoying others on purpose
Blaming others for his/her mistakes
Resentful, spiteful or vindictive
Lying
Stealing
Destroying property
Setting fires
Skipping school
Hurting other people or animals

Difficulty learning
Trouble understanding social cues
Difficulty forming or keeping friendships
Being very sensitive to sound, light, touch or smell

Tics, twitches or involuntary movements
Making involuntary sounds

Traumatic experiences: Has your child ever been exposed to actual or threatened death, serious injury, or sexual violence? No Yes

If yes, does he/she have any of the following symptoms related to the traumatic event?

Upsetting or intrusive memories
Nightmares
Flashbacks (feeling or acting like the event is happening again)
Avoiding talking or thinking about what happened
Feeling upset by reminders of the event
Having out of body experiences
Feeling like the world/surroundings are not real
Angry outbursts
Recklessness or self-destructive behavior
Getting startled very easily
Always looking around for signs of danger
Trouble remembering some or all of what happened

PAST PSYCHIATRIC HISTORY:

Has your child ever seen a **psychiatrist or therapist/counselor** before?

Name of provider	Dates seen	Reason

Has your child ever been admitted to a **psychiatric hospital**?

Name of the hospital	Dates	Reason

Has your child ever attempted suicide? No Yes If yes, please describe:

Does your child engage in any self-harm behaviors (like cutting)? No Yes If yes, please describe:

Has your child ever been violent or aggressive? No Yes If yes, please describe:

FAMILY HISTORY:

Please list any known psychiatric illnesses in **blood relatives** of the child:

Psychiatric illness:	Child's Mother	Child's Father	Child's siblings	Mother's side of the family	Father's side of the family
Depression					
Anxiety					
Bipolar disorder					
Psychosis					
Schizophrenia					
ADHD					
Intellectual disability or learning problems					
Autism					
Eating disorder					
Alcohol problems					
Drug problems					
Suicide					

Does the child have any blood relatives with heart defects or arrhythmias? No Yes Unknown

Does the child have any blood relatives who died suddenly at a young age? No Yes Unknown

SUBSTANCE USE HISTORY:

Does the child use: Alcohol Tobacco Illegal drugs

Specify: _____

MEDICAL HISTORY:

Does your child have any history of the following medical conditions *(circle all that apply)*?

Allergies (describe)	Loss of Consciousness
Asthma	Heart problems
Respiratory Illness	High Blood Pressure
Diabetes	Low Blood Pressure
Convulsions/Seizures/Epilepsy	Urogenital Problems
Head Injury	Vision Problems
Dizziness or Fainting	Hearing problems

Any other serious illness or disease? _____

Has your child ever had surgery? No Yes
If yes, describe and give dates:

Has your child ever had any serious injuries? No Yes
If yes, describe and give dates:

Biological females only:
Has your child started menstruation? No Yes
If yes, at what age _____
Are periods regular? No Yes
Date of last menstrual cycle _____ / _____ / _____
Is there any change in symptom severity with periods? No Yes
If yes, please describe_____

MEDICATIONS:
Please list all medication your child is **currently taking**:

Name of medication	Dose of medication	Who prescribes it?

Please circle any medications your child has **taken in the past**:

Alprazolam (Xanax)	Diazepam (Valium)	Mirtazapine (Remeron)
Amitriptyline (Elavil)	Duloxetine (Cymbalta)	Nortriptyline (Pamelor)
Amphetamine (Adderall)	Escitalopram (Lexparo)	Olanzapine (Zyprexa)
Aripiprazole (Abilify)	Fluoxetine (Prozac)	Oxcarbazepine (Trileptal)
Asenapine (Saphris)	Fluphenazine (Prolixin)	Paliperidone (Invega)
Atomoxetine (Strattera)	Fluvoxamine (Luvox)	Paroxetine (Paxil)
Bupropion (Wellbutrin)	Guanfacine (Intuniv)	Quetiapine (Seroquel)
Buspirone (BuSpar)	Haloperidol (Haldol)	Risperidone (Risperdal)
Carbamazepine (Tegretol)	Iloperidone (Fanapt)	Sertraline (Zoloft)
Citalopram (Celexa)	Imipramine (Tofranil)	Topiramate (Topamax)
Clomipramine (Anafranil)	Lamotrigine (Lamictal)	Trazodone (Desyrel)
Clonazepam (Klonopin)	Levomilnacipran (Fetzima)	Valproic Acid (Depakote)
Clonidine (Kapvay)	Lisdexamfetamine (Vyvanse)	Venlafaxine (Effexor)
Clozapine (Clozaril)	Lithium	Vilazodone (Viibryd)
Desipramine (Norpramin)	Lorazepam (Ativan)	Vortioxetine (Brintellix)
Desvenlafaxine (Pristiq)	Loxapine (Loxitane)	Ziprasidone (Geodon)
Dexmethylphenidate (Focalin)	Lurasidone (Latuda)	Other:
Amphetamine (Adderall)	Methylphenidate (Aptensio, Concerta, Daytrana, Metadate, Methylin, Ritalin, Quillivant)	

ALLERGIES (circle): No Known Drug Allergies Other:

Please list any allergies the child has: _____

SOCIAL HISTORY:

Name of child's current school:_____
Current grade: _____
Did the child repeat any grades? No Yes _____
Does the child have a 504 plan or IEP? No Yes _____
Is the child in ESE or special needs classes? No Yes _____
Has the child ever been suspended or expelled? No Yes _____
Does the child get bullied by peers? No Yes _____
Has the child ever been the victim of abuse? No Yes _____
Has the child been arrested? No Yes _____
Are there any weapons or guns in your home? No Yes
If so, does your child have access to them? No Yes _____

DEVELOPMENTAL HISTORY:
(Not all parents remember the answers to these questions. You can write down what you do remember or look back if you kept a baby book.)
What was the length of the pregnancy? _____
Were any medications or substances used during pregnancy? No Yes
If yes, what? _____
Any other complications of pregnancy or delivery? No Yes _____
How much did the baby weigh at birth? _____
Did the baby start breathing right away? No Yes _____
Were there any problems with the baby after he/she was born? No Yes _____
When did the baby leave the hospital? _____
When the baby came home, were there any problems? No Yes _____
When did the baby really smile (not "gas")? _____
When was the baby able to sit by him/herself (without help)? _____
When did the baby walk by him/herself (without holding on)? _____
When did baby say his/her first word? _____
When did the baby say short sentences (such as "go bye bye")? _____
Did the child have trouble learning to speak? _____
Was he/she different from brother or sister or other children? _____
Is the child toilet trained? No Yes
If yes, how old when trained? _____
How old was the child when he/she was able to:
When did the child learn to ride a tricycle? _____
When did the child learn to ride a bicycle without training wheels? _____
When was the child able to get dressed by him/herself? _____
When was the child able to tie shoelaces?_____

What hand does the child prefer to use? Right Left No Preference
At what age did you notice this? _____

Did anything else significant occur during the child's development years?
_____

TESTING HISTORY:
Did the child ever have IQ or achievement testing? No Yes _____
Has the child been tested for hearing abnormalities? No Yes _____
Has the child been tested for speech/ language abnormalities? No Yes _____
Has the child ever received occupational or physical therapy? No Yes _____

OTHER: Has the child experienced any of the difficulties below? Please circle all that apply:

Death of a parent, Death of other loved ones/close friend, Separation from parent or family, Parent separation/divorce, Loss of Home, Family financial problems, Parent with substance abuse problem, Conflicts with parents, Removal of child from home, Victim of crime or violence, Unwanted pregnancy, School problems, Illness in self, Illness in family (specify), Other: