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PRE-EVALUATION QUESTIONAIRE

To better help us understand your needs, please provide us with the following information prior to your appointment. All information is confidential and will become part of your clinical record. Please feel free to ask us questions about any of the information requested. (Attention: Parents completing this form should provide the child's information).

NAME:

DATE OF BIRTH: SEX: Male Female

1.) What is your ethnicity? ☐ Caucasian ☐ African American ☐ Alaska Native/American Indian ☐ Pacific Islander ☐ Hispanic ☐ Asian ☐ other:

2.) Please check any symptoms you are experiencing:

- ☐ Depression
- ☐ Mood swings
- ☐ Behavioral issues
- ☐ Coping
- ☐ Poor concentration
- ☐ Other
- ☐ Anxiety
- ☐ Anger
- ☐ Relational conflicts
- ☐ School issues
- ☐ Sleep disturbances

3.) What grade are you in currently?

4.) What school do you attend?

5.) Academic success: ☐ Good ☐ Average ☐ Poor

6.) Current grades:

7.) Have you ever been held back or repeated a grade? ☐ Yes ☐ No

8.) Do you have an IEP/special education or 504 plan? ☐ Yes ☐ No

9.) Do you have any learning disabilities? ☐ Yes ☐ No
List:

10.) Behavioral problems in school? ☐ Detentions ☐ Suspensions ☐ Skipping/missing school
Explain:

11.)Do you participate in any extra-curricular activities? ☐ Yes ☐ No
List:

12.)Have you ever had any legal issues or been picked up by the police? ☐ Yes ☐ No
☐ Running away ☐ Shoplifting ☐ Theft ☐ Alcohol/drugs ☐ Vandalism ☐ Assault
☐ other:

13.)Have you served any time in a youth detention center? ☐ Yes ☐ No

14.)Are you currently on probation? ☐ Yes ☐ No Name:

15.)Mother's age when pregnant with you?

16.)How was your mother's health during pregnancy with you? ☐ No concerns ☐ Gestational diabetes ☐ Pre-eclampsia ☐ Toxemia ☐ Illnesses

17.)Were there any prenatal events? ☐ None ☐ Stress/anxiety ☐ Trauma ☐ Prescribed medications Explain:

18.)Was there any prenatal exposure to drugs/alcohol? ☐ Yes ☐ Suspected ☐ Unknown
☐ None Explain:

19.)Birth weight: _____ pounds _____ounces.

20.)Were there any developmental delays (crawling, walking, talking, toileting)? ☐ Yes ☐ No
Explain:

21.)Do you have any active medical conditions? ☐ Yes ☐ No
Explain:

22.)What is the name of your primary care provider/pediatrician (doctor or nurse practitioner)?

23.)Date of your last physical exam?

24.)Have you had any blood-work done? ☐ Yes ☐ No

25.)Do you have any allergies? ☐ Drug allergies ☐ Seasonal/environmental allergies ☐ None
List allergy & reaction:

26.)Have you ever had surgeries or been hospitalized overnight? ☐ Yes ☐ No
Explain:

27.)Have you ever had a seizure? ☐ Yes ☐ No
Explain:

28.)Have you ever had a head injury, loss of consciousness, or concussion? ☐ Yes ☐ No
Explain:

29.)Have you ever had a sleep study?

30.)Have you ever had an EKG (measures heart rhythm)? ☐ Yes ☐ No

31.)Have you ever had an EEG(measures brain wave activity)? ☐ Yes ☐ No

Females only -

32.)At what age did you start menstruating?

33.)Date of last menstrual period:

34.)Do you have physical problems with your periods? ☐ Yes ☐ No
Explain:

35.)Do you have problems with noticeable mood changes around your periods? ☐ Yes ☐ No
Explain:

36.) Birth control?

37.)Are you currently taking any medications (including vitamins, supplements, or over the counter medications)? Please list name of medication, dose, and time taken.

38.)Have you ever been on psychiatric medications in the past (for ADHD, depression)? Please list names of medications.

39.)Is there any family history of medical conditions?

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Thyroid Condition

40.)Have you ever been admitted to a psychiatric hospital or residential treatment center?

☐ Yes ☐ No

41.) Have you currently or have you ever seen a therapist/counselor previously? ☐ Yes ☐ No

42.)Have you ever seen a psychiatrist, physician, or nurse practitioner for psychiatric medications previously? ☐ Yes ☐ No

43.) Have you had neuro/psychological testing? ☐ Yes ☐ No

44.)Have you ever done things to intentionally hurt yourself (cutting/burning)? ☐ Yes ☐ No

45.)Have you ever thought about or made comments about suicide? ☐ Yes ☐ No

46.)Have you ever seriously planned or attempted suicide? ☐ Yes ☐ No

47.) Have you ever used any of the following substances?

- ☐ Tobacco/chew
- ☐ Marijuana
- ☐ Inhalants
- ☐ IV Drugs
- ☐ Prescription medications (Oxycontin, Xanax, Ritalin, Adderall, etc.)
- ☐ Cough/Cold Medications to get high
- ☐ Alcohol
- ☐ Cocaine/crack
- ☐ Heroin/methadone
- ☐ Hallucinogens/'shrooms
- ☐ Amphetamines/Methamphetamines
- ☐ Other:

48.)Is there any known family history of mental illnesses?

- ☐ Depression
- ☐ Anxiety/PTSD/OCD
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ ADHD
- ☐ Developmental Disorders/Mentally Retarded
- ☐ Pervassive Developmental Disorder/Autism Spectrum Disorders
- ☐ Eating disorders (anorexia, bulimia)
- ☐ Personality Disorders
- ☐ Substance Abuse
- ☐ Legal problems

49.) Is there any history of abuse? ☐ None ☐ Verbal/emotional ☐ Physical ☐ Sexual ☐ Neglect Explain:

50.) Is there any history of traumatic events?

51.) Are there any grief & loss issues?

52.)Biological mother's name & age:

53.)Biological father's name & age:

54.)Parent's: ☐ Never married ☐ Married ☐ Separated ☐ Divorced

55.)Age when parents separated/divorced:

56.)Mother remarried? ☐ N/A ☐ Yes ☐ No Name:

57.)Father remarried? ☐ N/A ☐ Yes ☐ No Name:

58.)List brothers (full, half, and step) and ages:

59.)List sisters (full, half, and step) and ages:

60.)Spiritual/religious involvement. ☐ None ☐ A little ☐ Moderate ☐ Very much

61.)Are you a member of any spiritual/religious groups?