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

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? ☐ No ☐ Yes

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

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

10.) Behavioral problems in school? ☐ None ☐ Principal's Office ☐ Detentions ☐ Suspensions ☐ Skipping/missing school

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

12.) Have you ever had any legal issues or been picked up by the police? ☐ No ☐ Yes

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

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

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

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

19.) Birth weight: _____ pounds, _____ounces.

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

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

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

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

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

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

29.) Have you ever had a sleep study? ☐ No ☐ Yes

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

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

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? ☐ No ☐ Yes

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

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 other 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 ☐ Other:

40.) Have you ever been admitted to a psychiatric hospital or residential treatment center? ☐ No ☐ Yes

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

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

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

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

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

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

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

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

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

☐ Depression
☐ Anxiety/PTSD/OCD
☐ Bipolar Disorder
☐ Schizophrenia
☐ ADHD
☐ Developmental Disorders/Mentally Retarded
☐ Pervasive 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

50.) Is there any history of traumatic events? ☐ No ☐ Yes

51.) Are there any grief & loss issues? ☐ No ☐ Yes

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?