Piedmont Psychiatric Clinic - Parents Form

Today's Date: _____ Parent's Name: _____ Child's Name: _____

Age: _____ Birthdate: _____ School & Grade: _____

Referred by: _____ Treating Medical Doctor & Phone #: _____

Person(s) having legal custody / relationship to patient: _____

Allergies to Food or Medicines? Yes No What are your Allergies? _____

Family's perception of the problem(s) & severity of the problem(s): _____

_____

_____

_____

_____

_____

Child's perception of the problem(s) (as seen by the parent) including severity: _____

_____

_____

_____

_____

Previous Psychiatric Treatment: Outpatient Interventions

Treating Professional	Reason	Date	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatric or Substance Abuse Hospitalization / Day Treatment Program:

Name of Facility	Reason	Date	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Behaviors / Problems: (Please circle all that apply)

Anger (excessive)
Anxiety
Aggression / Fights
Appetite Changes
Bed-witting
Bullying
Carelessness
Concentration Problems
Cutting on Self
Counting
Crying Spells
Cruelty to Animals
Checking
Day Dreaming
Depression
Defiance
Disorganization
Eating Disorder
Expelled from School/Camp
Fears of Germs
Hair Pulling
Homicidal Threats/Behavior
Hiding Things
Hyperactive
Hallucinations
Hoarding
Hopeless
Headaches
Imaginary Friends
Impulsiveness
Lateness
Legal Problems
Loud
Lying
Low Energy
Learning Problems
Manipulative
Oppositional
Obsessive Thoughts / Rituals
Problems with Adults
Problems with Peers
Perfectionism
Picking (nose/skin)
Paranoia
Property Destruction
Poor Judgment
Pain Problems
People Pleaser
Quiet
Running Away
Risk Taking
Relationships
Secretive
Separation Problems
School Problems (learning)
School Problems (refusing to go)
Suicidal Thoughts/Threats
Self Abusive/ Self Harm
Self Esteem Problems
Self Image Problems
Sexual Promiscuity / Acting Out
Sexual Abuse Victim
Social Withdrawal
Soiling
School Refusal
Sleep Problems Too Much or Not Enough (hours a night _____)
Shame
Truancy
Unruliness
Vandalism
Victim of Bullying
Vomiting
Witnessed Violence
Worries About Death

Psychiatric Medicines taken in the past:

Name of Medicine	Taken from (date) to (date):	Results	Side Effects

Psychiatric Medicines – Current (taking now)

Medicine	Strength/Directions	Purpose	Results	Date

Do you have concerns about the current psychiatric medications? Yes No

What are they? _____

Diagnosed Medical Problems	Date Diagnosed	Physician	Resolved / Ongoing

Has the child gone through puberty? Yes No

Please circle all that apply, if your child has experienced the following medical problems:

Asthma	Ear Infections	Vision Problems	Hearing Problems
Respiratory (lung)	Infections	Headaches	Head Injuries
Intestinal Problems	Diabetes	Fever	Meningitis
Sexually Transmitted Disease	Encephalitis (Brain Infection)	Broken Bones	Seizures
Broken Bones	Hospitalization	Nausea / Vomiting	Heart Disease

Other: _____

Prescription Medicines for Physical Illness:

Medicine:	Strength/Directions	Purpose:	Results	Date Started

Over the Counter Medicines and or Home Remedies:

Drugs / Tobacco / Alcohol:

Drink alcohol - Yes No How much: _____ How often: _____

Cigarettes / Tobacco - Yes No how much: _____ How often: _____

Illegal (or not prescribed) Substances - Yes No Which Ones? (list below)

Name of Substance	Age 1st used	Frequency	Method	Last Used

Has the child experienced problems resulting from substance use? Please check the appropriate box and give a brief description.

Legal	Yes	No	_____
Family	Yes	No	_____
Relationship	Yes	No	_____
School	Yes	No	_____
Other	Yes	No	_____

Did certain events or persons precipitated or contributed to psychiatric or substance abuse problems? Yes No

_____

_____

Does the Child own or have access to weapons or dangerous substances? Yes No

_____

Sleep Quality –	Sleep Problems?	Yes	No
	Nightmares?	Yes	No
	Night Terrors?	Yes	No
	Refusing to sleep in own bed or alone?	Yes	No
	Difficulty falling a sleep?	Yes	No
	Difficulty staying a sleep?	Yes	No

Appetite - Normal Excessive Too Low

Weight - _____lbs. Normal High Low

Child perceives self as: fat Too Thin Don't care

Energy Level: Normal Hyper Fatigue

Developmental History:

Was the child adopted? Yes No If so, where did the child live prior to adoption? _____

Were parents married before pregnancy? Yes No

Was the pregnancy planned? Yes No

Was the pregnancy wanted? Yes No

Were there illness / problems during pregnancy? Yes No Describe: _____

Was alcohol / drugs used during pregnancy? Yes No Describe: _____

What was the length of pregnancy? _____weeks Did the mom and child go home together? Yes No

Was the delivery natural Yes No C-Section Yes No Other_____

Were there complications during the delivery with: Mother Yes No Infant Yes No

Birth weight: _____lbs. APGAR Scores (if known) _____

Breast Fed: Yes No Until what age: _____

Developmental delays: Yes No Please describe: _____

Age-toilet trained: _____ Age-slept through the night: _____ Temperament: _____

Appetite / Growth: _____

Living Arrangements and Family:

Parents:

Father's Name: _____ Age: _____ Mother's Name: _____ Age: _____

Living? Yes No Living? Yes No

Health (physical and mental): _____ Health (physical and mental): _____

Highest Level of Education? _____ Highest Level of Education? _____

Current & Past employment: _____ Current & Past employment: _____

Economic Status: _____ Economic Status: _____

List children born from this marriage whether natural or adopted:

Name:	Age:	School/Education:	Job:	Health:	Place of Living:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Father: # of Previous Marriages: _____ Duration for each: 1.____2.____3.____4.____5.____

List the children born or adopted in these marriages:

Name:	Age:	Last grade completed:	Job:	Relationship of this child to their parent & to parents
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Mother: # of Previous Marriages: _____ Duration for each: 1.____2.____3.____4.____5.____

List the children born or adopted in these marriages:

Name:	Age:	Last grade completed:	Job:	Relationship of this child to their parent & to parents
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Describe the relationship between the different natural, half, step and adopted siblings:

_____

_____

_____

Living Arrangements and Family continued

People living in the current household or having lived there for more than a short visit:

Name:	Age:	Job / School / Grade	Relationship to parent	Length of stay:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Step Parents having been involved or currently involved with the child:

Name:	Age:	Married to	for # of Years	Relationship to child:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has the child ever lived away from either parent or both parents for extended periods of time? (Explain where, why, with whom)

_____

_____

_____

Is the child in close / frequent contact with other relatives living outside the home? Yes No Please describe:

_____

_____

Family Medical / Psychiatric History:

Has any blood relative suffered from any of the following medical conditions: (Circle all that apply)

Depression	Anxiety	Drug / Alcohol Abuse	Suicide
Bipolar	OCD	ADHD	Depression
Neurological Disease	Heart Disease	Epilepsy	Diabetes
Obesity	Other: _____		

Relationship to patient: _____

School History:

School: _____ Grade: _____

Gifted / Advanced Classes: Yes No Special Education: Yes No

Repeated Grades: Yes No Which Grades? _____

Attendance: _____

School History continued

Extra Curricular Activities: Yes No What are they? _____

Behavior problems in class: Yes No

Suspended: Yes No Expelled: Yes No

Problems with teachers: Yes No Problems with peers: Yes No

Social History:

Relationship with peers: _____

Social Isolation: _____

Sports & Activities outside of school: _____

Relationship with family members: _____

Responsibilities: _____

Disciplinary Parent: _____ Methods of discipline: _____

Allowance: Yes No Chores: _____

Allowance: Yes No Chores: _____

Dating: _____

_____

History of Trauma's: (Circle all that appropriate)

Bullyism Teasing Physical Abuse Sexual Abuse Emotional Abuse

Domestic Violence Loss Injury Neglect Other: _____

Please describe trauma and reaction: _____

_____

_____

Is there anything else you would like to add that you think might be important to help us understand what is going?

_____

_____

_____

Parent's Name (Printed): _____

Parent's Signature: _____ Date: _____