BNI Psychiatry

Children and Adolescents Initial Evaluation

ID: _____

What is the main reason for your visit? _____ ***CC:*** _____

HPI:

When did it begin? _____

How has this problem affected his/her function?

at home _____

at school _____

with friends _____

Have you recently worried that your child has:

	Y
Depression (excessive sadness, hopelessness, poor sleep, crying)	☐
Mood Swings(energetic,little sleep, pleasure seeking,racing thoughts,talkative)	☐
Excessive Worries(worries, restlessness, fear, poor sleep)	☐
Behavioral Problmes(fights, anger, arguing)	☐
Attention/Hyperactivity(Poor attention, hyperactivity, impulsiveness)	☐
Social Anxiety(socially withrawn, shiness)	☐
Remembering past trauma(in nightmares, recurring memories)	☐
Autism(social and language impairments, rigidity)	☐
Psychosis(hearing voices, seeing things that aren't there, paranoia)	☐
Dissciated(feeling outside his/her body, as if things were not real)	☐

Patient's Signature _____ **Date:** _____

***P**ast Psychiatric History*

Has your child ever been SUICIDAL?

List *ALL* medications your child is taking *NOW*

Medication	Dose

Medication	Dose

PSH:

.

List all *psychotropic* medication your child has been on *before*

(i.e Ritalin 10 mg/d 05/08-03/09 poor appetite)

Medication	Dose	Duration	Reason for Stop

List all prior psychiatric hospitalization

Hospital	Duration	Reason for hospitalization

List all previous Psychiatrist/Therapists your child has seen

Name	Is BNI authorized to contact?	Phone Number

Patient's Signature _____ **Date:** _____

Medical History:

What illnesses or surgeries has your child had in the past?

MEDH/O:

Does your child have any illnesses at present? Yes No

If yes, please list:

Has he/she ever had a head injury? Yes No

If yes, when?

How did it occur?

Have he/she ever had an EEG, or CT or MRI scan of the head? Yes No

If yes, when, and what were the results?

Name of his/her primary care physician:

Address:

Phone:

Do you authorize your BNI psychiatrist/ therapist to communicate with the primary care physician? Yes No

Patient's Signature _____ **Date:** _____

Brief Review Of Systems**:**

Has he/she recently had any of the following?

Symptoms/ Problem	No	Yes	Date begun
Frequent headaches			
Dizziness/ vertigo			
Seizures/Convulsions			
Vision problems			
Hearing problems			
Smell,taste problems			
Thyroid problems			
Cough/ asthma			
Chest pain			
Shortness of breath			
Nausea,vomiting,Diarrhea			
Stomach pain			
Constipation			
Urinary problems			
Arthritis			
Diabetes			
Walking problems			
Cardiac pacemaker			
Vagal Nerve Stimulation			
Other			

Patient's Signature _____ **Date:** _____

***F**amily History*

Looking at the family and all of his/her blood-relatives on both sides, do you think anyone has or had (list all that apply):

Clinician's notes/ comments

Illness	**Mother's**	**Father's**	**Siblings**
Depression			
Bipolar D/O			
Anxiety			
ADHD			
Schizophrenia			
Alcoholism			
Drug Abuse			
Learning Disability			
Psychiatric Hospitalizaiton			
Suicide Attempts			
Jail or Prison			
Mental Retardation			
Seizures			
Asthma			
Diabetes			
Thyroid Disease			
Migraine			
Heart Problems			
Chromosomal Disorders			
Other Problems (describe)			

***D**evelopmental History*

Clinician's notes/ comments

Any in utero exposure to Medication/Drugs/Alcohol? Y ☐ N ☐

If yes please list:

Any complication during pregnancy? Y ☐ N ☐

If yes please describe?

Method of Delivery ☐ NVD ☐ C-Section ☐ Other:

Any complications at birth? Y ☐ N ☐

If yes please describe?

Patient's Signature _____ **Date:** _____

When did your child achieve the following milestones?

Use one of these letters: (E) for Early (A) for Average (L) for Late

____Language (age at which first words were utered and sentences created)

____Fine motor skills (building towers with cubes and drawing circle)

____Gross motor skills (rolling over, standing, and walking)

____Toilet training

***S**ocial History*

	Y	N
Is your child your biological child?		
If answer was "No" then at what age was he/she adopted?		
How frequent is their contact with the biological parent(s)?		

Where was your child born?

Where was your child raised?

How many times has your child moved?

if yes please list

PLACE	AGE	Reason for move

Parents: (including Step-Mother and Step-Father, if applicable)

Name	Occupation	Hrs per Wk	Relationship with Child

Patient's Signature _____ Date: _____

Please list the other siblings and other members of the household

Name	Age	Lives at home?	Relation to Child

	Y	N
Are you struggling with your (marital) relationship?		
Are you struggling with your parenting?		

If yes, please describe

School History

Name of the School	
Grade	
Average grades	
Academic weakness	
Academic Strenght	

	Y	N
Has your child received IQ or Academic testing?		

Describe the results

Does or has your child participated in any of the following?

"Special ed"	
Accelerated programs	
504 Plan	
Individual Education Plan (IEP)	
Home-hospital programming	

Has your child had problems with any of the following?

Truancy	
Fights	
Absenteeism	
Detention	
Suspension	

PEERS

How many quality relationships does your child have with other children?

If none, please explain

What are your child's favorite activities?

Patient's Signature _____ **Date:** _____

CULTURE

	Y	N
Do you have a religious preference in the household?		

If yes, what is that preference?

Has your child experienced any problems related to race, religion, or culture?		

If yes, please explain

TEEN/YOUNG ADULT SECTION

Do you have any concerns regarding your adolescent's friendships?

Please circle all that apply:

Too old	Too young	Truant	Gang-bangers
Drug use	Alcohol use	Fringe	Violent
Too many	Too Few	Gothic	Other

Has your adolescent had a recent change in friendships?

If yes, what changes, if any are you concerned with?

	Y	N
Are you concerned that your adolescent is using (or has used) drugs or alcohol?		
Has your adolescent had use of weapons?		
Is your adolescent currently dating?		
Is your adolescent sexually active?		
Has your adolescent started working?		

ABUSE

Has your child ever been the victim of abuse of neglect?		

If yes, what was the nature of the abuse? Please circle all that apply:

Physical	Emotional	Neglect
Accidents	Disasters	Sexual
Witnessing	Violence	Other

Is there anything else you would like us to know about your child?

to be completed by MD

MSE:

Appearance:

LOC

O

Memory

Attention

Speech

TP

TC

AH/VH

SI/HI

IN

Jud/IMP

A/P

AXIS I

AXISII

AXIS III

AXIS IV

AXIV V

1

2

3

4

Physician Sig

Patient's Signature _____ **Date: _____**