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Initial Visit Questionnaire (Ages 6 to 18)

Provider Name:	**Date:**

Patient Name: **D.O.B.** **Age:**

Mothers Name: **Age**	**Fathers Name:** **Age**

Parents Marital Status: __ Married __ Not Married __ Divorced __ Separated

Legal guardian: __ same as parents'? __ Other ____

Living in Household:

Name	Age	Relationship

General History/Development*: (DK = Don't Know)*

1 Do You consider your child to be in good health? __ yes __ no __ dk explain ______________________________

2 Does your child have any serious illnesses or medical conditions? __ yes __ no __ dk explain ______________________________

3 Has your child had any surgeries? __ yes __ no __ dk explain ______________________________

4 Has your child been hospitalized? __ yes __ no __ dk explain ______________________________

5 Is your child allergic to medicine or drugs? __ yes __ no __ dk explain ______________________________

6 During pregnancy, did mother use …

tobacco? __ yes __ no __ dk explain ______________________________

alcohol? __ yes __ no __ dk explain ______________________________

drugs or medications? __ yes __ no __ dk explain ______________________________

What, when? ______________________________

7 At what age did your child…

Walk? ____________________ __ dk

Talk? ____________________ __ dk

toliet trian? ____________________ __ dk

start school? ____________________ __ dk

8 Has your child had any problems with …

eating? __ yes __ no __ dk explain ______________________________

sleeping? __ yes __ no __ dk explain ______________________________

separation? __ yes __ no __ dk explain ______________________________

a major illness? __ yes __ no __ dk explain ______________________________

Medical History: *(DK = Don't Know)*

1 Frequent ear infections __ yes __ no __ dk explain ______________________________

2 Problems with ears or hearing __ yes __ no __ dk explain ______________________________

3 Alergies __ yes __ no __ dk explain ______________________________

4 Problems with eyes or vision __ yes __ no __ dk explain ______________________________

5 Asthma __ yes __ no __ dk explain ______________________________

6 Any heart problem or heart murmur __ yes __ no __ dk explain ______________________________

7 Anemia or bleeding problems __ yes __ no __ dk explain ______________________________

8 Frequent abdominal pain __ yes __ no __ dk explain ______________________________

9 Constipation requiring Dr. visits __ yes __ no __ dk explain ______________________________

10 Bed - Wetting after 5 yrs old __ yes __ no __ dk explain ______________________________

11 Sleep problems, snoring __ yes __ no __ dk explain ______________________________

12 Frequent headaches __ yes __ no __ dk explain ______________________________

Provider Name:	**Date:**
Patient Name: **D.O.B.** **Age:**	

Medical History: *Continued* *(DK = Don't Know)*

13 Convulsions or other neurologic problems __ yes __ no __ dk explain ______
14 Obesity __ yes __ no __ dk explain ______
15 Thyroid or other endocrine problems __ yes __ no __ dk explain ______
16 High blood pressure __ yes __ no __ dk explain ______
17 History of serious injuries/fractures/concussions __ yes __ no __ dk explain ______
18 Use of alcohol or drugs __ yes __ no __ dk explain ______
19 Tobacco use __ yes __ no __ dk explain ______
20 ADHD/anxiety/mood problems/drepression __ yes __ no __ dk explain ______
21 Developmental delay __ yes __ no __ dk explain ______
22 History of family violence __ yes __ no __ dk explain ______
23 Sexually transmitted infections __ yes __ no __ dk explain ______
24 (for girls) Pregnancy __ yes __ no __ dk explain ______
25 (for girls) Problems with her periods
Has first period started? __ yes __ no __ dk explain ______
26 Any other significant problems __ yes __ no __ dk explain ______

Family Mental Health*:* *(DK = Don't Know)*

1 Have you or anyone in your family been treated for mental illness including depression? __ yes __ no __ dk if yes, what is the diagnosis______
2 Have you or anyone in your family been treated and/or problems with alcohol or substance abuse? __ yes __ no __ dk if yes, who, when? ______
3 Have there been any concerns about domestic violence, physical or sexual abuse in the family? __ yes __ no __ dk if yes, explain______

Risk Assessment: Age 12 and UP

Home:

1 Gets along with others living at home? __ yes __ no __ dk explain ______
2 Has ever run away or been incarcerated? __ yes __ no __ dk explain ______
3 Living at home? __ yes __ no __ dk explain ______

Education:

4 Grades in school? ______
5 Gets along with school mates/teachers? __ yes __ no __ dk explain ______
6 Trouble at or suspension from school? __ yes __ no __ dk explain ______

Activities:

7 Describe extracurricular & sports activities ______
8 What does your child do with friends? ______

Drugs

9 What drugs including IV, alcohol, cigarettes & caffeine have been & are used by yourself, family & friends?

Sexuality

Sexual preference ______ Contraception? __ yes __ no
Age of first sexual experience ______ Number of partners? ______
History of sexual or physical abuse? __ yes __ no

History of STI? __ yes __ no

Suicide

Any thoughts of suicide? __ yes __ no
History of suicide attempts? __ yes __ no