CAROLINAEAST PEDIATRICS

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PEDIATRIC PSYCHIATRY NEW PATIENT QUESTIONNAIRE

Name: _____

Date: _____

Mother's Name: _____

Occupation: _____

Father's Name: _____

Occupation: _____

If adults in the household work outside the home, what child care arrangements are made for this child?

_____

PREGNANCY AND BIRTH

1. Mother's age at child's birth: _____
2. Did mother have any illnesses during pregnancy? ☐ No ☐ Yes
3. Did she take any medications other than vitamins and iron? ☐ No ☐ Yes
4. Was the baby: ☐ On Time ☐ Early ☐ Late
5. Check one: ☐ Vaginal Delivery ☐ C-Section
6. What was the baby's birth weight? _____
7. Did the baby have any trouble starting to breathe? ☐ No ☐ Yes
8. Did the baby have any trouble while in the hospital? (Jaundice, infections, other) ☐ No ☐ Yes

   What kind? _____

PAST MEDICAL HISTORY

1. Where has your child gone for well checkups until now?

   _____

   Date of last checkup: _____
2. Has your child had allergic reactions to any medications, foods, insect bites? ☐ No ☐ Yes
3. Any hospitalizations other than birth? ☐ No ☐ Yes

   For what? _____
4. Any serious injuries? ☐No ☐Yes

   What kind? _____
5. Are any medications taken regularly? ☐ No ☐ Yes

   Which ones? _____
6. Any prior surgeries? ☐ No ☐ Yes

   What kind? _____
7. Do you have a record of immunizations? ☐ No ☐ Yes

FAMILY HISTORY

1. Are the child's parents both in good health? ☐ No ☐ Yes
2. List age, sex, and general health of patient's brothers and sisters:

   _____
3. Have any of your children died? ☐ No ☐ Yes

DEVELOPMENTAL HISTORY

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Is the child toilet trained? If so, at what age did they start? _____
4. Did he/she say any words by 1 ½ years old? ☐ No ☐ Yes

DEVELOPMENTAL HISTORY CONTINUED

5. How does this child play with others?
   ☐ Not very interested ☐ Plays besides others ☐ Plays with others
6. Does he/she have trouble sleeping? ☐No ☐Yes

REVIEW OF SYSTEMS

1. Has your child had frequent ear infections? ☐ No ☐ Yes
2. Has he/she had any problems with teeth? ☐ No ☐ Yes
3. Does he/she have frequent colds or sore throat? ☐ No ☐ Yes
4. Is there asthma, pneumonia, or recurrent cough? ☐ No ☐ Yes
5. Does he/she have a heart murmur or any heart problems? ☐ No ☐ Yes
6. Any problems with urination? ☐ No ☐ Yes
7. Any problems with diarrhea or constipation? ☐ No ☐ Yes
8. Have there been any convulsions or other problems with the nervous system? ☐ No ☐ Yes
9. Any eczema, hives, or skin conditions? ☐ No ☐ Yes
10. Has your child ever been anemic? ☐ No ☐ Yes
11. Check if your child has had any of the following:

☐ Thumb sucking ☐ Bedwetting
☐ Bad temper ☐ Problems with toilet training
☐ Hyperactivity ☐ Nightmares
☐ Speech Problems ☐ Hair Pulling
☐ Problems with discipline
☐ Other: _____

12. Please list any other problems:

_____

SAFETY ENVIRONMENT

1. Do you live in a: ☐ Private House ☐ Apartment ☐ Mobile Home
   ☐ Other: _____
2. Are there any smokers in the household? ☐ No ☐ Yes
3. Are there any problems with the condition of your home? (Peeling paint, insects, rats, mice) ☐ No ☐ Yes
4. Does your child always wear a helmet when riding a bicycle? ☐ No ☐ Yes
5. Are there any guns in the home? ☐ No ☐ Yes

   If yes, what precautions are taken to secure the guns?

_____

EDUCATION HISTORY

1. What grade is the child in? _____
2. The number of schools the child has attended: _____
3. Has the child had to repeat any grades? ☐ No ☐ Yes

   If so, how many times? _____
4. Reading level (if known): _____

PSYCHIATRIC HISTORY

1. Has the patient ever been in a Psychiatric Hospital? ☐ No ☐ Yes

CONTINUED ON BACK

2. Medication Trials? ☐ No ☐ Yes
Was this helpful? ☐ No ☐ Yes

3. Has the patient ever communicated suicidal thoughts? ☐ No ☐ Yes

4. History of violence towards others? ☐ No ☐ Yes

5. Trials of therapy? ☐ No ☐ Yes
Was this helpful? ☐ No ☐ Yes

FAMILY HISTORY

Have any family members had the following:

Heart Disease (before age 50)	☐ Yes ☐ No	Who: _____
High Blood Pressure (before age 50)	☐ Yes ☐ No	Who: _____
Diabetes (before age 50)	☐ Yes ☐ No	Who: _____
Bed-wetting (after age 10)	☐ Yes ☐ No	Who: _____
Epilepsy or Convulsions	☐ Yes ☐ No	Who: _____
Substance abuse	☐ Yes ☐ No	Who: _____
Depression	☐ Yes ☐ No	Who: _____
Anxiety	☐ Yes ☐ No	Who: _____
Psychiatric Hospitalizations	☐ Yes ☐ No	Who: _____
Did this help?	☐ Yes ☐ No	Who: _____
Schizophrenia	☐ Yes ☐ No	Who: _____
ADHD	☐ Yes ☐ No	Who: _____
Learning Disorders	☐ Yes ☐ No	Who: _____
Mental Retardation	☐ Yes ☐ No	Who: _____
Thyroid Problems	☐ Yes ☐ No	Who: _____

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 252-636-1919.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 252-636-1919.