Children's Hospital New Orleans LCMC Health

Medical Psychology Clinic

NEW PATIENT CHILD/ADOLESCENT REGISTRATION

CHILD'S NAME:

PREFERRED NAME:

DATE OF BIRTH: SSN#:

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

ADOPTED? ☐ NO

☐ YES - ADOPTION KNOWN BY THE CHILD? YES ☐ NO ☐

FATHER: AGE: DATE OF BIRTH:

SSN#: PHONE (CELL): PHONE (HOME):

ADDRESS: EMAIL:

CITY/ZIP:

EMPLOYER: WORK PHONE:

CAN A MESSAGE BE LEFT AT WORK: ☐ Yes ☐ No

MOTHER: Age: DATE OF BIRTH:

SSN#: PHONE (CELL): PHONE (HOME):

ADDRESS: EMAIL:

CITY/ZIP: WORK PHONE:

EMPLOYER: CAN A MESSAGE BE LEFT AT WORK: ☐ Yes ☐ No

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME: RELATIONSHIP:

PHONE (HOME): PHONE (CELL):

PATIENT PRIMARY CARE PHYSICIAN:

NAME OF CLINIC:

ADDRESS:

PHONE #:

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CHILD/ADOLESCENT QUESTIONNAIRE- PLEASE COMPLETE ALL SECTIONS

Briefly describe the problems your child is having and when they began:

MENTAL HEALTH HISTORY:

Has your child ever been abused (emotionally, physically or sexually)? ☐ YES ☐ NO
If Yes, Please Explain:

Has your child ever experienced any other emotional or physical trauma? ☐ YES ☐ NO
If Yes, Please Explain:

Has your child ever.......

a. been in counseling ☐ YES ☐ NO
b. been hospitalized for emotional or alcohol/drug problems? ☐ YES ☐ NO
c. been professionally evaluated? ☐ YES ☐ NO

If yes to any of the above, please provide dates, name of agencies, reason for service and outcome:

Please list any medications your child has taken in the past for emotional/behavioral problems:

Is your child currently taking any prescription medications? ☐ YES ☐ NO If so, please list them:

Is your child currently taking any over the counter medications? ☐ YES ☐ NO If so, please list them:

*****PLEASE BRING YOUR CHILD'S MEDICATIONS TO THE FIRST SESSION*****

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GENERAL MEDICAL HISTORY:

This medical form should be completed by the parent/guardian of the child being evaluated or treated at Children's Hospital Medical Psychology Clinic

Are your child's immunizations up to date? ☐ YES ☐ NO

Has your child ever passed out during or after exercise? ☐ YES ☐ NO

Has your child ever had any dizziness during or after exercise? ☐ YES ☐ NO

Has your child ever had pain during or after exercise? ☐ YES ☐ NO

Does your child get tired more quickly than friends doing exercise? ☐ YES ☐ NO

Had your child ever had racing or skipping heart beats? ☐ YES ☐ NO

Have you ever been told your child has high blood pressure? ☐ YES ☐ NO

Have you ever been told your child has a heart murmur? ☐ YES ☐ NO

Has any family member or relative died of heart problems before the age of 50? ☐ YES ☐ NO

Has any family member or your child been diagnosed with:

Cardiac Conduction Defect? ☐ YES ☐ NO

Polymorphic Ventricular Tachycardia? ☐ YES ☐ NO

Any Genetic Disorder? ☐ YES ☐ NO

Enlarged heart? ☐ YES ☐ NO

Hypertrophic cardiomyopathy? ☐ YES ☐ NO

Long QT Syndrome? ☐ YES ☐ NO

Lev Lenegre's Syndrome? ☐ YES ☐ NO

Wolfe Parkinson White Syndrome? ☐ YES ☐ NO

Idiopathic Ventricular Fibrillation? ☐ YES ☐ NO

Polymorphic VT? ☐ YES ☐ NO

Is your child missing any paired organs? ☐ YES ☐ NO

Does your child have frequent headaches? ☐ YES ☐ NO

Has your child ever had a concussion or any head injury? ☐ YES ☐ NO

Has your child ever had any type of seizures? ☐ YES ☐ NO

Does your child have ANY chronic or current medical conditions? ☐ YES ☐ NO

If yes, please list:

Please list all allergies your child has to medications or other substances such as food allergies:

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FAMILY STATUS:

Are the child's biological parents currently married? ☐ YES ☐ NO

If No, custody is with: ☐ Mother ☐ Father ☐ Joint ☐ Other

PLEASE NOTE:
DOCUMENTATION OF CUSTODY ORDERS WILL BE REQUIRED FOR INITIAL APPOINTMENT

Please describe living arrangements, visitations, etc.:

Please list all people currently living in your home and the relationship of each to your child:

DEVELOPMENTAL HISTORY

Pregnancy:

Was your child's pregnancy planned? ☐ Yes ☐ No

☐ Full Term ☐ Premature? if so, by how many weeks?
☐ Late? if so, by how many weeks?

Please check any of the following experienced during mother's pregnancy with the child being evaluated:

☐ Drug Use
☐ Alcohol consumption
☐ Threatened miscarriage
☐ Prescription medications
☐ Toxemia/Infection
☐ Any Illness
☐ Smoking
☐ Excessive Vomiting
☐ Excessive spotting/blood loss
☐ Hospitalization (other than delivery)
☐ X-Rays

Were there any problems or complications with the pregnancy or delivery? please explain

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EARLY CHILDHOOD:

Milestones - Please review and select your answer:

Walked unassisted	☐ EARLY	☐ AVERAGE	☐ LATE
Spoke first words	☐ EARLY	☐ AVERAGE	☐ LATE
Said sentences	☐ EARLY	☐ AVERAGE	☐ LATE
Toilet Trained	☐ EARLY	☐ AVERAGE	☐ LATE

Were there any illnesses, behavioral difficulties or discipline problems during early childhood? ☐ **YES** ☐ **NO**

If Yes, please describe:

Did your child have Temper Tantrums? ☐ YES ☐ NO

Describe if yes:

What discipline methods are used at home?

Do you, as parents, use consistent disciplining? ☐ YES ☐ NO

EDUCATIONAL HISTORY:

Current School: Current Grade:

How many different schools has your child attended?

What has the child's attendance been like at school? ☐ GOOD ☐ POOR

If attendance is poor, please explain?

Has your child repeated or skipped a grade? ☐ YES ☐ NO

Please describe if yes:

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EDUCATIONAL HISTORY (cont'd)

Has your child had any discipline problems at school and/or been suspended/expelled? ☐ YES ☐ NO

If Yes, please explain:

What are your child's grades like? Have they changed recently?
Please explain:

With which subject(s) does your child have trouble with?

Has your child been diagnosed with a learning disability
or receive special education services? ☐ YES ☐ NO **If yes, briefly explain:**

****Please bring any school assessments to your first appointment****

SOCIAL HISTORY

Does your child make friends easily? ☐ YES ☐ NO
Does your child have difficulty keeping friends? ☐ YES ☐ NO

Briefly describe any peer interaction problems experienced by your child:

Have there been any recent losses, changes or transition in your child's life?

Please describe your child's strengths, weaknesses, accomplishments, talents and areas of interest:

I have reviewed my family and child's history and attest that the medical history form is accurate. I have read each question and completed the form to the best of my ability.

Parent/Guardian signature: ***Date:***