

**SUPPLEMENTARY INFORMATION SHEET**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**MEDICAL HISTORY:**

Were there any problems with pregnancy or delivery? \_\_\_\_\_ If so, please describe:

Was the child exposed to any medications, toxins, alcohol, or cigarettes before birth? \_\_\_\_\_  
If so, please describe.

Was your child born on time? \_\_\_\_\_ Birth weight: \_\_\_\_\_ APGAR scores: \_\_\_\_\_

Were any birth defects identified? \_\_\_\_\_

Were there any problems in the first few days of life? \_\_\_\_\_

Has your child had frequent ear infections? \_\_\_\_\_

Does your child have any illnesses for which he/she is currently being treated? \_\_\_\_\_ If so, please describe nature of illness and treatment:

Please list any surgeries your child has had and when they were performed:

Has your child ever had a seizure, head trauma, or loss of consciousness? \_\_\_\_\_ If so, please describe.

Has your child ever had a CT scan, EEG, or MRI? \_\_\_\_\_ If so, please describe:

Has your child ever been hospitalized? \_\_\_\_\_ If so, please describe where, when and for what reason:

Has your child ever been seen in the emergency room? \_\_\_\_\_ If so, please describe.

If your child is female, has she begun to have menses, if so, are they regular? \_\_\_\_\_

Has your child been evaluated for any type of heart condition? \_\_\_\_\_ If so, please describe:

Date of the most recent physical exam: \_\_\_\_\_

Is your child's vision within normal limits (without glasses)? \_\_\_\_\_ Is your child's hearing within normal limits? \_\_\_\_\_

Please list any medication and doses your child is taking currently including over-the-counter preparation, herbal preparations and vitamins.

Is your child allergic to any medications? \_\_\_\_\_ If so, please list the medication and the reaction:

Do you believe your child uses recreational drugs or alcohol? \_\_\_\_\_ If so, please describe:

**DEVELOPMENTAL MILESTONES**

At what age did your child:

Wean from breast? \_\_\_\_\_ From bottle? \_\_\_\_\_  
Walk? \_\_\_\_\_ Use two-word sentences? \_\_\_\_\_  
Toilet train? \_\_\_\_\_

Were there any delays in development (speech, motor) noted?

Please describe what your child was like between ages 0 and 4 with respect to the following attributes:

Ability to soothe self when upset:

Showed initiative and curiosity:

Seemed to be dependent on external rewards to achieve behaviors desired by parents?

Avoiding harm:

Activity level:

**EDUCATIONAL HISTORY**

Please list all schools attended and for which grades, grades on most recent report card, and any teacher comments:

**Current School:**

Has your child ever repeated or skipped a grade? \_\_\_\_\_ If so, please describe.

Has you child ever had an IEP (Individualized Educational Plan)? \_\_\_\_\_ Starting in which grade? \_\_\_\_\_

Please list any special services your child receives (tutoring, speech/language, advanced/gifted classes, occupational therapy)

Have any expulsions or suspensions occurred? \_\_\_\_\_ Please describe.

Has your child ever had educational testing to identify learning problems or giftedness? If so, please list where, when, and with what result? Please bring any reports of evaluation to your appointment

**FAMILY HISTORY**

*Please list any blood relative with the following: (Specify whether on maternal side or paternal side of the family)*

Substance abuse: \_\_\_\_\_

Attention deficit: \_\_\_\_\_

Learning problems or mental retardation: \_\_\_\_\_

Depression: \_\_\_\_\_

Bipolar disorder (manic-depression): \_\_\_\_\_

Schizophrenia: \_\_\_\_\_

Autism: \_\_\_\_\_

Obsessions/Compulsions: \_\_\_\_\_

Panic: \_\_\_\_\_

Eating disorders: \_\_\_\_\_

Other Anxiety: \_\_\_\_\_

Suicide: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Cancer (specify type): \_\_\_\_\_

Hypertension or heart disease: \_\_\_\_\_

Thyroid disease: \_\_\_\_\_

Liver disease: \_\_\_\_\_

Kidney disease: \_\_\_\_\_

Migraines: \_\_\_\_\_

Tics: \_\_\_\_\_

Genetic syndromes (please specify): \_\_\_\_\_

Neurologic disorders (Parkinson's, multiple sclerosis, Alzheimer's, etc.): \_\_\_\_\_

Epilepsy: \_\_\_\_\_

Sudden Unexplained Death before age 40 \_\_\_\_\_

**SOCIAL HISTORY**

Please list name and ages of all persons living in the home: If child lives at more than one location, please list separately:

- 
- 
- 
- 
- 
- 

How well does your child do socially?

Which of the following best describes your child's interactions with peers:

- No friends\_\_\_\_\_
- Few friends\_\_\_\_\_
- Loses friends\_\_\_\_\_
- Mean, aggressive\_\_\_\_\_
- Too shy/timid\_\_\_\_\_
- Bossy\_\_\_\_\_
- Chooses friends who get into trouble\_\_\_\_\_
- Other:\_\_\_\_\_

Please list other cities where your child has lived and at what ages:

Your child's extra-curricular activities:

Any legal or custody issues:

Any stressful issues your child has had:

**PREVIOUS TREATMENT**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is this your first mental health consultation? \_\_\_\_\_ If not, please list the following where applicable:

Previous evaluations (evaluator, date of evaluation, recommendations):

Previous psychotherapy (therapist, dates of treatment):

Previous medication trials (name of medications, dose, how long the medication was taken): *Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled.*

<b>Name of Medication</b>	<b>Maximum Dose</b>	<b>Dates Prescribed (from-to)</b>	<b>Reason for Stopping</b>
---------------------------	---------------------	-----------------------------------	----------------------------

Previous psychiatric hospitalizations (hospital name, dates of hospitalization, treatment received during the hospitalization):

Thank you. All information will remain strictly confidential.

If possible, please contact previous provider to request any pertinent old records to be sent to your 3-C clinician prior to your first appointment so they may be reviewed prior to your consultation.