111 Michigan Ave NW
Washington, DC 20010-2916
ChildrensNational.org

Psychiatry & Behavioral Sciences
New Patient
Intake Packet

Children's National Health System

CHILD'S HISTORY QUESTIONAIRE

Child's Full Name: _____

Child's Date of Birth: _____

_____

Name of the person completing this form Date

Contact Information:

Parent's full name: _____
Address: _____
_____
Phone: _____
Date of Birth/Age: _____
Profession and/or work activity _____

Parent's full name: _____
Address: _____
_____
Phone: _____
Date of Birth/Age: _____
Profession and/or work activity _____

Other primary caregiver (Guardian/ Significant Other/ Other)

Caregiver's full name: _____
Age: _____
Profession and/or work activity _____

Emergency Contact

Name : _____
Address: _____
_____
Phone: _____

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What are the main concerns that you have about your child? **(Required)**

_____
_____
_____
_____
_____
_____
_____

What would you like to accomplish at this first visit? **(Required)**

_____
_____
_____
_____

What is your expectation after your initial appointment? **(Required)**

_____
_____

Child's Race and Religion:

Race/Ethnicity:

American Indian/ Alaska Native	_____
Asian: Indian/Pakistani	_____
Asian: Chinese	_____
Asian: Other-specify	_____
Hispanic or Latino	_____
Black/African American	_____
White/Caucasian	_____
Other: Specify	_____

Religion:

Protestant	_____
Muslim	_____
Jewish	_____
Hindu	_____
Catholic	_____
Buddhist	_____
Other: Specify	_____
None	_____

Is the child adopted? Yes_____ No _____

Are there other children in the family? If yes please list

Name	Gender	Date of Birth	Age	Relation to child

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Other persons living in the home (significant other, friend, grandparents, foster child, etc)

Name	Gender	Date of Birth	Age	Relation to child

Languages spoken in the home: _____

List any Agencies or professionals currently providing services to your child and family.

Agencies or professional	Age of child when services begun

Pregnancy History

During pregnancy with this child did the mother experience any of the following:

Medical Problems No ____ Yes ____ If yes, how long _____
Special diet No ____ Yes ____ If yes, how long _____
Medications No ____ Yes ____ If yes, how long _____
Length of pregnancy Full-term (38-42 weeks) No ____ Yes ____
Number of weeks at birth _____
Any accidents/injuries No ____ Yes ____ If yes, describe_____

Birth History

Age of mother at birth of child _____

Complications for mother during delivery No _____ Yes _____
If yes, list _____
_____
_____

Child's birth weight _____

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Did the child need any of the following:

Was oxygen needed No _____ Yes _____ if yes, why? _____
Special care No _____ Yes _____ if yes, why? _____

How long did the child stay in the hospital after birth? _____

How long did the mother stay in the hospital after birth? _____

Describe your child in the first 6 months.

Easy baby	No _____ Yes _____
Enjoys people	No _____ Yes _____
Irritable	No _____ Yes _____
Difficult to sooth	No _____ Yes _____
Sleep/wake cycle poorly regulated	No _____ Yes _____
Unusually quiet	No _____ Yes _____
Unusually sick	No _____ Yes _____
Feeding difficulties	No _____ Yes _____
Strong reaction to light/sound/touch	No _____ Yes _____
Colic	No _____ Yes _____

Family History

Please list any medical or psychiatric illness in your family

_____
_____
_____

Child's Early Development (specify age)

Sat without support	_____
Crawled	_____
Walked without support	_____
Used single words (Other than mama or papa)	_____
Used 2-3 word sentences	_____
First began to sleep through the night	_____
Daytime wetting stopped	_____
Bed-wetting stopped	_____
Bowel control	_____

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Child's Medical History

Health Care Providers:

Child's primary care physician: _____

Address: _____

_____

Phone: _____

Date of last complete physical examination: _____

Does your child have any allergies (environmental, food, medication)? No ____ Yes ____

If yes, please list:

_____

_____

_____

Does your child take any medications? No ____ Yes ____

If yes, please list:
(Include vitamins, over the counter drugs, and herbal medications)

Name	Dosage	Frequency	Date began

Has your child ever been hospitalized for any reason? No ____ Yes ____

If yes, describe:

Reason	Date	Place	Length of stay

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Does your child have a current or past history of? Any of the following:

	No	Current	Past	List
Head injury				
Broken bones				
Surgeries				
Birth defects				
Poisoning (e.g.: lead)				
Heart problems				
Kidney problems				
Liver disease				
Lung disease				
Blood disease				
Cancer				
Seizure				
Other neurological problems (e.g.: headache)				
Genetic disorder				
Hormonal problems (e.g.: diabetes, thyroid)				
Skin problems				
Lyme disease				
Impaired Sight				
Impaired Hearing				
Speech Difficulty				
Sleeping Difficulty				
Eating Disorder				
Sleep Apnea				
Severe vomiting				
Choking events				
Other problems				

Childhood diseases (child's age in years)

Chicken pox No ____ Yes ____ Age _____
German measles/Rubella No ____ Yes ____ Age _____
Measles No ____ Yes ____ Age _____
Scarlet Fever No ____ Yes ____ Age _____
Whooping cough No ____ Yes ____ Age _____
Strep throat No ____ Yes ____ Age _____

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Social Development

Does your child make friends easily? No _____ Yes _____

Does your child have any difficulties interacting with other children?
No _____ Yes _____

Does your child have any difficulties interacting with adults?
No _____ Yes _____

Does your child have a "best friend"? No _____ Yes ____

Preschool/School History

Is your child attending preschool/school? No _____ Yes _____
If yes, name of school _____

Child's current school grade _____

Does your child attend any special classes or receive any special education services?
No _____ Yes _____
If yes, please name _____

Has your child ever repeated a grade in school or been "held-back" for any reason?
No _____ Yes _____
If yes, explain _____

Does your child have any learning or behavioral problems in school?
No _____ Yes _____
If yes, explain
_____
_____
_____

Sleep Habits

What time does your child generally go to bed? _____ pm/am
What time does your child generally wake up? _____ pm/am
On average, how many hours does your child sleep per night? _____hours
Does your child snore or seem to gasp for air during the night? No _____ Yes _____

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Stressors

Is your child facing significant stressors at this time? No _____ Yes _____
If yes, please describe

_____
_____
_____
_____
_____

Is your family facing any significant stressors just now?

_____
_____
_____
_____
_____
_____

Is there anything else you would like us to know that would assist us in understanding your child?

_____
_____
_____
_____
_____
_____
_____

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The SNAP-IV Teacher and Parent Rating Scale

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Name: _____ Gender: _____ Age: _____

Completed by: _____Date:_____Rx_____

For each item, check the column which best describes this child:	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
TOTAL				
INATTENTION AVERAGE SCORE (TOTAL/9) (2.56T; 1.78P)				
11. Often fidgets with hands or feet or squirms in seat				
12. Often leaves seat in classroom or in other situations in which remaining seated is expected				
13. Often runs about or climbs excessively in situations in which it is inappropriate				
14. Often has difficulty playing or engaging in leisure activities quietly				
15. Often is "on the go" or often acts as if "driven by a motor"				
16. Often talks excessively				
17. Often blurts out answers before questions have been completed				

18. Often has difficulty awaiting turn				
19. Often interrupts or intrudes on others (e.g., butts into conversations/games)				
TOTAL				
HYPERACTIVE/IMPULSIVE AVERAGE SCORE (TOTAL/9) (1.78T; 1.44P)				
For each item, check the column which best describes this child:	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
21. Often loses temper				
22. Often argues with adults				
23. Often actively defies or refuses adult requests or rules				
24. Often deliberately does things that annoy other people				
25. Often blames others for his or her mistakes or misbehavior				
26. Often touchy or easily annoyed by others				
27. Often is angry and resentful				
28. Often is spiteful or vindictive				
TOTAL				
ODD AVERAGE SCORE (TOTAL/8) (1.38T; 1.88P)				
29. Has difficulty getting started on classroom assignments				
30. Has difficulty staying on task for an entire classroom period				
31. Has problems in completion of work on classroom assignments				
32. Has problems in accuracy or neatness of written work in the classroom				
33. Has difficulty attending to a group classroom activity or discussion				
34. Has difficulty making transitions to the next topic or classroom period				
TOTAL				
ACADEMIC AVERAGE SCORE (TOTAL/6)				

35. Has problems in interactions with peers in the classroom				
36. Has problems in interactions with staff (teacher or aide)				
37. Has difficulty remaining quiet according to classroom rules				
38. Has difficulty staying seated according to classroom rules				
TOTAL				
DEPORTMENT AVERAGE SCORE (TOTAL/4)				
ADHD AVG SCORES (IN; H-I)				
ADHD-C AVERAGE SCORE (TOTAL/2) (2.00T; 1.67P)				