INTAKE EVALUATION (Attach additional sheets if needed)

Name: _____ Age: _____ Date: _____
Person completing this form: _____
Others present: _____
Are the patient's parents: ☐ Married ☐ Divorced/Separated ☐ Other_____
Please name all persons who have legal medical decision-making authority for this patient*:_____
_____
*If applicable, please bring a copy of the court decree stating who has medical decision-making authority.

Staff Use Only:	Court decree brought in_____ Accompanying adult instructed and agrees to get us copy of court decree_____

Current living situation (relationship of person(s) with whom patient resides)? _____
_____

Are you interested in natural approaches to your treatment? ☐ Yes ☐ No

Allergies to medication:
_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____
_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____
_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____

Reason for this appointment:

What are the reasons you scheduled an appointment with our office? _____
_____
_____
_____
_____

How long have you had these symptoms? _____
_____

Are these symptoms related to a life situation? ☐ Yes ☐ No If yes, please explain: _____
_____
_____
_____
_____

Do these symptoms seem to come and go regularly, as in a cycle? ☐ Yes ☐ No If yes, please describe: _____
_____

Current medications: (IMPORTANT: Please list any prescription & non-prescription medications, vitamins, supplements or herbs; include name, dose & how often taken)_____
_____
_____
_____
_____
_____
_____

Who has been prescribing your meds? _____

Name: _____ Date: _____

Medical History:
Do you have any of the following medical conditions? (check all that apply, use the space provided next to each condition to elaborate if needed)

- ☐ High/Low blood pressure _____
- ☐ High cholesterol _____
- ☐ Heart disease _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Liver problems _____
- ☐ Kidney problems _____
- ☐ Respiratory problems _____
- ☐ Asthma _____
- ☐ Nervous system disorder _____
- ☐ Seizures _____
- ☐ Gastrointestinal problems _____
- ☐ Blood disorder _____
- ☐ Thyroid disorder _____
- ☐ Other glandular disorder _____
- ☐ Sleep disorder _____
- ☐ Headaches/Migraines _____
- ☐ Pain disorder _____
- ☐ Other (please be specific) _____

When was your child's most recent physical? _____
Did their doctor have any concerns about their health? ☐ Yes ☐ No If yes, please describe: _____
_____
Did they have any blood work done (i.e., thyroid testing)? ☐ Yes ☐ No
If yes, was anything abnormal? _____

Has your child or anyone in the genetic family had cardiovascular (heart) disease such as increased heart rate, irregular heart beat or a heart birth defect? If yes please describe: _____
_____

Check any significant family medical illness or history:

- ☐ High/Low blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Kidney problems
- ☐ Respiratory problems
- ☐ Glucose intolerance and/or diabetes
- ☐ Asthma
- ☐ Nervous system disorder
- ☐ Seizures
- ☐ Gastrointestinal problems
- ☐ Blood disorder
- ☐ Thyroid disorder
- ☐ Other glandular disorder
- ☐ Sleep disorder
- ☐ Headaches/Migraines
- ☐ Pain disorder
- ☐ Other _____
_____

Reason for this appointment:

What are the reasons you scheduled an appointment with our office? _____
_____
_____
_____
_____
_____
_____
_____

How long has your child had these symptoms? _____

Are these symptoms related to a life situation? ☐ Yes ☐ No
If yes, please explain: _____
_____

Name: _____ Date: _____

Do these symptoms seem to come and go regularly, as in a cycle? ☐ Yes ☐ No
If yes, please describe: _____

Has your child experienced Post-Traumatic Stress Disorder (PTSD) or any traumas including physical, emotional or sexual abuse? ☐ Yes ☐ No
If yes, please describe: _____

How is your child's appetite? _____

Does your child become more hyperactive after eating:

☐ Sugar	☐ Eggs	☐ Chocolate
☐ Milk products	☐ Yellow food dye	☐ Red food dye

Please check the boxes below for all that apply to your child:

- ☐ Runny or stuffy nose
- ☐ Frequent coughing or wheezing
- ☐ Dark circles or bags under the eyes
- ☐ Dry, flaky lips
- ☐ One or both ears red and/or burning
- ☐ Refusal to be touched
- ☐ Aggression such as biting, hitting, spitting, pinching, punching and kicking

Does your child have any family history of allergies? ☐ Yes ☐ No
If yes, please provide details: _____

Do you suspect your child has any food allergies? ☐ Yes ☐ No
If yes, please describe: _____

Have you consulted a doctor regarding this? ☐ Yes ☐ No
If yes, what was the outcome of the consultation? _____

Has your child had any recent changes in weight? ☐ Yes ☐ No
If yes, please describe: _____

Name: _____ Date: _____

ADD/ADHD Symptom Information:

Has your child previously been evaluated for ADD/ADHD? ☐ Yes ☐ No
If yes, please tell us who evaluated them, with what tests and what the results were: _____

What are the primary symptoms related to your child's ADD/ADHD:

☐ Attention	☐ Impulsivity	☐ Focus
☐ Distractibility	☐ Restless/always active	☐ Oppositional

Please describe these symptoms in more detail and how they are affecting your child's life in the following areas:
Home: _____

School or work: _____

Relationships: _____

How long have these symptoms been a problem for your child?
Are these symptoms: ☐ Always present ☐ Intermittent
Please describe: _____

Sleep Habits:

Does your child have trouble falling asleep? ☐ Yes ☐ No
If yes, how long does it take for your child to fall asleep and please describe why your child has trouble if you know?

How is the quality of your child's sleep (e.g. light, deep, etc.)? _____

Does your child wake up in the middle of the night? ☐ Yes ☐ No
If so, how often and are they able to fall back to sleep? _____

Does your child seem to feel rested in the morning? ☐ Yes ☐ No ☐ Sometimes

Name: _____ Date: _____

Please check all that apply:
☐ My child snores
☐ My child has stopped breathing, gasps, snorts or thrashes in bed while sleeping
☐ My child has unexplained bedwetting
☐ My child experiences alterations in mood
☐ My child misbehaves to a greater degree than other children
☐ My child has poor school performance
☐ My child sleepwalks
☐ My child has night terrors
Please describe any items endorsed above: _____
_____
_____

What time does your child typically go to sleep and awaken? _____

Is it hard to awaken your child in the morning? ☐ Yes ☐ No
What kind of mood is your child usually in when he/she awakens? _____

Has your child ever had a sleep study? ☐ Yes ☐ No

Psychiatric History:

Has your child received any past psychiatric treatment or psychotherapy? ☐ Yes ☐ No
If yes, please list the names of the psychiatrists or therapists they have seen, why they were seen and for how long they were treated.

Has your child had any hospitalizations for a psychiatric condition? 0 Yes 0 No
If yes, please describe (include when, where, how long, what treatment did he/she receive and who was the treating psychiatrist). _____
_____
_____
_____

Is your child currently in psychotherapy? ☐ Yes ☐ No
If yes, who is the therapist and how long has the child been seen? _____
_____
If no, do you think therapy would be beneficial to your child or your family? ☐ Yes ☐ No

Is there any family genetic psychiatric history? ☐ Yes ☐ No
If yes, please be specific (who has what problem? on mother's or father's side?). If no formal diagnoses were made, what is your "gut" feeling about your family genetic psychiatric history? _____
_____
_____
_____

Has there been any past history or has your child expressed any thoughts of harming themselves or anyone else (thoughts, plans, attempts, cutting, self-mutilation, passive thoughts of wishing they weren't here, etc.)? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____

Name: _____ Date: _____

Support System:

Do you feel that your child has a support system? Check all that apply:
☐ Family ☐ School ☐ Friends ☐ Other:

Head Injuries:

Has your child ever had any head injury, sports injury to the head, falls, concussions or car accidents?
☐ Yes ☐ No (If no, skip to next section) ☐ Don't Know
If yes, describe where on the head the injury occurred and at what age: _____
_____
_____

Was there any loss of consciousness or amnesia? ☐ Yes ☐ No

Has there been any change in mood or memory since the head trauma occurred? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____

Was your child hospitalized for the head injury? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____

Was any type of scan performed (CAT scan, MRI, EEG, etc.)? ☐ Yes ☐ No ☐ Don't know
If yes, what did it show? _____
_____
_____

Childhood/Cultural History:

Describe your child's family life (include if family is intact, if parents are divorced and if so how old your child was, any custody arrangements, etc.) _____
_____
_____
_____
_____
_____

Please tell us who lives with the child:
Name: Relationship: Age:
_____
_____
_____
_____
_____

Was the child adopted? ☐ Yes ☐ No If yes, please tell us about the adoption: _____
_____
_____

Name: _____ Date: _____

Are there any cultural or spiritual factors that you would like to tell us about? _____

Legal History:

Has your child ever been involved in the legal system? ☐ Yes ☐ No
If yes, please explain: _____

Is your child presently on diversion or probation? ☐ Yes ☐ No
If yes, what are the requirements of their diversion or probation? _____

Substance Use:

Do you have any concerns about substance or alcohol abuse with your child? ☐ Yes ☐ No
If yes, please describe: _____

Do any genetic relatives have a history of problems with alcohol or substance abuse? ☐ Yes ☐ No
If yes, which relative(s)? _____

For Menstruating Female Patients only:

Does your child have regular periods? ☐ Yes ☐ No ☐ N/A
If no, please describe: _____

At what age did she start menstruating? _____

Does she have any PMS symptoms? ☐ Yes ☐ No ☐ N/A
If yes, please describe including how many days of her cycle the symptoms last: _____

School performance (If patient is out of school, complete as to what did occur):

Current grade & school (if applicable): _____

How does the patient do in school? (In grade school and high school; what do teachers say; do they live up to their academic potential; absences, tardiness, alertness in class, etc.). _____

Name: _____ Date: _____

Were any grades repeated? If so, which ones? _____

On average, what grades does the student receive? _____

Has school performance gotten worse as they've gotten older? _____

In what grade did you notice a decline in grades? _____

Is homework an issue in receiving poor grades? ☐ Yes ☐ No
Does the student complete homework? ☐ Yes ☐ No
Does the student forget to turn in homework? ☐ Yes ☐ No
Is there a variation in grades from year to year or subject to subject? ☐ Yes ☐ No
If so, please explain: _____

What subjects are the biggest struggles? _____

Are these struggles related to the subject matter or the teacher? _____

If problems are in math, does the student struggle with retention of math facts or comprehension of how to solve the problem? _____

What is the best subject(s) for the student? _____

What was unique or different about the student's favorite teacher? _____

Does the student receive any special education assistance or tutoring, either now or in the past? ☐ Yes ☐ No
If yes, what kind? _____

Does the student have an IEP (Individualized Education Program) or 504? ☐ Yes ☐ No
If so, please bring a copy to the evaluation.
Do you understand why the student has an IEP or 504? If so, please describe your understanding of it.

Do you feel that the school has followed through with the suggested accommodations described in the IEP or 504?

Name: _____ Date: _____

ADD/ADHD/Learning Disorder Background Information:

Are there any ADD/ADHD/Learning Disorders or Behavioral Problems in the family genetics? ☐ Yes ☐ No

If so, in whom (also state whether it was on mother's or father's side)? If no formal diagnosis was ever made, what is your "gut" feeling about this question? _____

_____

_____

Were there any problems in pregnancy or birth (i.e. cord wrapped around neck or ankle, oxygen required at birth, etc.)?

_____

_____

What was the patient's Apgar score, if known? _____

Were there many ear infections as a child? ☐ Yes ☐ No
If yes, how many would you estimate: ☐ <5 ☐ 5-10 ☐ >10
Were tubes ever surgically inserted? ☐ Yes ☐ No
Were any antibiotics taken? ☐ Yes ☐ No
If yes, which ones? _____

How does the patient get along with friends and peers (e.g., isolated, age appropriate, attention seeking, respect for other's personal space and possessions, oppositional, aggressive, etc.)? _____

_____

_____

_____

_____

What are the patient's strengths and talents? _____

_____

_____

Any other miscellaneous information we should know? _____

_____

_____

Developmental Milestones: Check any of the following that may apply. As an infant, the patient usually:

☐ Was restless, squirmy, into everything
☐ Had difficulty in how they handled change in routine
☐ Protested when first introduced to new foods, places, or people
☐ Was intense and/or loud
☐ Was unpredictable in feeding and sleeping
☐ Was sensitive to noise, texture, clothing
☐ Was fussy and unhappy
☐ Did not enjoy cuddling
☐ Was not calmed by holding or stroking
☐ Had colic
☐ Had sleep problems
☐ Was hard to arouse while asleep
☐ Had bedwetting or problems with soiling (until what age _____)

Name: _____ Date: _____

Behavior/Characteristics: Check any of the following symptoms that apply to the patient (off medication) either now or in the past:

- ☐ Fails to pay attention to details or is careless
- ☐ Has difficulty organizing tasks and activities
- ☐ Is forgetful in daily activities
- ☐ Doesn't seem to listen to what is being said
- ☐ Avoids, dislikes or is reluctant to engage in tasks requiring sustained mental effort
- ☐ Is easily distracted by external stimuli
- ☐ Neither follows through on instructions nor completes chores, schoolwork or jobs (not because of oppositional behavior or failure to understand)
- ☐ Loses things
- ☐ Has trouble keeping attention on tasks or play
- ☐ Shifts from one uncompleted activity to another
- ☐ Has difficulty remaining seated
- ☐ Has difficulty awaiting turns
- ☐ Blurts out answers to questions before they have been completed
- ☐ Has difficulty playing quietly
- ☐ Talks excessively
- ☐ Interrupts or intrudes on others
- ☐ Squirms in seat or fidgets
- ☐ Inappropriately runs or climbs
- ☐ Appears driven or "on the go"

Please answer the following questions for your child in his/her infancy:

How often did your child eat seafood? _____ Servings/month

Did your child have any negative reactions to any vaccinations? ☐ Yes ☐ No
If yes, please rank the severity using the scale below:
1 – mild fever for one day
2 – high fever, up to 2 days
3 – up to 1 week, major reaction, long-term effects
Please explain the reaction, including the vaccination name if you know: _____
_____

Did your child eat or lick paint? ☐ Yes ☐ No
If yes, please describe: _____

Did your child eat any non-food items? ☐ Yes ☐ No
If yes, please describe: _____

Did your child have any of the following symptoms?
- ☐ Gastrointestinal problems: chronic diarrhea/constipation after 1 year of age
- ☐ Sleep problems: problems falling asleep and/or waking during the night
- ☐ Low muscle tone: general muscle weakness
- ☐ Excessive salivation/drooling
- ☐ Thrush: white yeast infection in the mouth

If you checked any of the above, please describe: _____
_____
_____

Name: _____ Date: _____

Did your child experience a period of major regression, during which they lost important skills? ☐ Yes ☐ No
If yes, please explain: _____
_____
_____

How old was the home where your child spent their infancy through toddler years? _____

Did your child spend any appreciable time in a home older than 20 years? _____

Is your child regularly around any antique furnishings? ☐ Yes ☐ No
If yes, please explain: _____
_____

Does your child have any fillings? ☐ Yes ☐ No
If yes, are they: ☐ composite ☐ mercury

Did the mother breastfeed? ☐ Yes ☐ No
If yes, how long did the mother nurse? _____

During pregnancy:

How often did the mother eat seafood? _____

Did the mother have a Rhogam shot (due to an Rh difference between mother and child)? ☐ Yes ☐ No

Did the mother have any vaccinations during your pregnancy/breastfeeding? ☐ Yes ☐ No
If yes, please explain: _____
_____

Did the mother do any painting or reside in a home that had been recently painted during your pregnancy or before it?
☐ Yes ☐ No

Did the mother smoke while she were pregnant and/or breastfeeding? ☐ Yes ☐ No
If yes, please estimate the number of cigarettes per day: _____

Was the mother exposed to second-hand smoke due to spouse, officemates, or any others? ☐ Yes ☐ No
If yes, please estimate the extent: ☐ mild/infrequent ☐ moderate ☐ severe

Did the mother take a prenatal supplement? ☐ Yes ☐ No

Did the mother use any pesticides in her home during your pregnancy? ☐ Yes ☐ No
If yes, list the number of times: _____

Did the mother have any dental work done while pregnant? ☐ Yes ☐ No
If yes, please explain: _____
_____

MEDICATION HISTORY

Name: _____ Date: _____

Instructions: Check the box next to the names of any medications that you have EVER taken, and complete the remaining boxes as completely as possible.

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	**Generic Name**	**Max Total Daily Dose**	**Start Date Mo / Yr**	**Stop Date Mo / Yr**	-1 Worse, 0 No change, 1 Marginally improved, 2 Markedly improved, 3 Resolved, 9 No information	List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
Selective Serotonin Reuptake Inhibitors (SSRIs)					Circle Answer		Circle Answer	(if 2 or 3, describe)
☐Celexa	citalopram		/	/	-1 0 1 2 3 9		1 2 3	
☐Lexapro	escitalopram		/	/	-1 0 1 2 3 9		1 2 3	
☐Luvox	fluvoxamine		/	/	-1 0 1 2 3 9		1 2 3	
☐Paxil	paroxetine		/	/	-1 0 1 2 3 9		1 2 3	
☐Prozac	fluoxetine		/	/	-1 0 1 2 3 9		1 2 3	
☐Zoloft	sertraline		/	/	-1 0 1 2 3 9		1 2 3	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)								
☐Cymbalta	duloxetine		/	/	-1 0 1 2 3 9		1 2 3	
☐Effexor	venlafaxine		/	/	-1 0 1 2 3 9		1 2 3	
Other Antidepressants								
☐Desyrel	trazodone		/	/	-1 0 1 2 3 9		1 2 3	
☐ECT			/	/	-1 0 1 2 3 9		1 2 3	
☐Remeron	mirtazapine		/	/	-1 0 1 2 3 9		1 2 3	
☐Serzone	nefazodone		/	/	-1 0 1 2 3 9		1 2 3	
☐Wellbutrin	bupropion		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name: _____ Date: _____

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	Generic Name	Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr	-1 Worse, 0 No change, 1 Marginally improved, 2 Markedly improved, 3 Resolved, 9 No information	List any that occurred while taking that medication	1. Lack of therapeutic Effect; 2. Side Effects (describe below); 3. Other (describe below)	
Tricyclic Antidepressants					Circle Answer		Circle Answer	(if 2 or 3, describe)
☐Adapin	doxepin		/	/	-1 0 1 2 3 9		1 2 3	
☐Anafranil	clomipramine		/	/	-1 0 1 2 3 9		1 2 3	
☐Asendin	amoxapine		/	/	-1 0 1 2 3 9		1 2 3	
☐Endep/Elavil	amitriptyline		/	/	-1 0 1 2 3 9		1 2 3	
☐Ludiomil	maprotiline		/	/	-1 0 1 2 3 9		1 2 3	
☐Norpramin	desipramine		/	/	-1 0 1 2 3 9		1 2 3	
☐Pamelor/Aventyl	nortriptyline		/	/	-1 0 1 2 3 9		1 2 3	
☐Sinequan	doxepin		/	/	-1 0 1 2 3 9		1 2 3	
☐Surmontil	trimipramine		/	/	-1 0 1 2 3 9		1 2 3	
☐Tofranil	imipramine		/	/	-1 0 1 2 3 9		1 2 3	
☐Vivactil	protriptyline		/	/	-1 0 1 2 3 9		1 2 3	
Monoamine Oxidase Inhibitors (MAOIs)								
☐Eldepryl/EMSAM	selegiline		/	/	-1 0 1 2 3 9		1 2 3	
☐Manerix	moclobemide		/	/	-1 0 1 2 3 9		1 2 3	
☐Marplan	isocarboxazid		/	/	-1 0 1 2 3 9		1 2 3	
☐Nardil	phenelzine		/	/	-1 0 1 2 3 9		1 2 3	
☐Parnate	tranylcypromine		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name: _____ Date: _____

Medications		Dosage Information			Response -1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	Side Effects List any that occurred while taking that medication	Reason Stopped 1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
Brand Name	**Generic Name**	**Max Total Daily Dose**	**Start Date Mo / Yr**	**Stop Date Mo / Yr**				
Stimulants					Circle Answer		Circle Answer	(if 2 or 3, describe)
☐Adderall	dexlevoamphetamine		/	/	-1 0 1 2 3 9		1 2 3	
☐Concerta	methylphenidate		/	/	-1 0 1 2 3 9		1 2 3	
☐Cylert	pemoline		/	/	-1 0 1 2 3 9		1 2 3	
☐Daytrana			/	/	-1 0 1 2 3 9		1 2 3	
☐Dexadrine	dextroamphetamine		/	/	-1 0 1 2 3 9		1 2 3	
☐Eldepryl	selegiline		/	/	-1 0 1 2 3 9		1 2 3	
☐Focalin	dexmethylphenidate		/	/	-1 0 1 2 3 9		1 2 3	
☐Provigil	modafinil		/	/	-1 0 1 2 3 9		1 2 3	
☐Ritalin	methylphenidate		/	/	-1 0 1 2 3 9		1 2 3	
☐Strattera	atomoxetine		/	/	-1 0 1 2 3 9		1 2 3	
Anti-Convulsants/Mood Stabilizers								
☐Depakote, Depakene	valproic acid		/	/	-1 0 1 2 3 9		1 2 3	
☐Eskalith, Lithobid	lithium carbonate		/	/	-1 0 1 2 3 9		1 2 3	
☐Kepra	levetiracetam		/	/	-1 0 1 2 3 9		1 2 3	
☐Lamictal	lamotrigine		/	/	-1 0 1 2 3 9		1 2 3	
☐Neurontin	gabapentin		/	/	-1 0 1 2 3 9		1 2 3	
☐Tegretol, Epitol, Carbatrol	carbamazapine		/	/	-1 0 1 2 3 9		1 2 3	
☐Topamax	topiramate		/	/	-1 0 1 2 3 9		1 2 3	
☐Trileptal	oxcarbazepine		/	/	-1 0 1 2 3 9		1 2 3	
☐Zonegran	zonisamide		/	/	-1 0 1 2 3 9		1 2 3	
Beta Blockers								
☐Inderal	propranolol		/	/	-1 0 1 2 3 9		1 2 3	
☐Pindolol			/	/	-1 0 1 2 3 9		1 2 3	
☐Tenormin	atenolol		/	/	-1 0 1 2 3 9		1 2 3	
☐Toprol	metoprolol		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name: _____ Date: _____

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	**Generic Name**	**Max Total Daily Dose**	**Start Date Mo / Yr**	**Stop Date Mo / Yr**	-1 Worse, 0 No change, 1 Marginally improved, 2 Markedly improved, 3 Resolved, 9 No information	List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
Minor Tranquilizer / Hypnotics					Circle Answer		Circle Answer	(if 2 or 3, describe)
☐Ambien	zolpidem		/	/	-1 0 1 2 3 9		1 2 3	
☐Atarax	hydoxyzine		/	/	-1 0 1 2 3 9		1 2 3	
☐Ativan	lorazepam		/	/	-1 0 1 2 3 9		1 2 3	
☐Benedryl	diphenhydramine		/	/	-1 0 1 2 3 9		1 2 3	
☐Buspar	buspirone		/	/	-1 0 1 2 3 9		1 2 3	
☐Dalmane	flurazepam		/	/	-1 0 1 2 3 9		1 2 3	
☐Doral	quazepam		/	/	-1 0 1 2 3 9		1 2 3	
☐Halcion	triazolam		/	/	-1 0 1 2 3 9		1 2 3	
☐Klonopin	clonazepam		/	/	-1 0 1 2 3 9		1 2 3	
☐Librium	hlordiazepoxide		/	/	-1 0 1 2 3 9		1 2 3	
☐Lunesta	eszopiclone		/	/	-1 0 1 2 3 9		1 2 3	
☐Prosom	estazolam		/	/	-1 0 1 2 3 9		1 2 3	
☐Restoril	temazepam		/	/	-1 0 1 2 3 9		1 2 3	
☐Rozerem	ramalteon		/	/	-1 0 1 2 3 9		1 2 3	
☐Serax	oxazepam		/	/	-1 0 1 2 3 9		1 2 3	
☐Sonata	zaleplon		/	/	-1 0 1 2 3 9		1 2 3	
☐Tranxene	clorazepate		/	/	-1 0 1 2 3 9		1 2 3	
☐Unisom	doxylamine		/	/	-1 0 1 2 3 9		1 2 3	
☐Valium	diazepam		/	/	-1 0 1 2 3 9		1 2 3	
☐Xanax	alprazolam		/	/	-1 0 1 2 3 9		1 2 3	
☐	chloral hydrate		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name: _____ Date: _____

Medications		Dosage Information			Response -1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	Side Effects List any that occurred while taking that medication	Reason Stopped 1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
Brand Name	**Generic Name**	**Max Total Daily Dose**	**Start Date Mo / Yr**	**Stop Date Mo / Yr**				
Major Tranquilizers/Atypicals					Circle Answer		Circle Answer	(if 2 or 3, describe)
☐Abilify	aripiprazole		/	/	-1 0 1 2 3 9		1 2 3	
☐Clozaril	clozapine		/	/	-1 0 1 2 3 9		1 2 3	
☐Geodon	zipazodone		/	/	-1 0 1 2 3 9		1 2 3	
☐Haldol	haloperidol		/	/	-1 0 1 2 3 9		1 2 3	
☐Loxitane	loxapine		/	/	-1 0 1 2 3 9		1 2 3	
☐Mellaril	thioridazine		/	/	-1 0 1 2 3 9		1 2 3	
☐Moban	molindone		/	/	-1 0 1 2 3 9		1 2 3	
☐Navane	thiothixene		/	/	-1 0 1 2 3 9		1 2 3	
☐Prolixin	fluphenazine		/	/	-1 0 1 2 3 9		1 2 3	
☐Risperdal	risperdone		/	/	-1 0 1 2 3 9		1 2 3	
☐Seroquel	quetiapine		/	/	-1 0 1 2 3 9		1 2 3	
☐Sonazine, Thorazine	chlorpromazine		/	/	-1 0 1 2 3 9		1 2 3	
☐Stelazine	trifluoperazine		/	/	-1 0 1 2 3 9		1 2 3	
☐Symbyax	olanzapine/fluoxetine		/	/	-1 0 1 2 3 9		1 2 3	
☐Trilafon	perphenazine		/	/	-1 0 1 2 3 9		1 2 3	
☐Zyprexa	olanzapine		/	/	-1 0 1 2 3 9		1 2 3	
Others								
	verapamil		/	/	-1 0 1 2 3 9		1 2 3	
			/	/	-1 0 1 2 3 9		1 2 3	
			/	/	-1 0 1 2 3 9		1 2 3	

Childhood Symptoms
(For Child Patients Only)

Name: _____ Date: _____

Circle the number next to each behavior your child currently exhibits or has exhibited in the past.

1. Is excessively distressed when separated from family
2. Exhibits excessive anxiety or worry
3. Has difficulty arising in AM
4. Is hyperactive and excitable in PM
5. Sleeps fitfully or has difficulty getting to sleep
6. Has night terrors or frequently wakes in the middle of the night
7. Is unable to concentrate at school
8. Has poor handwriting
9. Has difficulty organizing tasks
10. Has difficulty making transitions
11. Complains of being bored
12. Has many ideas at once
13. Is very intuitive or very creative
14. Is easily distracted by extraneous stimuli
15. Has periods of excessive, rapid speech
16. Is willful and refuses to be subordinated
17. Displays periods of extreme hyperactivity
18. Displays abrupt, rapid mood swings
19. Has irritable mood states
20. Has elated or silly, giddy mood states
21. Has exaggerated ideas about self or abilities
22. Exhibits inappropriate sexual behavior
23. Feels easily criticized or rejected
24. Has decreased initiative
25. Has periods of low energy or withdraws or isolates self
26. Has periods of self-doubt and poor self-esteem
27. Is intolerant of delays
28. Relentlessly pursues own needs
29. Argues with adults or bosses others
30. Defies or refuses to comply with rules
31. Blames others for his or her mistakes
32. Is easily angered when people set limits
33. Lies to avoid consequences of actions
34. Has protracted, explosive temper tantrums or rages
35. Has destroyed property intentionally
36. Curses viciously in anger
37. Makes moderate threats against others or self
38. Has made clear threats of suicide
39. Is fascinated with blood and gore
40. Has seen or heard hallucinations

TOTAL _____