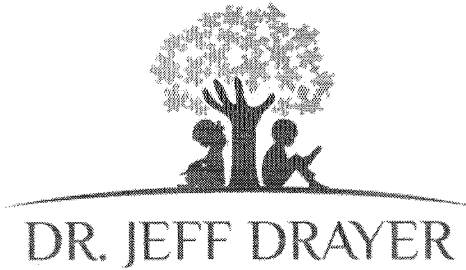

DR. JEFF DRAYER

Dear parent or guardian, thank you for contacting the practice. The following information will be reviewed by Dr. Drayer. I understand that I am asking for a lot of information and I ask that you complete each section to the best of your ability. The more thorough and accurate the information, the better the care I can provide to your child and your family.

INSTRUCTIONS: Please complete this questionnaire and return it to the office prior to your first appointment. For your convenience, this questionnaire can be completed on your computer (you may also print and complete with handwritten responses). Return the completed questionnaire by mail or by e-mail (jdrayer@drdrayer.com) I cannot guarantee the confidentiality of information sent over the internet.

Basic Information

Child's Name: ____________________ Date of Birth: ____________

Primary/Preferred Language: ____________________ Secondary Language: ____________

Child's Gender: ☐ Female ☐ Male ☐ Transgender ☐ ____________

Referral Information:

Who referred you to the practice: ____________________ Relationship: ____________

Ethnicity:

☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African-American ☐ Hispanic/Latino

☐ White ☐ Multiracial ☐ ____________________

Pediatrician:

Name: ____________________ Phone: ____________

Practice: ____________________ Fax: ____________

Address: ____

Family Information:

Please list sibling(s), parent(s), immediate family members (including those not living in the home), and anyone else currently residing with the child.

NAME	AGE	RELATIONSHIP TO THE CHILD

Parent A: ____________________ ☐ Cell ☐ Home ☐ Work

Occupation: ____________________ Preferred Phone Contact #: ____________

E-mail Address: ____________________ Highest Education/Degree: ____________

Parent B: ____________________ ☐ Cell ☐ Home ☐ Work

Occupation: ____________________ Preferred Phone Contact #: ____________

E-mail Address: ____________________ Highest Education/Degree: ____________

Parent's Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Living with Partner

If the parents are not married or were never married, do you have SOLE LEGAL CUSTODY? ☐ Yes ☐ No

If parents are not together, please describe custody, visitation, and living arrangement: ____________________

____

____

Is the child adopted? ☐ Yes ☐ No If yes, adopted at what age? ________ Where from? ____________________

Please list any details of adoption you feel may be relevant: ____________________

____

Primary Concerns

Briefly describe your concerns for which you are requesting services and your goals for treatment.

____

____

____

____

____

____

Medical History

Please be very thorough. Note any past or current symptoms or diagnosis.

Pregnancy & Birth:

Was the child born more than 3 weeks before his/her due date? ☐ Yes ☐ No - If Yes, how early? ____________

Child's birth weight: ______ Lbs. ______ Oz. AGPAR Score? ______ @1 minute ______ @5 minute

Any fertility treatments used to conceive? ☐ Yes ☐ No If Yes, briefly describe: ____________________

Any complications associated with pregnancy or birth? ☐ Yes ☐ No If so, please briefly describe: ____________

Any exposure to toxins? ☐ Yes ☐ No

Please check if any of the following occurred during pregnancy and birth of the child:

☐ Decreased oxygen (anoxia or hypoxia) at birth
☐ Cerebral palsy
☐ Genetic or chromosomal abnormality
☐ Exposure to alcohol or drugs during pregnancy
☐ Exposure to toxic substances after birth (i.e. lead)
☐ Exposure to prescription medication during pregnancy

Date of last physical exam: ____________________

Does the child have any vision or hearing problems? ☐ Yes ☐ No If Yes, describe briefly: ____________

____

When was your child's last hearing test? ____________ Who conducted the test? ____________________

When was your child's last vision test? ____________ Who conducted the test? ____________________

What is the child's dominant hand? ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Neurological History: ☐ None Observed

If Yes, please describe and include any treatment:

Head or brain injury (including concussions):	
Structural abnormalities of the head/brain/central nervous system (e.g., microcephaly, spina bifida):	
Hydrocephalus and/or shunt placement:	

Head CT scan or MRI (results?):	
Incidents of loss of consciousness:	
Migraines or other problematic headaches:	
Seizures:	
Strokes or other cerebrovascular abnormalities:	
Staring spells:	
Brain tumor or cancer:	
Memory problems:	
Encephalitis or meningitis:	
Abrupt loss or regression of language, motor or other cognitive skills:	
Paralysis or abnormal weakness:	
Repetitive movements, noises, or tics:	
Other neurological problems:	

Cardiac History: ☐ None Observed
If Yes, please describe and include any treatment:

Murmurs:	
Structural heart abnormalities:	
High blood pressure:	
High cholesterol:	
Syncope or fainting spells:	
Racing heart or palpitations:	
Heart rhythm abnormalities (e.g., Wolff-Parkinson-White syndrome):	
Other heart/cardiac problems:	

Hematological/Oncology History: ☐ None Observed
If Yes, please describe and include any treatment:

Bleeding or blood abnormalities:	
Leukemia:	
Anemia:	
Immune deficiency or other immunological abnormality:	
Cancer and/or exposure to radiation or chemotherapy:	

Respiratory History: ☐ None Observed
If Yes, please describe and include any treatment:

Asthma:	
Problems with shortness of breath:	
Other respiratory problems:	

Sleep History: ☐ None Observed
If Yes, please describe and include any treatment:

Insomnia (*onset, waking during night, waking too early*):	
Apnea diagnosed or suspected *(signs can include overweight, snoring, irregular breathing while asleep)*:	
Sleep walking:	
Excessive nightmares:	
Sleep terrors (*distinct from nightmares as child typically does not remember)*:	

Gastrological/Urinological History: ☐ None Observed
If Yes, please describe and include any treatment:

Peptic ulcers:	
Frequent stomach aches and/or nausea and vomiting:	
Celiac disease:	
Liver damage or illness (e.g. hepatitis):	
Renal (kidney) damage or illness:	
Urinary problems or abnormalities:	
Problems with weight (i.e., overweight, underweight, rapid weight gain or loss):	
Problems with eating (i.e., too much, too little, binging, purging):	

Endocrinological History: ☐ None Observed
If Yes, please describe and include any treatment:

Diabetes or other blood sugar abnormalities:	
Thyroid abnormalities:	
Other endocrine problems:	

Gynecological History: ☐ None Observed ☐ N/A
If Yes, please describe and include any treatment:

Menses onset (age?):	
Menstrual irregularities:	
Possibility of pregnancy:	
Known or suspected sexual activity:	

Miscellaneous: ☐ None Observed
If Yes, please describe and include any treatment:

Broken bones/Fractures:	
Nerve damage or disorder:	
Fibromyalgia:	
Chronic pain:	
Other:	

Have any of the child's biological relatives been diagnosed or treated for any of the above? ☐ Yes ☐ No
If Yes, please list diagnosis, treatment, and relation to the child (it is especially important to note any family history of seizures, diabetes, cardiac problems, sudden deaths, or hereditary illness):

List any previous or planned medical surgeries/hospitalizations. Please provide reports or records you have prior to the first appointment. List additional hospitalizations/surgeries on back if necessary and check below where indicated.

☐ No Surgeries/Hospitalizations

DATE	DOCTOR	HOSPITAL	SURGERY/HOSPITALIZATION	REASON

Allergies/Adverse Reactions:

Please list any allergies or bad reactions your child has had to medication or foods? ☐ None

Please Note: Medical records are extremely helpful and, if available, copies should be provided prior to the appointment.

Developmental History

Early Temperament: Check all that apply to the child's early temperament.

☐ Affectionate
☐ Bossy
☐ Clingy
☐ Defiant
☐ Easy going
☐ Easily angered
☐ Easily frustrated
☐ Empathic
☐ Explosive
☐ Fearful
☐ Fussy
☐ Happy
☐ Helpful
☐ Hyperactive
☐ Impulsive
☐ Introverted
☐ Out going
☐ Rigid and Inflexible
☐ Shy
☐ Stubborn
☐ Withdrawn
☐ Liked physical contact
☐ Did not like physical contact
☐ Interested in others
☐ Not interested in others
☐ Sensitive to loud noises

Milestones: Please note whether the following milestones were met at an appropriate age, or if not, if/when they were met.

Toilet Training: ☐ Met All at Appropriate Age

Urinates regularly in a toilet: ____________________

Uses toilet regularly for bowel movements: ____________________

Stays dry most days: ____________________

Stays dry most nights: ____________________

Language Skills: ☐ Met All at Appropriate Age

Vocalizes pleasure/displeasure with sounds (i.e., laughs, giggles, cries, fusses): ____________________

Babbles (says ba-ba-ba, ma-ma, or da-da): ____________________

Says 8-10 words (pronunciation may be unclear): ____________________

Knows 50 words: ____________________

Puts two words together: ____________________

Begins to use plurals such as "shoes": ____________________

Repeats sentences: ____________________

Engages in conversation: ____________________

Uses sentences with 8 or more words: ____________________

Motor Skills ☐ Met All at Appropriate Age

Crawling: ____________________

Walking: ____________________

Holds object between finger and thumb: ____________________

Ties Shoes: ____________________

Holds a crayon so it can be used: ____________________

Draws a person with at least 2 parts: ____________________

Can throw a ball: ____________________

Rides a bike: ____________________

Social Skills: ☐ Met All at Appropriate Age

Watches your face when you speak: ____________________

Responds to name: ____________________

Follows simple directions accompanied by gestures: ____________________

Eye contact: ____________________

Shares toys and interests: ____________________

Emotion recognition: ____________________

Educational History

Current grade or highest level of schooling completed and/or degree: ____________________

What school does your child currently attend (including address):

____

Please describe how your child is doing in school at this time:

____

____

____

Is this a change from the previous level of performance? ☐ Yes ☐ No

If Yes, briefly explain:

____

____

Has Your Child...

If Yes, please provide a description and dates on the lines provided next to each question.

Received early intervention services: ☐ Yes ☐ No ______________________

Repeated a grade: ☐ Yes ☐ No ______________________

Received special education accommodations or services: ☐ Yes ☐ No ______________________

Had any type of CORE/Special Education Evaluation: ☐ Yes ☐ No ______________________

Been on an individualized educational plan (IEP): ☐ Yes ☐ No ______________________

Had reading challenges (currently or during early reading years): ☐ Yes ☐ No ______________________

Received speech and language therapy: ☐ Yes ☐ No ______________________

Received occupational therapy: ☐ Yes ☐ No ______________________

Received physical therapy: ☐ Yes ☐ No ______________________

Used private tutoring: ☐ Yes ☐ No ______________________

Please provide copies of any educational records, including any evaluations/testing and IEP reports.

Mental Health History

Diagnoses: Suspected or Previously Diagnosed Mental Health Issues (Past and Present). Please check only if relevant diagnosis.

ADHD/ADD	☐ Prev. Diagnosed	☐ Suspected
Oppositional Defiant Disorder	☐ Prev. Diagnosed	☐ Suspected
Major depression	☐ Prev. Diagnosed	☐ Suspected
Panic disorder	☐ Prev. Diagnosed	☐ Suspected
Generalized anxiety	☐ Prev. Diagnosed	☐ Suspected
Social anxiety	☐ Prev. Diagnosed	☐ Suspected
Bipolar	☐ Prev. Diagnosed	☐ Suspected
Obsessive Compulsive Disorder	☐ Prev. Diagnosed	☐ Suspected
Phobias (describe):	☐ Prev. Diagnosed	☐ Suspected
Autism	☐ Prev. Diagnosed	☐ Suspected

Asperger's	☐ Prev. Diagnosed	☐ Suspected
PTSD	☐ Prev. Diagnosed	☐ Suspected
Alcohol problem/ dependence/abuse	☐ Prev. Diagnosed	☐ Suspected
Substance dependence/ abuse	☐ Prev. Diagnosed	☐ Suspected
Schizophrenia	☐ Prev. Diagnosed	☐ Suspected
Tourettes	☐ Prev. Diagnosed	☐ Suspected
Borderline personality	☐ Prev. Diagnosed	☐ Suspected
Other:	☐ Prev. Diagnosed	☐ Suspected

Treatment: Past Mental Health Treatment including both Outpatient and Psychiatric Hospitalizations.

Please list any previous neurological, psychological, psychiatric, neuropsychological, educational, occupational, speech/ language or other related evaluations. Please provide any reports or records you have prior to the first appointment. ☐ None

TYPE OF EVALUATION	DATE	DONE BY	REASON FOR EVALUATION

Outpatient Treatment:

CLINICIAN	DATES	WHERE	REASON/TREATMENT/OUTCOME

Psychiatric Hospitalization and Partial Hospitalization Programs:

CLINICIAN	DATES	WHERE	REASON/TREATMENT/OUTCOME

Medications:

List any psychotropic medications the child is currently receiving or has received in the past.

MEDICATION	DOSAGE/ FREQUENCY	PROVIDER	REASON	DATES

Alternative Treatments:

List any alternative treatment/therapies, herbal remedies, dietary supplements, or other treatments the child is currently receiving or has received in the past.

TREATMENT	DOSAGE/ FREQUENCY	PROVIDER	REASON	DATES

☐ Check here if more medications or treatments are listed on the back.

Family Mental Health History: ☐ None Observed

Do any of the child's biological relatives have any mental health history (e.g., anxiety, depression, bipolar disorder, OCD, etc.) and/or developmental (e.g., autism, mental retardation, learning, attention, etc.) and/or substance abuse problems, either now or in the past? Please include parents, grandparents, great grandparents, uncles, aunts, cousins, and siblings in your summary. ☐ Yes (Describe below) ☐ No

Substance Abuse History

Please describe your child's use or suspected use, abuse, exposure to, and/or experimentation with alcohol, nicotine, drugs, or other substances. ☐ None

Trauma History

Have you or your child experienced any form of serious psychological/emotional trauma or loss?

☐ Yes (Check all that apply) ☐ No

☐ Exposure to violence ☐ Physical abuse ☐ Emotional abuse ☐ Sexual abuse

☐ Family/interpersonal loss ☐ Neglect ☐ Other: ____________

☐ Medical crises ☐ Life threatening incident

If YES to any of the above, please describe: ____________

Legal History

Do you have any concerns about your child engaging in risky behavior (i.e. promiscuity or unprotected sex, substance use/ experimentation, driving recklessly or without seatbelt, seeking dangerous thrills, etc.)? ☐ Yes (Describe below) ☐ No

Does your child have any history of legal involvement or law breaking behavior (i.e. CHINS, DCF, Citations, Arrest, Juvenile Court, Probation)? ☐ Yes (Describe below) ☐ No

Does your child have any history of involvement with the Department of Children and Families or the Department of Youth Services? ☐ Yes (Describe below) ☐ No

General Information

Please provide a description of your child's strengths, special interests, and areas of skill. Include any relevant extracurricular activities.

Other information that you think is relevant to your child's treatment:

Thank you for taking the time to complete this questionnaire. As a reminder, please remember to send this back in advance of your appointment if possible AND please remember to bring copies of relevant medical records, prior psychological or neuropsychological evaluations, previous treatment records, and school evaluations (special education testing, IEPs, etc.).

Completed by: ______________________ Date: __________

Relationship to patient: ______________________