



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@drjeffdrayer.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:

- | | |
|--|---|
| <input type="checkbox"/> Decreased oxygen (anoxia or hypoxia) at birth | <input type="checkbox"/> Exposure to alcohol or drugs during pregnancy |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Exposure to toxic substances after birth (i.e. lead) |
| <input type="checkbox"/> Genetic or chromosomal abnormality | <input type="checkbox"/> 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 (<i>onset, waking during night, waking too early</i>):	
Apnea diagnosed or suspected (<i>signs can include overweight, snoring, irregular breathing while asleep</i>):	
Sleep walking:	
Excessive nightmares:	
Sleep terrors (<i>distinct from nightmares as child typically does not remember</i>):	

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- Easily frustrated Hyperactive Withdrawn

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	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Oppositional Defiant Disorder	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Major depression	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Panic disorder	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Generalized anxiety	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Social anxiety	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Bipolar	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Obsessive Compulsive Disorder	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Phobias (describe):	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Autism	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected

Asperger's	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
PTSD	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Alcohol problem/dependence/abuse	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Substance dependence/abuse	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Schizophrenia	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Tourettes	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Borderline personality	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> Suspected
Other:	<input type="checkbox"/> Prev. Diagnosed	<input type="checkbox"/> 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: _____