



# CAROLINA COMPLETE PSYCHIATRY

Patient Name:

Patient Date of Birth:

Person giving history and relationship to patient:

Did patient assist with completion of intake forms? Y/N

If biological parents are divorced, who has primary custody of the child? Visitation schedule?

## Pregnancy and Developmental:

Was mother's pregnancy healthy? Y/N

Any complications during delivery? Y/N Specify:

Full term birth? Y/N

Did child meet typical developmental milestones? (crawling, walking, talking) Y/N

If no, specify:

Age of toilet training? \_\_\_\_\_

## Family/Home Life and Relationship:

Are there concerns for the relationships between the patient and any parent or sibling? Y/N

If yes, please explain.

Does the patient complete activities of self-care (bathing, brushing teeth, dressing) by his/her self? Y/N

Does the patient do well when under the care/supervision of others (ie: babysitter, grandparents)?  
Y/N If no, specify:

How is the patient disciplined and by whom?

Are there defined household rules/expectations? **Y/N**

Is there consistent structure to household?

Meal times? \_\_\_\_\_

Homework time? \_\_\_\_\_

Bedtime time? \_\_\_\_\_

School:

School information: Presently attending: \_\_\_\_\_ Grade \_\_\_\_\_

How well is child doing in current classroom/school situation?

Typical Academic Performance/Grades:

Have any of child's teachers/principals/counselors complained to parents or noted a need for improvement in child's behavior or academic performance? Please describe:

Any school suspensions or expulsions? If so, please describe:

Peer Groups and Self-Activities:

How well does the patient interact with his/her peers?

How well does the patient interact with other adults?

How well does the patient complete activities on his/her own, such as art projects, reading books, or any other interests?

Please place a checkmark or n/a for not applicable for each question below. Further information will be gathered during our visit.

- Bed wetting or problems with toileting;
- Tics (unusual movements);
- Seizures/spells;
- Suspected or previous diagnosis of an eating disorder;
- Has this patient ever done anything to harm him/herself?
- History of violence or harming others including animals?
- Historical diagnosis or suspicion of Autism Spectrum Disorder?
- Any problems taking medicine?