CAROLINA COMPLETE PSYCHIATRY

Patient Name: Patient Date of Birth:

Person giving history and relationship to patient:

Did patient assist with completion of intake forms? **Yes** ☐ **or** ☐ **No**

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

Pregnancy and Developmental:

Was mother's pregnancy healthy? **Yes** ☐ **or** ☐ **No**

Any complications during delivery? **Yes** ☐ **or** ☐ **No** Specify:

Full term birth? **Yes** ☐ **or** ☐ **No**

Did child meet typical developmental milestones? (crawling, walking, talking) **Yes** ☐ **or** ☐ **No**

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?

Yes ☐ **or** ☐ **No**

If yes, please explain.

Does the patient complete activities of self-care (bathing, brushing teeth, dressing) by his/her self? **Yes** ☐ **or** ☐ **No**

Does the patient do well when under the care/supervision of others (ie: babysitter, grandparents)?

Yes ☐ **or** ☐ **No** If no, specify:

How is the patient disciplined and by whom?

Are there defined household rules/expectations? **Yes ☐ or ☐ No**

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 check mark 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?