Mitchel G. Katz, MD
New Patient Questionnaire (0-18 years of age)

Child's Name: ______________________ **Age:** ___ **Today's Date:** ________

Address: ____ **City:** ______________________

State/Province: ________________________________ **Zip Code/Postal Code:** _______

How long at this address? ________

Child's sex: ___ **Child's Birthplace:** ____________________ **Birthdate:** _________________

Child's race: ______________________

Person completing this form: _______________________ **Relation to Child:** ___________

Biological Father's Name: __________________ **Age:** ____ **Education:** ________________

Employed: ________________________ **Work phone:** ____________________

Type of work: _____________________ **Home phone:** ____________________

Biological Mother's Name: ________________ **Age:** ____ **Education:** ________________

Employed: _________________________ **Work phone:** ______________________

Type of work: ______________________ **Home phone:** ______________________

Please describe the problems for which help is needed at this time or questions you wish answered (may use supplemental sheets):

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Current School Information:

Name of school: ______________________________________ Phone number: __________________

Teacher's name: ______________________________________ Grade: _______________

Type of school: ☐ Public ☐ Private ☐ Special

List previous schools and dates attended:

Grades repeated: _______Grades skipped:_____ Suspensions/expulsions _____if yes supply details on supplemental page

Any known learning disabilities? ☐ Yes ☐ No If Yes, explain: _______________________________
____
____

Is your child in any special programs (speech, reading, etc.)? ☐ Yes ☐ No

If yes, explain: ____

How does the school describe this child's classroom behavior?

What does this child do best in at school?

Which of the following problems, if any, does this child have in school? (check those that apply)

- ☐ Does not do homework
- ☐ Poor handwriting
- ☐ Poor reading skills
- ☐ Does not remain seated
- ☐ Non-compliant in class
- ☐ Test anxiety
- ☐ Problems with written language
- ☐ Starts but does not finish homework
- ☐ Poor spelling
- ☐ Forgets assignments
- ☐ Incomplete classroom work
- ☐ Talks out inappropriately in class
- ☐ Excessive time to complete assignments
- ☐ Fails to check homework
- ☐ Poor math
- ☐ Messy and disorganized
- ☐ Poor attention in class
- ☐ Distracted
- ☐ Makes many careless errors

Which of the following, if any, describe(s) this child's interactions with peers? (check those that apply)

- ☐ No friends
- ☐ Mean, aggressive
- ☐ Bossy, controlling
- ☐ Few friends
- ☐ Too shy or too timid
- ☐ Loses friends
- ☐ Trouble making new friends

Further comments on homework, academic functioning, and peer relations:

Family Medical History:

Do medical illnesses run in the family? (examples: seizures, thyroid problems, allergies) ☐ No ☐ Yes

If yes, please describe, specifying relationship to this child:

Psychiatric Medication History:

Has this child ever taken psychiatric medications? ☐ No If no, please turn to page 5 and continue
☐ Yes If yes, please complete the following.

	Medication	Medication
Drug Name		
Given by Whom		
When Started		
When Stopped		
For What Problems		
Dose		
Benefits		
Side Effects		
Results		

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Side Effects		
Results		

Therapy History:

Has this child ever received mental health related therapy? ☐ No If no, please turn to page 6
☐ Yes If yes, please complete the following
☐ Don't Know

How would you describe the effectiveness of this treatment?

☐ Much improvement ☐ Some improvement ☐ No improvement

Please use the following chart to describe all therapies this child has received previously:

	Therapy	**Therapy**
Type of Therapy		
Given by Whom		
For What Problems		
When Started		
When Stopped		
How often		
Benefits		
Adverse Effects		
Results		

Continue to next page →

Pregnancy:

Was the pregnancy with this child under a doctor's care? ____Yes ____No ____Don't know

Where there complications with the pregnancy? ____No ____Yes (describe below)

Was the child born prematurely? ____No ____Yes; if yes how many weeks early?_____________

Were there problems during labor and delivery? ____No ____Yes (describe below)

Were there problems with the child immediately after birth? ____No ____Yes(describe below)

Did the child go home at the same time as mother? ____Yes ____No (describe below)

Growth and Development:

Motor development (sitting, crawling and walking): ☐ Normal ☐ Fast ☐ Slow ☐ Don't Know

Speech and language: ☐ Normal ☐ Fast ☐ Slow ☐ Don't Know

Social skills: ☐ Normal ☐ Fast ☐ Slow ☐ Don't Know

Continue to next page →

Temperament (infancy, Toddler, Preschool): Check any that apply

- ☐ Shy or timid
- ☐ Stubborn
- ☐ Affectionate
- ☐ Temper outburst
- ☐ Easy to manage
- ☐ Dare-devil
- ☐ Blank spells
- ☐ Fearful
- ☐ Cautious
- ☐ Underachiever
- ☐ Overactive
- ☐ Slow to warm up
- ☐ Wanted to be left alone
- ☐ Falling spells
- ☐ Impulsive
- ☐ Poor sleep
- ☐ Curious
- ☐ Happy
- ☐ Poor eating
- ☐ More interesting in things than in people
- ☐ Tore up toys more than normal
- ☐ Rocking
- ☐ Heading banging
- ☐ Into everything
- ☐ Aggressive

Bowel trained: ☐ Average ☐ Early ☐ Late ☐ Don't Know

Bladder trained: ☐ Average ☐ Early ☐ Late ☐ Don't Know

Eating behavior: ☐ Picky ☐ Eats too much ☐ Overeats sugar/carbohydrates

Family Psychiatric History:

(Please note any that apply:ADHD, learning issues, major depression, bipolar disorder, obsessive-compulsive disorder, tic disorders, other anxiety disorders, schizophrenia, substance abuse, suicide attempts, other psychiatric problems)

Have any of this child's **biological relatives** had psychiatric problems? ☐ No ☐ Yes ☐ Don't Know

If yes, which biological relative(s) (mother, father, brother, sister, grandparents, aunt, uncle, etc.) ?
____

If yes, please describe problem(s), including treatment: ____

____
____

Outside of biological relatives, are there any **other people with whom child has significant contact** who have psychiatric problems? ☐ No ☐ Yes ☐ Don't Know

If yes, please specify the contact(s) and describe the problem(s), including treatment: ________________

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Other than psychiatric medications noted earlier, does the child take any other medications on a regular basis? ____No ____Yes

Has the child ever been hospitalized? ____No ____Yes

Has the child suffered any significant head trauma (including concussions)? ____No ____Yes

Has the child suffered from any significant illnesses? _____No ____Yes

(If answered "Yes" to any of the above, please provide details below)

Is there anything else you would like us to know about this child before we meet together?

Are there any questions that should have been asked but were not?

Signature ________________________________ Date ________________

Please feel free to use additional sheets of paper to supply additional information and/or details