



**Medical History:**

1. To your knowledge, what were the conditions of the patient's birth/early development (select all that apply):

<input type="checkbox"/> Normal, no problems	<input type="checkbox"/> Stay in the NICU
<input type="checkbox"/> Born prematurely; how early? _____	<input type="checkbox"/> Delayed milestones (e.g., walking, talking, toilet training)
<input type="checkbox"/> Complications with delivery	<input type="checkbox"/> Other: _____

2. Please list all of the patient's current medical conditions (e.g., asthma, genetic conditions, etc.):
3. Please list any surgeries or major hospitalizations/illnesses the patient has had:
4. Has the patient ever been diagnosed with Covid-19? If yes, what were their symptoms?
5. Has the patient received any Covid-19 vaccinations? If yes, how many?
6. Please list all of the patient's current medications and dosages:
7. How much sleep does the patient typically get in a 24-hour period?
8. Does the patient have any of the following problems with sleep (check all that apply)?

<input type="checkbox"/> Sleep too little	<input type="checkbox"/> Sleep too much
<input type="checkbox"/> Trouble falling asleep/insomnia	<input type="checkbox"/> Trouble staying asleep
<input type="checkbox"/> Poor quality sleep	<input type="checkbox"/> Nightmares/disturbing dreams
<input type="checkbox"/> Heavy snoring/stop breathing	<input type="checkbox"/> Other: _____

9. Have there been any recent changes to the patient's weight or appetite? If yes, please describe:

10. Has the patient ever consumed alcohol? If yes, please describe:

11. Has the patient ever used tobacco products? If yes, please describe:

12. Has the patient ever used any recreational drugs? If yes, please describe:

**Psychiatric History:**

1. Is the patient currently receiving counseling/psychotherapy or have they received these services in the past? If yes, please list the therapist's name and practice:

2. Has the patient ever been given any formal diagnoses related to their mental health (select all that apply)?

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Post-traumatic Stress Disorder (PTSD)
<input type="checkbox"/> Generalized Anxiety Disorder	<input type="checkbox"/> Obsessive-Compulsive Disorder (OCD)
<input type="checkbox"/> Major Depressive Disorder	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Other: _____

3. If one or more are selected above, please specify when this was diagnosed and by whom:

4. Is the patient currently taking prescribed medication for their mood/behavior (e.g., antidepressants)? If yes, please list medication names and dosages:

5. Has the patient ever experienced any of the following (select all that apply)?

<input type="checkbox"/> Extreme depressed mood	<input type="checkbox"/> Wild mood swings
<input type="checkbox"/> Extreme anxiety	<input type="checkbox"/> Rapid speech
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Nightmares/sleep disturbance
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusional beliefs
<input type="checkbox"/> Alcohol/substance abuse	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Suicidal thoughts/attempts	<input type="checkbox"/> Homicidal thoughts/attempts

6. Has the patient ever had to be psychiatrically hospitalized? If yes, please describe when or for what reason:

7. Has anyone in the patient’s family (immediate family or relatives) experienced any of the following?

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Post-traumatic Stress Disorder (PTSD)
<input type="checkbox"/> Generalized Anxiety Disorder	<input type="checkbox"/> Obsessive-Compulsive Disorder (OCD)
<input type="checkbox"/> Major Depressive Disorder	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Other: _____

**Developmental/Social History:**

1. Where was the patient born and raised?
2. Who raised the patient (e.g., biological parents, adoptive parents, grandparents)? If the patient’s parents divorced, please describe when and who the patient lived with afterward?
3. How many siblings does the patient have? Are they older or younger?
4. How would you describe the patient’s childhood (including family relationships, traumatic events, childhood abuse, your personality, etc.)?
5. Who all lives in the patient’s home currently?

**Educational/Occupational History:**

1. Is English the patient's first/primary language? If no, please list first language(s) and when the patient learned English:
2. What grade is the patient in?
3. Which of the following describes the patient's academic experience in grade school (select all that apply and add notes as applicable)?

<input type="checkbox"/> Normal, no problems
<input type="checkbox"/> Gifted classes/skipped a grade (what grade?) _____
<input type="checkbox"/> Special classes for learning disability (what was the disability?) _____
<input type="checkbox"/> Had to repeat a grade (what grade?) _____
<input type="checkbox"/> Tutoring outside of school (for what subject?) _____
<input type="checkbox"/> Other: _____

4. Which of the following describes the patient's social experience in grade school (select all that apply)?

<input type="checkbox"/> Enjoyed school	<input type="checkbox"/> Disliked school
<input type="checkbox"/> Had many friends	<input type="checkbox"/> Had a few friends
<input type="checkbox"/> Had no friends/were bullied	<input type="checkbox"/> Rarely got into trouble
<input type="checkbox"/> Had to be disciplined frequently (e.g., detention, suspension, etc.)	<input type="checkbox"/> Other: _____

5. Has the patient ever had contact with the legal system (e.g., been arrested, charged with, or convicted of a crime)? If yes, please describe what happened:
6. Has the patient ever demonstrated difficulty cooperating with authority figures or complying with rules? If yes, please describe:
7. Has the patient ever had difficulty interacting with peers? If yes, please describe:

**Other:**

If there is anything else you'd like to add or explain further, please do so here: