

**All Things New Therapy Services, Inc.**

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New Patient Information - Child

Ages 11 and under

Dear Parent: To help your clinician understand and help your child, please answer the questions on this form and bring it with you to your child's first appointment. Please print using black or blue ink.

Child's Legal Name: _____

Date of birth: _____

Form completed by: _____

Relationship to child: _____

Did anyone refer you to All Things New? _____

Today's date: _____

PRESENTING PROBLEM/REASON FOR TREATMENT

What is your primary reason for having your child come to All Things New? _____

Please check any concerns you may have about your child in the boxes below :

<input type="checkbox"/> Sad or unhappy most of the time <input type="checkbox"/> Cries a great deal <input type="checkbox"/> Decreased energy <input type="checkbox"/> Feelings of being worthless/helpless <input type="checkbox"/> Apathy—doesn't seem to care <input type="checkbox"/> Frequently negative thinking <input type="checkbox"/> Loss of interests-doesn't enjoy things <input type="checkbox"/> Thoughts of suicide or self-harm <input type="checkbox"/> Angry/easily irritated	<input type="checkbox"/> Temper tantrums <input type="checkbox"/> Frequently Lies <input type="checkbox"/> Frequently Swears <input type="checkbox"/> Talks back to adults <input type="checkbox"/> Is aggressive/confrontational to adults <input type="checkbox"/> Rarely follows instructions <input type="checkbox"/> Can't be trusted <input type="checkbox"/> Unmotivated <input type="checkbox"/> Runs away from home	<input type="checkbox"/> Bites nails/pulls own hair <input type="checkbox"/> Lots of aches and pains <input type="checkbox"/> Difficulty sleeping (e.g.: can't fall asleep, nightmares, sleep walks) <input type="checkbox"/> Does not get enough sleep (stays up late) <input type="checkbox"/> Self-mutilates <input type="checkbox"/> Body image difficulties <input type="checkbox"/> Substantial recent change in weight or appetite
<input type="checkbox"/> Afraid of many things <input type="checkbox"/> Very shy <input type="checkbox"/> Panic attacks <input type="checkbox"/> Avoids going places/being with others <input type="checkbox"/> Checks things repeatedly <input type="checkbox"/> Needs things to be perfect <input type="checkbox"/> Sensitive to criticism <input type="checkbox"/> Excessive or senseless worries <input type="checkbox"/> Lacks confidence in abilities <input type="checkbox"/> Dependent/needs a lot of reassurance	<input type="checkbox"/> Picks on other children <input type="checkbox"/> Tries to boss others around <input type="checkbox"/> Has few or no friends <input type="checkbox"/> Is seen as weird or different by peers <input type="checkbox"/> Isolates self away from others <input type="checkbox"/> Poor loser <input type="checkbox"/> Afraid of rejection <input type="checkbox"/> Doesn't trust other people <input type="checkbox"/> Victim of bullies <input type="checkbox"/> Physical fights with other children	<input type="checkbox"/> Exhibits inappropriate sexual behavior <input type="checkbox"/> Trouble with knowing what is real <input type="checkbox"/> Demonstrates bizarre behavior (e.g.: hearing voices/seeing things) <input type="checkbox"/> Rapid mood changes without cause <input type="checkbox"/> Extreme risk taking or impulsivity <input type="checkbox"/> Recurrent intrusive thoughts <input type="checkbox"/> Cruel to animals <input type="checkbox"/> Immature <input type="checkbox"/> Dating problems
<input type="checkbox"/> Concentration difficulties <input type="checkbox"/> Daydreams <input type="checkbox"/> Needs lots of reminders <input type="checkbox"/> Doesn't finish things <input type="checkbox"/> Can't sit still/very active <input type="checkbox"/> Acts without thinking <input type="checkbox"/> Easily distracted <input type="checkbox"/> Demands too much attention	<input type="checkbox"/> Has problems learning in school <input type="checkbox"/> Hates going to school <input type="checkbox"/> Seems afraid of going to school <input type="checkbox"/> Difficulty following school rules <input type="checkbox"/> Often skips school <input type="checkbox"/> Has conflicts with teachers <input type="checkbox"/> Performs below his/her ability <input type="checkbox"/> Problems with homework	<input type="checkbox"/> Concerns with alcohol <input type="checkbox"/> Concerns with drug use <input type="checkbox"/> Has been in trouble with the law <input type="checkbox"/> Has had problems with pornography <input type="checkbox"/> Steals <input type="checkbox"/> Breaks things <input type="checkbox"/> Has used a weapon <input type="checkbox"/> Has been the victim of abuse

Are there other concerns (not listed above) that you want to discuss? _____

How have these concerns impacted your child's daily life? _____

Is there anyone that you want All Things New to be working with regarding your child's treatment (e.g.: teacher, pediatrician, probation, court)? _____



New Patient Information - Child

RACE & ETHNICITY

RACE: American Indian or Alaska Native Asian Black or African American
 Hispanic Native Hawaiian or Other Pacific Islander Two or more races White

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

YOUR CHILD’S FAMILY AND SUPPORTIVE RELATIONSHIPS

Are parents divorced or separated? Yes No

If yes, how long? _____

What are the current custody/visitation arrangements? _____

Please tell us about the household/family with whom your child spends the majority of his/her time (or who currently lives with your child). List primary household information first, then list other living situations/supportive relationships:

Name	Age	Relationship <small>(e.g. Father, Mother, Brother, Sister, Step-Sibling, Aunt)</small>	Quality of Relationship	Living with you?
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have significant concerns about your child’s relationship with a family member? Yes No Not Sure
(e.g.: sibling, step-parent, extended family)

If so, please describe your concerns _____

New Patient Information - Child

ABUSE HISTORY

Has your child ever been the victim of abuse or neglect? Yes No

If yes, was the abuse: Physical Sexual Emotional Neglect Verbal

LEGAL HISTORY

Please list any contacts your child has had with the courts (including Friend of the Court): _____

TOBACCO USE HISTORY

Has your child ever: Used chewing tobacco? Yes No Smoked? Yes No

Explain any "Yes" answers above (including if daily or occasional use): _____

SUBSTANCE USE HISTORY

Has your child ever had a problem with alcohol or other drugs? Yes No

Explain any "Yes" answers above: _____

SPIRITUAL DEVELOPMENT

What is your child's present religious affiliation? _____

Does your child have any spiritual concerns that should be addressed? Yes No Not sure

Describe _____

MEDICAL HISTORY

Does your child have any current medical concerns? _____

Has your child had any past surgical procedures? Yes No

If yes, please list: _____

Has your child been exposed to any contagious diseases such as Tuberculosis? Yes No

If yes, to what and when did the exposure take place?: _____

Are immunizations current? Yes No

Please list all current medications and/or supplements your child is currently taking:
(attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency

New Patient Information - Child

MEDICAL INFORMATION

Please check all **medical issues** for which your child has had treatment:

Allergies

(e.g., allergic reactions, seasonal allergies, etc)

Bone disease

(e.g., osteoporosis, arthritis, broken bones, etc)

Endocrine disease

(e.g., diabetes, hypothyroid, low testosterone, etc)

Head and brain illness or injury

(e.g., fainting, concussion, seizures, dementia, etc)

Immune disease

(e.g., serious infections, MRSA, Rheumatoid Arthritis, etc)

Mouth and teeth disease

(e.g., gum disease, cold sores, canker sores, etc)

Poisoning & chemical exposure

(e.g., overdose, lead exposure, work fumes, etc)

Other _____

Blood disease

(e.g., anemia, bleeding disorders, etc)

Digestive system disease

(e.g., ulcers, heartburn, Celiac Disease, IBS, etc)

Genetic disease

(e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc)

Heart/cardiovascular disease

(e.g., heart arrhythmia, heart attack, high blood pressure)

Lungs and breathing disease

(e.g., asthma, COPD, emphysema, etc)

Muscle and movement disease

(e.g., tremors, tics, Restless Legs, Parkinson's, etc)

Serious injuries and wounds

(e.g., burns, cuts, stabs, crushed limbs, etc)

Check all areas where your child has had past **surgeries**:

Cancer

(e.g., procedures for cancer treatment)

Ear, Nose, Throat

(e.g., tonsillectomy, thyroidectomy, etc)

Obstetrics & Gynecology

(e.g., hysterectomy, c-section, abortion, etc)

Plastic surgery

(e.g., reduction, implant, reconstruction, etc)

Urology

(e.g., kidney stones, hypospadias, erectile dysfunction, etc)

Weight loss

(e.g., gastric bypass, band, sleeve, etc)

Cardiac / Vascular

(e.g., procedures for heart, blood clot, stroke)

Gastroenterology (digestive system)

(e.g., stomach, gall bladder, liver, etc)

Orthopedic

(e.g., joint replacement, bones, spinal fusion, etc)

Neurosurgery

(e.g., brain surgery, spinal fusion, etc)

Vision

(e.g., LASIK, eye muscle correction, etc)

Other: _____

Comments: _____

Does your child have any current or ongoing medical concerns? _____

Does your child have problems with pain? Yes No

Severity of pain? (low) 1 2 3 4 5 6 7 8 9 10 (high)

Location of pain? _____

Has your child's medical concerns interfered with daily life activities such as school, or other activities?

Yes No

If yes, please explain _____



New Patient Information - Child

YOUR CHILD'S BIRTH AND EARLY DEVELOPMENT

Has your child ever had an allergic reaction to medication(s)? Yes No

Name of medication

Explain reaction

FAMILY/MEDICAL HISTORY

Biological Father's Name: _____ Age: _____ Education: _____

Occupation: _____ Deceased? Yes No If yes, when? _____

Description of relationship between father and child: _____

Biological Mother's Name: _____ Age: _____ Education: _____

Occupation: _____ Deceased? Yes No If yes, when? _____

Description of relationship between mother and child: _____

Has anyone in your child's extended family (ex: parent, grandparent) had a psychiatric illness? Yes No

If yes, please describe to the best of your ability (Who, symptoms/diagnosis, were they hospitalized?) _____

Has anyone in your child's family attempted suicide? Yes No

If yes, who? _____

Has anyone in your child's family had a problem with or treated for substance abuse problems? Yes No

If yes, who? _____

Feel free to list any additional information you feel may be helpful to the clinician working with your child:

Completed by: _____ Date: _____

(please sign your name)

THANK YOU!

New Patient Information - Child

PRE-TREATMENT MEDICATION CHECKLIST

Please indicate all the medications your child has ever been prescribed, include comments on effectiveness and reasons for discontinuing the medication.

<p>ANTIDEPRESSANTS</p> <p><input type="checkbox"/> Anafranil (Clomipramine) _____</p> <p><input type="checkbox"/> Celexa (Citalopram) _____</p> <p><input type="checkbox"/> Cymbalta (Duloxetine) _____</p> <p><input type="checkbox"/> Desyrel (Trazodone) _____</p> <p><input type="checkbox"/> Effexor, (Venlafaxine) _____</p> <p><input type="checkbox"/> Elavil (Amitriptyline) _____</p> <p><input type="checkbox"/> ENSAM Transdermal Patch (Selegiline) _____</p> <p><input type="checkbox"/> Lexapro (Escitalopram) _____</p> <p><input type="checkbox"/> Luvox, (Fluvoxamine) _____</p> <p><input type="checkbox"/> Nardil (Phenelzine) _____</p> <p><input type="checkbox"/> Norpramin (Desipramine) _____</p> <p><input type="checkbox"/> Pamelor (Nortriptyline) _____</p> <p><input type="checkbox"/> Parnate (Tranlycypromine) _____</p> <p><input type="checkbox"/> Paxil, (Paroxetine) _____</p> <p><input type="checkbox"/> Pristiq (Desvenlafaxine) _____</p> <p><input type="checkbox"/> Prozac; Sarafem (Fluoxetine) _____</p> <p><input type="checkbox"/> Remeron, (Mirtazapine) _____</p> <p><input type="checkbox"/> Serzone (Nefazodone) _____</p> <p><input type="checkbox"/> Sinequan (Doxepin) _____</p> <p><input type="checkbox"/> Surmontil (Trimipramine) _____</p> <p><input type="checkbox"/> Tofranil (Imipramine) _____</p> <p><input type="checkbox"/> Vivactil (Protriptyline) _____</p> <p><input type="checkbox"/> Wellbutrin, (Bupropion)/Zyban _____</p> <p><input type="checkbox"/> Zoloft (Sertraline) _____</p> <p>ANTI-ANXIETY and INSOMNIA MEDICATIONS</p> <p><input type="checkbox"/> Ambien, (Zolpidem) _____</p> <p><input type="checkbox"/> Ativan (Lorazepam) _____</p> <p><input type="checkbox"/> Benadryl (Diphenhydramine) _____</p> <p><input type="checkbox"/> BuSpar (Buspirone) _____</p> <p><input type="checkbox"/> Dalmane (Flurazepam) _____</p> <p><input type="checkbox"/> Halcion (Triazolam) _____</p> <p><input type="checkbox"/> Klonopin (Clonazepam) _____</p> <p><input type="checkbox"/> Librium (Chlordiazepoxide) _____</p> <p><input type="checkbox"/> Lunesta (Eszopiclone) _____</p> <p><input type="checkbox"/> Noctec (Chloral hydrate) _____</p> <p><input type="checkbox"/> ProSom (Estazolam) _____</p> <p><input type="checkbox"/> Restoril (Temazepam) _____</p> <p><input type="checkbox"/> Rozerem (Ramelteon) _____</p> <p><input type="checkbox"/> Serax (Oxazepam) _____</p> <p><input type="checkbox"/> Sonata (Zaleplon) _____</p> <p><input type="checkbox"/> Tranxene (Clorazepate) _____</p> <p><input type="checkbox"/> Unisom (Doxylamine) _____</p> <p><input type="checkbox"/> Valium (Diazepam) _____</p> <p><input type="checkbox"/> Vistaril, Atarax (Hydroxyzine) _____</p> <p><input type="checkbox"/> Xanax (Alprazolam) _____</p> <p>OTHER MEDICATIONS NOT LISTED ABOVE</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>STIMULANT MEDICATIONS</p> <p><input type="checkbox"/> Adderall _____</p> <p><input type="checkbox"/> Concerta, Daytrana TD Patch, Metadate, Ritalin (Methylphenidate) _____</p> <p><input type="checkbox"/> Dexedrine (Dextroamphetamine) _____</p> <p><input type="checkbox"/> Focalin (Dexmethylphenidate) _____</p> <p><input type="checkbox"/> Provigil _____</p> <p><input type="checkbox"/> Straterra (Atomoxetine) _____</p> <p><input type="checkbox"/> Tenex (Guanfacine) _____</p> <p><input type="checkbox"/> Vyvanse (Lisdexamfetamine) _____</p> <p>MEDICATIONS FOR SIDE EFFECTS</p> <p><input type="checkbox"/> Artane (Trihexyphenidyl) _____</p> <p><input type="checkbox"/> Benadryl (Diphenhydramine) _____</p> <p><input type="checkbox"/> Cogentin (Benztropine) _____</p> <p><input type="checkbox"/> Inderal (Propranolol) _____</p> <p><input type="checkbox"/> Parlodel (Bromocriptine) _____</p> <p>MOOD STABILIZERS</p> <p><input type="checkbox"/> Carbatrol, Equetro, Tegretol (Carbamazepine) _____</p> <p><input type="checkbox"/> Depakote, (Divalproic Acid) _____</p> <p><input type="checkbox"/> Eskalith, Lithobid (Lithium) _____</p> <p><input type="checkbox"/> Lamictal (Lamotrigine) _____</p> <p><input type="checkbox"/> Topamax (Topiramate) _____</p> <p><input type="checkbox"/> Trileptal (Oxcarbazepine) _____</p> <p>ANTIPSYCHOTICS</p> <p><input type="checkbox"/> Abilify, (Aripiprazole) _____</p> <p><input type="checkbox"/> Clozaril, Fazacllo (Clozapine) _____</p> <p><input type="checkbox"/> Geodon, (Ziprasidone) _____</p> <p><input type="checkbox"/> Haldol (Haloperidol) _____</p> <p><input type="checkbox"/> Invega (Paliperidone) _____</p> <p><input type="checkbox"/> Loxitane (Loxapine) _____</p> <p><input type="checkbox"/> Mellaril (Thioridazine) _____</p> <p><input type="checkbox"/> Moban (Molindone) _____</p> <p><input type="checkbox"/> Navane (Thiothixene) _____</p> <p><input type="checkbox"/> Prolixin (Fluphenazine) _____</p> <p><input type="checkbox"/> Risperdal, (Risperidone) _____</p> <p><input type="checkbox"/> Serentil (Mesoridazine) _____</p> <p><input type="checkbox"/> Seroquel, (Quetiapine) _____</p> <p><input type="checkbox"/> Stelazine (Trifluoperazine) _____</p> <p><input type="checkbox"/> Thorazine (Chlorpromazine) _____</p> <p><input type="checkbox"/> Trilafon (Perphenazine) _____</p> <p><input type="checkbox"/> Zyprexa, (Olanzapine) _____</p> <p>MEMORY</p> <p><input type="checkbox"/> Aricept (Donepezil) _____</p> <p><input type="checkbox"/> Exelon (Rivastigmine) _____</p> <p><input type="checkbox"/> Namenda (Memantine) _____</p> <p><input type="checkbox"/> Reminyl (Galantamine) _____</p>
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