Revised 9/10/2019

ADVANCED
Psychiatric Therapeutics, LLC

Patient/Child's Name:_____ **Date:** _____

Your Name: _____ **Relationship to child:** _____

PSR: Vital signs
Height:
Wt:
BP:
Pulse:

In your own words, please describe the reason for this visit and your child's current difficulties and symptoms:

How long has this been going on? _____

What makes these symptoms better or worse? _____

How has this affected your child's life? _____

What are your goals for treatment? _____

Psychiatric History:

Please list any other mental health providers: _____

Previous mental health diagnoses: _____

Has your child ever been hospitalized for Mental Health Illness or to a rehab facility?

____Yes ____ No *If Yes when and what for:

_____

Has your child ever attempted Suicide? ___Yes ___No * If yes, when and how?

_____

Has or does your child use any of the following (mark all that apply): ( ) Cannabis ( ) Alcohol

( ) Nicotine / vaping ( ) Narcotics/Pain Killers ( ) Other Illicit Drugs or street drugs:

_____

Is there a history of trauma or abuse (physical, sexual, other) ? ____Yes ___No * If yes, when & how?

_____

Has your child ever been charged/arrested before ? _____Yes ____No * If yes, when and what for?

_____

Is there any access to any firearms? __Yes __No. * If yes, where? _____

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Medical History:

Illnesses, complications, medications or substance use during pregnancy and delivery:

_____

Difficulties or complications post-delivery, early development:

_____

List all current medical problems: _____

Surgical and hospitalization history: _____

Does your child have any allergies? Please list source and reaction _____

List of medications currently taken:

Family History:

Has anyone in your child's family been diagnosed with any of the following (mark all that apply):

( ) Bipolar Disorder ( ) Anger/Violence ( ) Depression ( ) Post-traumatic Stress Disorder

( ) ADHD ( ) Autism ( ) Learning, developmental, or Intellectual differences ( ) Eating Disorder

( ) Schizophrenia ( ) Anxiety ( ) Alcohol Abuse ( ) Other substance abuse/addiction

( ) Attempted or completed suicides ( ) Legal problems ( ) Domestic violence

History of medication used in the treatment of the above?

Social History:

Where was your child born and raised?

_____

Who lives at home and how are they related? _____

_____

Parent's marital status: ( ) Married ( ) Separated/Divorced Custody: _____

Does anyone in your child's home use any of the following (mark all that apply): ( ) Cannabis

( ) Nicotine ( ) Alcohol ( ) Narcotics/Pain Killers ( ) Other Illicit Drugs or street Drugs:

_____

Describe any legal problems for your child or others in the home: _____

Parent's employment: _____

Child's School: _____ Grade Level: _____ Repeats or difficulties: _____

Child's average grades and performance: _____

Hours of screen time/day, and what does he/she do? _____

Cultural and religious considerations: _____

List any additional supports/services from school or the community that your child receives:

Physical Symptoms as of Today:

□ Headache □ Fatigue □ Weight Changes □ Fever □ Chills □ Sudden Vision Changes □ Sinus problems □ Sudden Hearing Changes □ Ringing in your Ears □ Throat problems □ Cough □ Chest pain/discomfort □ Shortness of Breath □ Frequent Urination □ Difficulty starting urine stream □ Low Sex Drive □ Erectile Dysfunction □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Muscle or Joint pain □ Numbness/Tingling □ Cold intolerance □ Heat intolerance

Women: □ Unusual discharge or bleeding □ Menopause □ Date of last period:_____

Other: