Initial Consultation Survey

School Information:

Child Attends School? YES / NO (circle one) If YES, Grade level?_____

School Name_____ Teacher's Name_____

Current grades: _____

Has the patient ever been suspended to expelled? YES / NO (circle one)

Has the patient ever been retained in a grade? YES / NO (circle one)

Have you had special conferences or extra meetings with teachers or school administrators for your child's behavior or learning problems?

YES / NO (circle one) If YES, when?_____

Has the patient ever had an IEP, 504 Plan or other special education services? YES / NO (circle one)

Describe: _____

Developmental Information:

Any problems with pregnancy or delivery? YES / NO (circle one)

Concerns with drug/alcohol use or cigarette use during pregnancy? YES / NO (circle one)

Was your child born prior to 36-40 weeks gestation? YES / NO (circle one)

What is your impression of your child's health / development during first year of life?
Good / Fair / Poor (circle one)

Any problems with Vison? YES / NO (circle one)

Hearing? YES / NO (circle one)

Speech? YES / NO (circle one)

Specialists/health care providers that are currently involved with patient's care? YES / NO (circle one)

Hospitalizations? YES / NO (circle one)

Surgeries? YES / NO (circle one)

Head Trauma / Brain Injury or Loss of Consciousness? YES / NO (circle one)

Palm Beach PEDIATRICS

Mental Health History:

Has patient ever received medications for behavioral / emotional concerns? YES / NO (circle one)

Has patient ever received counseling or psychotherapy for behavioral / emotional concerns? YES / NO

Has the parent or other family members received psychological medication, counseling, or psychotherapy? YES / NO

Has anyone in patient's family (including parents, siblings, grandparents, uncles, aunts) ever been diagnosed with any of the following problems? ADHD, Learning Problems, Depression, Anxiety, Bipolar, Alcohol/Drug Abuse, Schizophrenia, OCD? YES / NO (circle one)

Does anyone in the immediate family / household have concerns related to substance use? YES / NO

Has the patient had any criminal behavior or contact with law enforcement? YES / NO (circle one)

Do parents or other family members have criminal records? YES / NO (circle one)

Has the child experienced neglect, physical or sexual abuse, or witnessed domestic violence? YES / NO

Has Department of Children and Families (DCF) ever been involved with the family or patient? YES / NO

Substance Use/Abuse by patient (12 years old and older)

	Daily	Weekly	Occasionally	Once/Twice	Never
Caffeine					
Nicotine/Cigarettes					
Alcohol					
Marijuana					
Cocaine					
Prescription					
Over the counter drugs					
Other _____					

Does your child have a bedtime routine? YES / NO (circle one)

Bed time? _____ Wake up time? _____

Palm Beach PEDIATRICS

Behavioral Health Information:

Describe the best things about your child?

Clubs/Groups and favorite activities of your child:

Patient's work or volunteer experience:

Community Resources and church activities:

Palm Beach PEDIATRICS

Religious Preference / Involvement:

What concerns you most about your child?

Please provide any other information you would like to discuss during your child's upcoming appointment?

Palm Beach PEDIATRICS

Which of the following have recently been or currently are problems with your child?

Recent / Current Concerns	Never	Sometimes	Often	Always
Too active				
Anger/Temper				
Clumsy				
Destructive				
Easily Upset				
Toileting problems				
Impulsive				
Suicidal Thoughts				
Harms self				
Nervous				
Cries a lot				
Very Shy				
Clings to Parent				
Nightmares				