



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**

Has the patient ever been retained in a grade? **YES / NO**

Have you had special conferences or extra meetings with teachers or school administrators for your child's behavior or learning problems? **YES / NO** If **YES**, when? _____

Has the patient ever had an IEP, 504 Plan or other special education services? **YES / NO**

Describe: _____

Developmental Information:

Any problems with pregnancy or delivery? **YES / NO**

Concerns with drug/alcohol use or cigarette use during pregnancy? **YES / NO**

Was your child born prior to 36-40 weeks gestation? **YES / NO**

What is your impression of your child's health / development during first year of life?
GOOD / FAIR / POOR (circle one)

Any problems with Vision? **YES / NO**

Hearing? **YES / NO**

Speech? **YES / NO**

Specialists/health care providers that are currently involved with patient's care? **YES / NO**

Hospitalizations? **YES / NO**

Surgeries? **YES / NO**

Head Trauma / Brain Injury or Loss of Consciousness? **YES / NO**

Mental Health History:

Has patient ever received medications for behavioral / emotional concerns? **YES / NO**

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**

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**

Do parents or other family members have criminal records? **YES / NO**

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**

Bed time? _____ Wake up time? _____

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:

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.

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				