Child/Adolescent Pre-Visit Questionnaire

Legal Name:_____Preferred Name (if different): _____

Medication Allergies: _____Pharmacy: _____

Medications:

Please list all medications currently taking, including dosages, and include over the counter medications taken regularly:_____

_____

Previous Psychiatric Treatment:

Previous Psychiatric Hospitalizations Y N If yes, _____

_____

Suicide Attempts: Y N If yes, _____

Previous or current self-harming behaviors (i.e. cutting, etc.)? Y N If yes, please list method and frequency

_____

Past psychiatric medications:

_____

_____

Medical History:

Did the patient's mother receive prenatal care during pregnancy? Y N

Did the patient's mother use any alcohol, cigarettes, drugs, or prescription medications during pregnancy? Y N

The patient was delivered at approximately _____ weeks via **vaginal** or **C-section delivery** (circle one).

Were there any complications with the pregnancy, delivery, or after the patient was born? Y N If yes,

_____

_____

Any delay in milestones (i.e. sitting, crawling, walking talking, toilet training?) Y N If yes,

_____

_____

Current/Chronic Illness or Surgeries: Y N If yes,

_____

_____

Head Injuries/Seizures: Y N If yes,

_____

Date of last routine physical exam:_____

Female Only: Last period: _____ Birth control: Y N If yes, _____

Substance Use:

Please circle: Y N

If yes, please list substance type and amount/frequency of use (including alcohol, vaping, marijuana, tobacco, etc.):

_____
_____
_____

Caffeine _____cups coffee/day _____colas/day _____glasses of tea/day

Family History:

Please list any relatives with known or suspected **medical or psychiatric problems**, **attempted or completed suicides**, or history of **drug or alcohol abuse**.

_____
_____
_____

Social and Educational History:

Who lives at home with the patient (name, age, relationship to the patient, occupation)?

_____
_____
_____

Current school: _____Current grade:_____

Ever held back? Y N Ever expelled? Y N If yes, _____

Does the patient have accommodations in school (i.e. 504 plan, IEP, etc.)? Y N

The patient takes: **regular**/ **advanced** / **special education classes** (please circle)

Extracurricular activities:_____

Abuse: Physical/Sexual/Emotional Y N If yes,

_____
_____

Has DHS ever been involved in the home? Y N

Legal Issues (i.e. FINs petition, jail/JDC time, etc.): Y N If yes,

_____
_____

Conduct Problems: *Circle all that apply to the patient*

None	Truancy	Fighting with a weapon	Fighting without a weapon
Setting fires	Running away	Cruel to animals	Stealing
Smoking or drinking at school		Property destruction	

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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NICHQ National Initiative for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0352

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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NICHQ National Institute for Children's Health Quality

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Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Medical Review of Systems

Check next to any symptoms you have experienced since LAST VISIT/recently, or for which you have concerns about.

Name:_____

Date:_____

BP_____/_____ p_____ Ht_____ Wt_____

General	
	Recent unexpected weight loss
	Chronic fatigue
	Anemia
	Lack of regular exercise
	Overweight

Eyes	
	Failing vision
	Eye pain
	Double vision
	Blurred vision
	Frequent eye infections
	Glaucoma
	Cataracts

Ears, Nose, Mouth	
	Decreased hearing
	Ringing in ears
	Frequent ear infections
	Frequent nose bleeds
	Sinus trouble
	Frequent sore throat
	Prolonged hoarseness
	Tooth or jaw pain

Cardiovascular	
	Chest pain
	Dizzy spells
	Fainting spells
	High blood pressure
	Swollen ankles
	Irregular pulse
	Shortness of breath

Pulmonary	
	Pneumonia/pleurisy
	Bronchitis/chronic cough
	Asthma/wheezing

Gastrointestinal	
	Recent loss of appetite
	Difficulty swallowing
	Heartburn/gastritis
	Persistent nausea/vomiting
	Chronic abdominal pain
	Gall bladder trouble
	Jaundice
	Change in appearance of stool
	Diarrhea
	Constipation
	Bloody or very dark stools
	Hemorrhoids
	Hernia

Genito-Urinary	
	Frequent urine infections
	Blood in urine
	Kidney stones
	Painful urination
	Loss of control of urine
	Decrease in flow
	Urination more than 2x per night
	Any venereal disease in the past? (Herpes, Chlamydia, Gonorrhea)

Musculoskeletal	
	Pain in joints
	Pain in muscles
	Recurrent back pains
	Past injury to bones, spine, or joints
	Gout attacks in the past
	Concerned about osteoporosis

Integumentary	
	Skin rashes
	Hives
	Skin moles – black or changing
	Breast mass
	Nipple discharge

Neurologic	
	Frequent headaches
	Tremor/hand shaking
	Muscle weakness
	Numbness/tingling
	Seizures/convulsions
	Difficulty sleeping
	Excessive daytime sleeping
	Memory loss

Psychological	
	Feeling depressed
	Nervous or anxious feeling
	Excessive moodiness
	Difficulty concentrating
	Phobias/unexplained fears
	Loss of pleasure in life

Endocrine	
	Excessive thirst and urination
	Feet and hands numbness/pain
	Low blood sugar problems
	Intolerance to heat or cold

Hematologic/Lymphatic	
	Excessive bruising
	Swollen glands in neck, armpit, or groin
	Unexplained fever, chills, night sweats

Allergic/Immunologic	
	Hay fever/allergies
	Acquiring many infections
	Desire HIV discussion

Substance/Chemical Use	
	More than 6 drinks a week
	Tobacco use
	Caffeine use
	Over-the-counter meds/vitamins

Women only	
	Irregular periods
	Excessive flow/pain
	Hot flashes/night sweats
	Abnormal PAP smear

Anything else you want your doctor to be aware of?