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	

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Severity Measure for Generalized Anxiety Disorder—Child Age 11–17

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During **the PAST 7 DAYS**, I have…	**Never**	**Occasionally**	**Half of the time**	**Most of the time**	**All of the time**	**Item score**
1.	felt moments of sudden terror, fear, or fright	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	felt anxious, worried, or nervous	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	avoided, or did not approach or enter, situations about which I worry	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	left situations early or participated only minimally due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
8.	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
9.	sought reassurance from others due to worries	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
10.	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

NICHQ Vanderbilt Assessment Scale—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. When completing this form, please think about your child's behaviors in the past 6 months.

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
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

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

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

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

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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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?