

CHILD AND ADOLESCENT MEDICAL SCREENING

PATIENT'S NAME: _____

DATE of BIRTH: ____/____/____ SOCIAL SECURITY #: _____

NAME OF PARENT(S): _____

ADDRESS: _____

TELEPHONE: home: _____ work: _____

fax: _____ email: _____

cell: _____

Other contact information: _____

Primary Care Physician: _____ SPECIALTY _____ PHONE _____

Referring Psychiatrist/Psychologist: _____ SPECIALTY _____ PHONE _____

CHIEF COMPLAINT (SPECIFY ONSET AND DURATION): _____

MEDICATION(S) (specify dosage, route, frequency, reason for prescription, and duration of treatment): _____

MEDICATION ALLERGIES?

Gestational History

During this pregnancy did the mother have: anemia elevated blood pressure swollen ankles

kidney diseases heart disease bleeding measles German measles flu

other virus vomiting injury medication during pregnancy emotional problems

threatened miscarriage or early contractions

other illness: _____

Describe: _____

In the 6 months preceding this pregnancy did the mother have exposure to:

drugs or alcohol x-rays

Describe: _____

PERINATAL HISTORY

1. Where was the patient delivered? _____

2. What type of delivery was used? _____

3. What complications were encountered in the delivery? _____

4. What was the baby's birth weight? _____

5. What was the baby's condition at birth; what was the Apgar score? _____

6. What problems did the mother experience at delivery or just afterwards? _____

Has anyone else questioned the patient's hearing ability? YES NO

Has there been any illness involving the ears? NO YES:

What eye problems has the child had?

Has the patient used glasses; has there been any strabismus; has there been any eye therapy? NO YES:

Has the patient experienced any seizures, with or without fever? NO YES:

Have there been any trance-like episodes or minor lapses which could be petit mal or other seizure fragments?

NO YES:

Has the child been excited by medications which would normally be sedative in nature or without anticipated psychotropic effect? NO YES:

Has there been: excessive urination? NO YES:

excessive fluid intake? NO YES:

bed wetting? NO YES:

urinary tract infection? NO YES:

What neurological complaints are present, such as headache, vomiting, poor balance, double vision, dizziness, weakness, numbness, etc.?

Have there been severe or repeated blows to the head? NO YES:

Girls: Age of onset of menses: _____ Is menstruation regular? YES NO:

Family History of:

Learning problems or behavioral disturbances

Abortions (2 for anyone mother)

Stillbirths

Congenital anomalies

Mental retardation

Neurological disorders

Other (list)

Physical Features

Height: _____

Weight: _____

Normal Growth Rate this Past Year in: Height: YES NO Weight: YES NO

Blood pressure normal high low

NAME OF PARENT: _____

Relationship to Patient: _____

SIGNATURE: _____

DATE: ____/____/____

Comments (continue on reverse):