**Today's Date: __________**

## Confidential Research Patient Information

**Child's Name:**

**First:** ____________________ **Middle Initial:** _____ **Last:**_________________________

**Age**: _______ **Date of Birth**: ____________ **Sex at birth**: Male ____ Female ____

**Race**: Caucasian ____ African American ____ Native American ____ Asian ____
Pacific Islander ____ Hispanic/Latino ____ Mixed ___ Other: ___________________

**Name of adult completing this form**: ____________________________________________________

**Relationship to child**: _________________________________________________________________

**Who does the child live with? (If joint custody/more than one home, please describe both homes)**
_____________________________________________________________________________________
_____________________________________________________________________________________

**Contact Information:**

**Home Phone**: __________________________ **Ok to leave a message?** __ Yes __ No

**Cell Phone:** ____________________________ **Ok to text?** __ Yes __ No

**E-mail:** ____________________________________________________

**Home Address:** ____________________________________________________________________

____________________________________________________________________

**Is your child of childbearing potential?** ___ Yes ___ No ___ N/A

If Yes, she on birth control? ___ Yes ___ No

Birth Control Method: ______________________________

**Please describe the main concerns regarding your child:**

______________________________________________________________________________

______________________________________________________________________________

**How long has your child had these problems?** ____________________________________________

**<u>Behavioral and Emotional Problems you observe:</u> (check all that apply)**

___ Easily distracted
___ Difficulty following directions
___ Is irritable
___ Difficulty playing quietly
___ Fidgets or squirms in seat
___ Often loses temper
___ Often argues with adults
___ Often spiteful or vindictive
___ Deliberately does things that annoy others
___ Wets bed
___ Soils pants
___ Refuses to go to school
___ Isolates himself/herself from others
___ Cries frequently
___ Worries excessively
___ Says he/she wants to die
___ Threatens suicide
___ Has stolen something
___ Has run away overnight
___ Lies
___ Sets fires on purpose
___ Often initiates fights
___ Has engaged in inappropriate sexual activity
___ Is anxious or fearful

**Has your child ever taken medication to help with these symptoms?** ___ Yes ___ No

- **If yes, please provide the following information for each previous medication:**

| Name of Medication | Dose | Dates Taken | Helpful? Y/N |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Any medication allergies?** ___ Yes ___ No Details: ______________________________

**Is your child currently taking any medications?** ___ Yes ___ No

| Name of Medication | Dose | Start Date | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Current school:** ______________________________________________ **Grade:** _________

**IEP?** ___ Yes ___ No **Receives Tutoring?** ___ Yes ___ No

**Special Education Classes?** ___ Yes ____ No **Details:** _________________________________

**Any grades repeated?** ___ Yes ___ No **Details:** _______________________________________

**Standardized Testing Scores:** ___ Below average ___ Average ___ Above Average

**Ever been suspended or expelled from school?** ___ Yes ___ No **Details:** __________________

**Does child smoke?** ___ Yes ___ No

**Alcohol use?** ___ Yes ___ No

**How much caffeine does your child drink each day?** ______ **servings/day**

**How many friends does your child have?** __________________________________________________

**What hobbies/activities does your child enjoy?**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Thank you for completing this confidential form. You will have the opportunity to discuss your answers when you meet with your clinician.**

## Please check Yes or No for each condition below and provide details:

| Condition: | YES | NO | Details: | Start: | Stop: |
|---|---|---|---|---|---|
| Ear, Nose, Throat Disease? | | | | __/__/__ | __/__/__ |
| Eye Disease? | | | | __/__/__ | __/__/__ |
| Thyroid Disease / Goiter? | | | | __/__/__ | __/__/__ |
| Heart Disease? | | | | __/__/__ | __/__/__ |
| Lung Disease? | | | | __/__/__ | __/__/__ |
| Diabetes? | | | | __/__/__ | __/__/__ |
| Liver / Gallbladder Disease? | | | | __/__/__ | __/__/__ |
| Stomach / Intestinal Disease? | | | | __/__/__ | __/__/__ |
| Kidney / Bladder Disease? | | | | __/__/__ | __/__/__ |
| Epilepsy / Seizures/ Stroke or TIA? | | | | __/__/__ | __/__/__ |
| Neurological Disease? | | | | __/__/__ | __/__/__ |
| Bone or Joint Disease? | | | | __/__/__ | __/__/__ |
| Skin Disease? | | | | __/__/__ | __/__/__ |
| Psychological Problems? | | | | __/__/__ | __/__/__ |
| Blood Disease? | | | | __/__/__ | __/__/__ |
| Cancer or Tumors? | | | | __/__/__ | __/__/__ |
| Other? | | | | | |
| | | | | | |