Omaha Childrens Behavioral Health Form

Please complete the following information prior to your child's first appointment with Dr. Holly Roberts.

PATIENT INFORMATION

Patient Name:___________________________________

Nickname:______________________________________

Date of Birth: ___/___/___ Age: ______________

Sex: Male Female

Email Address:_____________________________________

Home Address:_____________________________________

____

Phone: ____

Cell Phone/Work Phone: ______________________________

Ethnicity (circle all that apply): African-American Asian-American Hispanic Native American White/Caucasian Other:_________

REFERRAL INFORMATION

Patient's Physician________________________________

Who referred patient to the clinic________________________

Is it okay to have reports mailed to the Physician? Yes No Unsure

Reason for Referral / Primary Concerns: ____

____

FAMILY INFORMATION / PATIENT BACKGROUND INFORMATION

Biological parents are: Married _____ (Date) Divorced _____ (Date) Separated _____ (Date) Never Married

Patient resides with: Mother — Biological Adoptive Foster Step Other _____

Father — Biological Adoptive Foster Step Other _____

Mother's Name ____________________________________

(circle one) Biological Adoptive Step Foster/Guardian

Age ___________ Occupation __________________

Employer ____

Work Schedule ____________________________________

Father's Name ____________________________________

(circle one) Biological Adoptive Step Foster/Guardian

Age ___________ Occupation __________________

Employer ____

Work Schedule ____________________________________

Other Members of the Household (for example, siblings, step-siblings, foster children):

Name	*Age*	*Sex*	*Relationship to patient*

Other Regularly Involved Adults (for example, grandparents, non-custodial parents/step-parents):

Name	*How often*	*Relationship to patient*

Please list previous residences (city & state) and length of time lived there:

____

Any problems/stressors in the family in the last year? (for example, death in the family, move, parental/marital conflict, financial stressors, accidents/traumatic events) ____

MEDICAL / DEVELOPMENTAL INFORMATION (please circle answers)

Were there any problems with pregnancy or delivery? NO YES, explain: ______________________________________

Were there any concerns with drug/alcohol abuse, cigarette use, high blood pressure during pregnancy? NO YES

What is your general impression of your child's infant development? GOOD FAIR POOR

Note the month in which your child achieved the following activities:

Sat alone ______ Crawled ______ Walked ______ Fed Self ______ Spoke Words ______ Toilet Trained ______

(Normal development: Sit 6-8 mos; Crawl 9 mos; Walk 12-18 mos; Feed 10-12 mos; Speak 10 mos; Toilet 24-36 mos)

Any problems with the patient's vision?	NORMAL	ABNORMAL	CORRECTED
Any problems with the patient's hearing?	NORMAL	ABNORMAL	CORRECTED
Any problems with the patient's speech?	NORMAL	ABNORMAL	CORRECTED
Any problems with the patient's motor skills?	NORMAL	ABNORMAL	CORRECTED

Circle all conditions in which this child has had or currently has:

ALLERGIES ASTHMA CANCER DIABETES GENETIC CONDITION SEIZURES

Other medical conditions/health concerns: ____

Current Medications

Medication Name	*Dosage*	*Purpose*
________________________	________________	________________
________________________	________________	________________
________________________	________________	________________

Has the patient ever received medications, counseling/psychotherapy for behavioral/emotional concerns? NO YES

If yes, describe problems, medications, therapist, and dates: ____

Family Health History

Has either parent or other family members received medication, counseling/psychotherapy? NO YES

Has anyone in the patient's family (including parents, siblings, grandparents, uncles, aunts) ever been diagnosed with any of the following problems? (circle all that apply)

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD) LEARNING PROBLEMS DEPRESSION

ANXIETY MANIC DEPRESSION/ BIPOLAR ALCHOHOL/ DRUG ABUSE SCHIZOPHRENIA

OBSESSIVE- COMPULSIVE DISORDER (OCD) NONE OTHER: ______________________________

SCHOOL INFORMATION

Child attends daycare? NO YES (name of daycare/child care provider) ______________________________________

Child attends school? NO YES (grade) ___________ (If summer, what grade will child be entering).

School ______________________________________ Teacher's Name ______________________________________

Child's current grades are: _______________________ Grades last semester were: _____________________________

Has the patient ever been suspended, expelled, or retained in a grade? NO YES (when)__________________________

Have you had special conferences or extra meetings with teachers or school administrators for your child's behavior or learning problems? NO YES (when) _______________________

Has the patient ever had an IEP, 504 Plan, or other Special Education Services? NO YES

(for example, learning disability, behavioral/emotional disorder class, speech/language services, resource room)

BEHAVIORAL HEALTH INFORMATION

Describe the best things about your child? ____

____

List the clubs/groups and favorite activities of your child: ____

____

Does your child have a bedtime routine? NO YES

What time does your child typically go to bed? __________

What time does he/she typically fall asleep? _________

What time does he/she wake up in the morning? __________

Does the patient snore loudly? NO YES

Does the patient typically wake up in the middle of the night? NO YES

Does the patient typically take a nap each day? NO YES (how long) ________________

Which of the following have recently been or currently are problems with your child?

	Never	Some	Often	Always
Won't mind	_____	_____	_____	_____
Too active	_____	_____	_____	_____
Anger/Temper	_____	_____	_____	_____
Clumsy	_____	_____	_____	_____
Destructive	_____	_____	_____	_____
Easily upset	_____	_____	_____	_____
Toileting problems	_____	_____	_____	_____
Impulsive	_____	_____	_____	_____

	Never	Some	Often	Always
Suicidal thoughts	_____	_____	_____	_____
Nervous	_____	_____	_____	_____
Cries a lot	_____	_____	_____	_____
Harms self	_____	_____	_____	_____
Very shy	_____	_____	_____	_____
Clings to parent(s)	_____	_____	_____	_____
Nightmares	_____	_____	_____	_____
Aggressive to others	_____	_____	_____	_____

What concerns you most about your child? ____

____

Please provide any other information you would like to discuss during your child's upcoming appointment.

____