Welcome and thank you for choosing Tanner Clinic Psychiatry!

Dear Parent/Guardian,

The information you provide here will help your provider in identifying your child's needs and how to best serve your family.

If you have not completed the child/adolescent psychiatry packet before your appointment, please plan on arriving **30 minutes early** to complete the paperwork.

If you cannot keep this appointment please call and cancel as soon as possible. If you fail to do so, you may not be allowed to reschedule your appointment. We do have a **10 minute late** policy which will require rescheduling your appointment; along with a no-show policy with a charge of $250.

Please complete the attached assessment forms prior to your appointment.

Please bring your completed paperwork, updated insurance information and any current medications in their original bottle to your appointment.

Our office is located in the main Tanner Clinic building at 2121 N 1700 W; on the basement floor in the west wing. If you have any questions or need to reschedule, please call (801) 773-4840 Ext 3183.

Thank you for choosing Tanner Clinic for your family's healthcare needs and we look forward to serving you!

PARENT OR GUARDIAN: PLEASE COMPLETE AND BRING THIS FORM TO THE CLINIC

(p) 801.773.4840 ext. 3183 | (f) 801.525.8752 | 2121 N 1700 W, Layton, UT 84041

Health Intake-Confidential Personal History-Child

Patient's Name_____ Date of Birth_____ Gender_____ Today's Date _____

Form completed by:_____ Relationship to Patient:_____

For what reason(s) are you seeking services from our office? (What are your concerns for your child academically, personally, socially?)

What is the duration of these symptoms? (How long? Has the intensity varied?)

FAMILY MEMBERS

Name	Age	Adopted? (Y or N)	Education/Occupation	Right or Left-handed?
Father:		☐Y ☐N		☐R ☐L ☐B$_{oth}$
Mother:		☐Y ☐N		☐R ☐L ☐B$_{oth}$

Marital status of parents: ◯ Married ◯ Separated ◯ Divorced ◯ Remarried ◯ Other:

Children: Please list in order of birth (Include patient)

Name	Age	Gender	Adopted? (Y or N)	Education (grade in school) or Occupation	Right or Left-handed?
			☐Y ☐N		☐R ☐L ☐B$_{oth}$
			☐Y ☐N		☐R ☐L ☐B$_{oth}$
			☐Y ☐N		☐R ☐L ☐B$_{oth}$
			☐Y ☐N		☐R ☐L ☐B$_{oth}$
			☐Y ☐N		☐R ☐L ☐B$_{oth}$

FAMILY ENVIRONMENT

Is your marital situation stable and positive at this time? ☐**Y** ☐**N** *Please Describe:*

What stresses, if any are affecting your family at this time? ☐**Y** ☐**N** *Please Describe:*

What language(s) is spoken in the home?

Are there any other individuals or family members living at home? ☐**Y** ☐**N** *Please Describe:*

FAMILY ADAPTATION

At home, how would you describe their general adjustment?

How does he/she get along with members of the family?

Father:

Mother:

Siblings:

Have there been any major traumatic events in the course of the patient's development? ☐ **Y** ☐ **N** (please describe)

Have there been any major moves? (city to city or state to state or country to country) ☐ **Y** ☐ **N** (please describe)

PREGNANCY

(if patient was adopted, please complete the ADOPTION section instead)

What kind of experience was the pregnancy for the father and mother?

Father:

Mother:

Was the pregnancy planned? ☐ **Y** ☐ **N** Comments:

Were there complications? ☐ Shock (emotional) ☐ Loss of a loved one ☐ Accident ☐ Health Problems ☐ Confinement to bed ☐ Tiredness/fatigue ☐ Other:

Please give additional information in relation to any complications you checked.

During the pregnancy, was the mother:

			Comments
☐ Y	☐ N	Exposed to consistently loud noise?	
☐ Y	☐ N	Physically active?	

During the pregnancy, did the mother:

			Comments
☐ Y	☐ N	Smoke?	
☐ Y	☐ N	Consume alcohol?	
☐ Y	☐ N	Take any medication?	
☐ Y	☐ N	Talk much?	
☐ Y	☐ N	Sing?	
☐ Y	☐ N	Play a musical instrument?	

During the pregnancy, what language was spoken by the mother?

Were any previous pregnancies complicated? ☐ **Y** ☐ **N** *If yes, please explain:*

LABOR AND DELIVERY

Please describe the labor and delivery experience?

Specific information:

Was the pregnancy full term? ☐ **Y** ☐ **N** Comments:

Length of Labor (hrs)_____ Birth weight: _____ APGAR rating:_____ Delivery Position: _____

Did the baby cry immediately? ☐ **Y** ☐ **N** Comments:

Were forceps or high forceps required/used? ☐ **Y** ☐ **N** Comments:

Any special treatment (required oxygen, had jaundice, etc.? ☐ **Y** ☐ **N** Comments:

Did newborn have immediate physical contact with mother? ☐ **Y** ☐ **N** Comments:

Was there a positive bonding experience between mother and infant? ☐ **Y** ☐ **N** Comments:

Was the newborn breastfed immediately? ☐ **Y** ☐ **N** Comments:

Did the mother experience any post-partum depression? ☐ **Y** ☐ **N** Comments:

Describe any separation from mother during first days of life:

ADOPTION (if applicable)

Child's age when adopted: **Is the child aware of their adoption?** ☐ Y ☐ N

Describe circumstances surrounding the adoption:

Were they in prior foster homes? ☐ **Y** ☐ **N** Comments:

Physical appearance when adopted:

Response to their new home:

INFANCY (complete for all children)

Going back to the first two years of the child's life, what type of baby was he/she? (feeding, sleeping, activity level, etc.)

		Comments
☐ Y ☐ N	Was the child breastfed?	
☐ Y ☐ N	Extended separations during the first two year (over 3 Days)?	
☐ Y ☐ N	Any specific health problems during this period?	
☐ Y ☐ N	Feeding or sleeping problems?	
☐ Y ☐ N	Thumb sucking?	Until what age?
☐ Y ☐ N	Toilet trained?	Until what age?

CHILDHOOD ILLNESSES

Has your child had any of the following childhood illness?	Yes	No	Age	Frequency
Respiratory Problems	☐	☐		
High Fever	☐	☐		
Meningitis	☐	☐		
Ear Infections	☐	☐		
Adenoid problems	☐	☐		
Frequent colds	☐	☐		
Strep throat	☐	☐		
Allergies?	☐	☐		Please list

Has your child ever been hospitalized? ☐Y ☐N *If yes, please explain:*

Has your child ever had any serious accidents or injuries? ☐ Y ☐ N *If yes, please explain:*

Does your child have any of the following problems?	Yes	No	Please give details
Asthma	☐	☐	
Bronchitis	☐	☐	
Skin problems	☐	☐	
Gastro-intestinal problems	☐	☐	
Convulsions	☐	☐	
Epilepsy	☐	☐	
Nightmares	☐	☐	
Fitful Sleep	☐	☐	
Bedwetting	☐	☐	
Nail biting	☐	☐	

Are there any other medical illnesses or conditions which have been diagnosed? ☐ **Y** ☐ **N** *Please explain:*

What vaccinations has your child been given? (check all that apply)

☐	**Hepatitis B**	☐	**HIB**	☐	**DPT**
☐	**MMR**	☐	**Polio**	☐	**Chickenpox**
☐	**Other:**			☐	**Other:**

Is your child in good health at the present time? ☐ **Y** ☐ **N** *Please explain:*

Temperament/Mood: Check moods your child often displays.

☐ Overly excited	☐ Easily Agitated	☐ Irritable
☐ Angry Outbursts	☐ Crying Spells	☐ Giddiness

When was your child's most recent medical checkup? **Doctor/Provider:**

Medications: Please list any prescriptions your child is currently taking.

Medication	Dosage	Reason for taking	Response to Medication

SENSORI-MOTOR DEVELOPMENT

How would you describe your child's motor development? ☐ Normal ☐ Delayed ☐ Advanced

At what age did your child crawl? _____ **At what age did your child walk?** _____

Hand preference: ☐ **Right** ☐ **Left** ☐ **Mixed** **Did/does your child toe walk?** ☐ Y ☐ N

Is your child unusually sensitive to touch or are some clothes "scratchy?" ☐ Y ☐ N *If yes, please explain:*

General coordination (large muscle): ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Small muscle coordination (for example, is your child's handwriting legible?**):** ☐ Poor ☐ Fair ☐ Good ☐ Excellent

General Balance: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Is your child accident prone? ☐ Y ☐ N **Do they fall or stumble often**? ☐ Y ☐ N

Does your child participate in sports? ☐ Y ☐ N *If yes, which type and at what level?*

VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision? ☐ Y ☐ N *If yes, please explain:*

Are there any current problems of which you are aware? ☐ Y ☐ N *If yes, please explain:*

When was the last time his/her eyesight was tested?

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (operations, infections, tubes, etc) ☐ Y ☐ N

If yes, please explain:

Frequency of ear infections:

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Mild ☐ Moderate ☐ Severe

Are there any current problems of which you are aware which involve listening? ☐ Y ☐ N *If yes, please explain:*

Do you feel your child responds to sounds in an unusual way? ☐ Y ☐ N *If yes, please explain:*

Is your child over- or under- sensitive to high pitches, noises or other sounds? ☐ Y ☐ N *If yes, please explain*:

SPEECH AND LANGUAGE DEVELOPMENT

How would you describe your child's speech and language development? ☐ Normal ☐ Delayed ☐ Advanced

Did your child begin speaking in single words, then two, then a sentence --- or --- did he/she not talk for a long while, then all of a sudden speak in complete sentences? ☐ Y ☐ N *If yes, please explain:*

What were their first words and at what age did they begin to speak?

Describe any other speech-related problems.

Does there appear to be a reversal of sounds in speech production? ☐ Y ☐ N *If yes, please explain*:

Is there stuttering, slow response time, or hesitant vocal emissions? ☐ Y ☐ N *If yes, please explain:*

ASSESSMENTS

Assessment type	Yes	No	Location	Specialist	Date mm/yyyy
Medical/Neurological	☐	☐			
Audiological/Hearing	☐	☐			
Speech	☐	☐			
Educational (school IEP)	☐	☐			
Psychological	☐	☐			
Occupational Therapist	☐	☐			
Vision Developmental Optometrist	☐	☐			
Sensory Integration Physical Therapist	☐	☐			

Additional comments:

Has your child been previously diagnosed as having a specific disorder? ☐ Y ☐ N *If yes, please explain:*

Has your child received any special education or special therapy? ☐ Y ☐ N *If yes, please explain:*

Have there been any specific events or traumas linked to the onset of your child's difficulties? ☐ Y ☐ N

If yes, please explain:

EDUCATION

In general, how would you describe your child's learning experience at school from preschool or kindergarten to the present time?

How did your child adapt to the first day(s) oat school or preschool? ☐ Mostly positive ☐ Mixed ☐ Mostly negative

How old was he/she? **How much did he/she attend per week?**

Please give us more detailed information about any difficulties your child encountered in school, beginning with the earliest experience.

Initial school adjustment:

Preschool/daycare:

Primary (K-3):

Junior (4-6):

Intermediate (7-8):

High school (9-12):

Has there been remedial help given outside the school system? ☐ Y ☐ N *If yes, please explain*:

Does he/she like dancing and sports? ☐ Y ☐ N *If yes, please explain:*

Does he/she take risks or learn only when very comfortable?

BEHAVIOR/CHARACTER

How would you describe your child's personality?

What are your child's strengths?

What are your child's weaknesses?

Have there been any specific behavior problems in the course of your child's development?

What kinds of interests and activities does your child have (hobbies sports, clubs)? Please list them in the order of preference, beginning with the more favorite activity.

How would you describe your child's social adjustment at:
Home-

School-

Neighborhood-

With peers-

With adults-

Who does the child have for a personal support system (i.e. family, family friends, personal friends, sports groups, activity groups, mentors, etc.)?

Please add any other comments you might have regarding your child's behavior and character.

MEDICATION REPORT

Current Medications

Name	Total Daily Dosage	Start Date	End Date	Reason for taking	Response/Side Effects

Current Supplements and/or Vitamins (including over the counter)

Name	Total Daily Dosage	Start Date	End Date	Reason for taking	Response/Side Effects

Past Medications

It is very helpful to know of past medications taken and how they affected the patient.
(If you don't remember exact information, please provide the best information you can.)

Medication Type: SSRI's

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Celexa (citalopram)				Allergic	
Lexapro (escitalopram)				Allergic	
Luvox (fluvoxamine)				Allergic	
Paxil, Paxil CR, (paroxetine, paroxetine CR)				Allergic	
Prozac (fluoxetine)				Allergic	
Trintellix (vortioxetine)				Allergic	
Viibryd (vilazodone)				Allergic	
Zoloft (sertraline)				Allergic	

Medication Type: SNRI's

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Cymbalta (duloxetine)				Allergic	
Effexor (incl. IR & XR) (venlafaxine)				Allergic	
Pristiq (desvenlafaxine)				Allergic	
Strattera (atomoxetine)				Allergic	

Medication Type: Augmented

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Abilify (aripiprazole)				Allergic	
Depakote (divalproex)				Allergic	
Geodon (ziprasidone)				Allergic	
Invega (paliperidone)				Allergic	
Neurontin (gabapentin)				Allergic	
Risperdal (risperidone)				Allergic	
Saphris (asenapine)				Allergic	
Seroquel (quetiapine)				Allergic	
Zyprexa (olanzapine)				Allergic	

MEDICATION REPORT - Cont.

Medication Type:
Stimulants

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Adderall (d/l amphetamine)				Allergic	
Dexadrine (d-amphetamine)				Allergic	
Intuniv/Tunix (guanfacine)				Allergic	
Ritalin (methylphenidate)				Allergic	

Medication Type: TCA/Tetracyclic

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Anafranil (clomipramine)				Allergic	
Elavil, Endep (amitriptyline)				Allergic	
Ludiomil (maprotilene)				Allergic	
Merital (nomifensine)				Allergic	
Norpramin, Pertofrane (desipramine)				Allergic	
Pamelor, Aventyl (nortriptyline)				Allergic	
Sinequan (doxepin)				Allergic	
Surmontil (trimipramine)				Allergic	
Tofranil (imipramine)				Allergic	
Vivactil (protriptyline)				Allergic	

Medication Type: MAOI

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Eldepryl (Selegine)				Allergic	
Ensam (Selegine patch)				Allergic	
Nardil (phenelzine)				Allergic	
Marplan (isocarboxazid)				Allergic	
Parnate (tranylcypromine)				Allergic	

Medication Type: Hormone Replacement

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Estrogen Hormone				Allergic	
Progesterone Hormone				Allergic	
Testosterone Hormone				Allergic	
Thyroid Hormone				Allergic	

Medication Type: Other

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Ativan (lorazepam)				Allergic	
Buspar (buspirone)				Allergic	
Catapres (clonidine)				Allergic	
Desyrel (trazodone)				Allergic	
Lithium (Carbonate)				Allergic	
Mellaril (thioridazie)				Allergic	
Minipress (prazocin)				Allergic	
Remeron (mirtazapine)				Allergic	
Serzone (nefazodone)				Allergic	
Valium (diazepam)				Allergic	
Wellbutrin (buproprion)				Allergic	
VNS				Allergic	
Light Box				Allergic	

FAMILY MEDICAL HISTORY

Did the child's parents have a history of alcohol or drug abuse? ☐ **Yes** ☐ **No** ☐ **Not sure** *If yes, please explain:*

Has anyone in the child's family been diagnosed with or treated for:

Condition			**What relative(s)?**	**Condition**			**What relative(s)?**
Anxiety	☐ Yes	☐ No		Depression	☐ Yes	☐ No	
Anger	☐ Yes	☐ No		Schizophrenia	☐ Yes	☐ No	
Bipolar Disorder	☐ Yes	☐ No		Post-Traumatic Stress	☐ Yes	☐ No	

PERSONAL HISTORY

Does the child have a history of Self-Harm? ☐ Yes ☐ No ☐ Not sure *If yes, please explain:*

Does the child have a history of physical, sexual, or emotional abuse? ☐ Yes ☐ No ☐ Not sure *Please explain:*

Does the child have a history of alcohol and drug use? ☐ Yes ☐ No ☐ Not sure *Please explain:*

Has the child been hospitalized for psychiatric reasons? ☐ Yes ☐ No ☐ Not sure *Please explain:*