Fort Bend Psychiatry

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Child & Adolescent New Patient Information

Patient Name:	**Birthdate**: / /	**Today's Date:** / /
Name of Person completing this form:		Relationship to Patient:
Patient's Address: Street		City, State, Zip
Preferred Phone Number:		Email:
Is this patient adopted? YES NO		Date of Adoption:
Please list names/ relationships of all people living with child:		
Emergency Contact Name:		Phone:
Are you this patient's legal guardian? YES NO		
Name of other parent/legal guardian(s):		
What is your main goal/concern that led you to this appointment?		
MEDICAL INFO		
Pediatrician/ PCP Name:		Phone:
Medical Problems (such as asthma, heart problems, murmur, head injury, seizure):		
Please list all *current* medications (name and dose):		
PSYCHIATRIC HISTORY		
Has this patient ever seen a psychiatrist? YES NO		If so, when?
Please list all *past psychiatric medications* (name and dose):		
FAMILY HISTORY Please circle anything that has affect *biological* family members of this child:		
Anxiety Depression ADHD Bipolar Disorder Alcoholism Drug Abuse Suicide Schizophrenia OCD Autism Sudden Cardiac Death Heart Disease Hypertension Cancer		
MEDICATION ALLERGIES Please list medication and reaction:		
PREFERRED PHARMACY NAME and PHONE OR LOCATION:		

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DEVELOPMENTAL

Was this patient born prematurely? YES NO If so, at how many weeks?

Any complications during pregnancy? YES NO If so, please explain:

Developmental Milestones (please provide age at which milestones were achieved):

Walk: Spoke Sentences:

Toilet Training (day): Toilet Training (night):

Did you have any concerns about this patient's development? Please explain:

SCHOOL

Name of School: Grade:

Has this patient repeated a grade?: YES NO If so, which one?

Does this child have concerns in school? (behaviors, grades, etc.) YES NO If so, please explain:

Name of School Counselor: Phone:

Name of Teacher:

OTHER

Has CPS (Child Protective Services) ever been involved with this child or family? If so, please provide a brief explanation:

Has this patient ever had legal problems? YES NO If so, please explain:

Do you suspect this patient has ever used drugs? YES NO If so, please explain:

ADDITIONAL CONCERNS:

Please list any other concerns such as: family conflict, divorce, abuse, trauma, family move, or other contributing factors:

Signature: **Date:**