Carolina Partners in Mental HealthCare, PLLC

James Smith III, MD Elizabeth Bruce, MSN, PMHNP-BC Robin Cassidy, ANP-BC
Elizabeth Corbett, MSN, PMHCNS/NP-BC J. Gray McAllister III, MD
Vida Robertson, MD

Clinician Notes

Date: _____

Patient Name: _____ Date of Birth: _____/_____/_____

Age of Patient: _____ Name of person completing this form _____

Relationship to the patient: _____

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

1. Please describe, in detail, the present problem (including when it started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any treatment for the problem? If yes, explain.

2. Medical History

Name of Pediatrician/Family Doctor: _____ Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? **Yes** **No**

Please check any of the following medical conditions for which your child was evaluated or diagnosed:

Seizures	Heart Problems	Weight Problems	Head Injury
Asthma	Chronic Fatigue	Chronic Headaches	Depression
Surgeries	Stomach Problems	Chronic Hearing Loss	Suicidal Thoughts

Other: _____

Please list any medications previously prescribed: _____

_____.

Please list any allergies: _____.

Please list any medications your child is currently taking: _____

_____.

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3. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? **Yes** **No**
If yes, please explain and include dates of service, location, and physician and/or counselor's name

List any psychiatric or mood medications that your child has been prescribed in the past:

1.

2.

3.

4. Developmental History

A. Relating to your child's birth:

Your child's weight at birth _____ lb _____ oz. Was this a full term birth? **Yes** **No**

Did either parent use drugs or alcohol at the time of conception? **Yes** **No**
If yes, explain:

Were there any complications with the labor & delivery (jaundice, infection, etc.)?
Yes **No** If yes, explain:

Were there any problems after birth? **Yes** **No** If yes, explain:

B. Preschool/Toddler Temperament: Please check all of the following items that apply.

Did not enjoy being held	Excessive restlessness	Colic
Feeding problems	Sleep problems	Head banging
Fussy or Unhappy	Difficulty bonding	Sensitive to light/noise/texture

C. Developmental Milestones: please indicate the approximate age in months when your child achieved the following tasks:

_____ Sitting Alone. _____ Walking. _____ Put words together. _____ Toilet trained.

D. Unusual Behaviors/Speech Patterns:

Spinning	Putting things in mouth	Repeating words/phrases
Hand flapping	Sniffing excessively	Saying "I" for "You"

5. School/Daycare History

Did your child attend daycare? **Yes** **No** If yes, what was their age? _____ .

Any Problems? _____.

What were your child's grades on their last report card? _____.

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Name of Current School: _____

Dates Attended: _____ Present Grade Placement: _____

Behavior Problems: **Yes** **No** Learning Problems: **Yes** **No**

Name of Previous School: _____

Dates Attended: _____ Grade Placement: _____

Behavior Problems: **Yes** **No** Learning Problems: **Yes** **No**

Name of Previous School: _____

Dates Attended: _____ Grade Placement: _____

Behavior Problems: **Yes** **No** Learning Problems: **Yes** **No**

Has your child ever been evaluated for a learning disability? **Yes** **No**

If yes, what grade? _____ When? _____

Has your child ever been placed in a special education class? **Yes** **No**

If yes, what type of class?

Has your child ever been tested by the school system? **Yes** **No**

If yes, what grade? _____ When? _____

Has your child ever been suspended or expelled? **Yes** **No**

If yes, please describe:

Does your child have a current IEP (individualized learning plan)? **Yes** **No**

Does your child have a current 504 plan? **Yes** **No**

6. Legal / Juvenile Court / State Department of Health and Human Services:

Has your child ever been arrested? **Yes** **No**

Has your child been assigned a probation officer? **Yes** **No** If yes, name:

Has your child ever been jailed? **Yes** **No**

Has your child ever appeared in juvenile court? **Yes** **No**

Has your child or other family member ever been reported to DHHS? **Yes** **No**

Has your child or other family member been assigned a caseworker? **Yes** **No**

If yes, name:

Has your child ever been a victim of sexual abuse? **Yes** **No**

If yes, explain:

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7. Family Medical and Psychiatric History (please indicate all that apply):

Sudden death	Heart disease	Diabetes mellitus
Obesity	Narrow angle glaucoma	Seizures

Has any member of your child's family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADHD? **Yes** **No**

If yes, please explain:

8. Social / Family History

Biological mother's full name: _____

Biological father's full name: _____

Biological parents' marital status: __ married to each other __ separated __ divorced

If divorced from one another, has either parent remarried?

Mother **Yes** **No** stepparent's name _____

Father **Yes** **No** stepparent's name _____

If biological parents are divorced or separated, who has custody of the patient? _____

Type of custody _____

List all relatives who presently live in the same household as your child:

	Name	Relationship	Employment/Grade Level
1.			
2.			
3.			
4.			
5.			

Please indicate any of the following stressors that presently affect your child:

Family financial problems	Family relationships	Legal problems
Child rearing problems	Drug or alcohol problems	Abuse behavior
Health problems	Employment problems	School problems
Peer relationships	Frequent moves	Frequent change of household

Please explain how any indicated items affect your child:

Clinician Signature

_____