Johns Creek Psychology

Confidential Patient Questionnaire

IDENTIFYING INFORMATION

Child's Name _____Date of Birth ____/____/___

Parents' Names _____

Address _____Age of Child_____

_____Male _____ Female _____

Phone _____

Handedness: _____right_____left_____both

Referred by (Who suggested you have this Evaluation?):_____

_____

Reason for Referral (Please describe in detail the problems that are affecting your child and family): _____

_____

Person completing form: _____

Relationship to child: _____Today's date: _____

Diagnosis:_____

PREGNANCY AND NEWBORN HISTORY

Pregnancy: Full term: Yes _____No _____ How long? _____Weeks

Problems during pregnancy:

Medications taken: _____

Illnesses: _____

Bleeding: _____

Smoking: _____

Alcohol: _____

Drugs: _____

Accidents: _____

Unusual circumstances: _____

Number of previous pregnancies: _____ Child is from pregnancy #: _____

Child's birth weight: _____ lbs. _____ oz.

Labor: Spontaneous _____ Induced _____ Length of labor _____

Any difficulties _____

Delivery: Vaginal _____ C-section ____ Explain _____

Forceps _____ Apgar scores _____ Color _____ Jaundice _____

Any complications _____

Special procedures used after birth _____

Special Care Nursery _____ Length of stay _____

Other problems _____

(Please circle) colic sleeping problems rocking irritability feeding problems excessive crying seizures head banging fevers ear infections

DEVELOPMENTAL HISTORY

At what age did your child:	Age	Problems/Comments
Sit alone	_____	_____
Walk	_____	_____
Crawl	_____	_____
Speak first word	_____	_____
Understand speech	_____	_____
Speak two word sentences	_____	_____
Toilet trained for day	_____	_____
Toilet trained for night	_____	_____
Previous evaluations	_____	_____
Services provided	_____	_____

	Yes	No
Preschool problems	_____	_____
Academic readiness problems	_____	_____
Fine motor difficulties (i.e. drawing, buttons, zippers)	_____	_____
Gross motor difficulties (i.e. hopping, bike riding)	_____	_____
Difficulty sitting still for T.V. or stories	_____	_____
Difficulty socializing with other children	_____	_____

MEDICAL HISTORY:

Serious falls or injuries? (please describe) _____

Head injuries, seizures, or head trauma? _____

Serious or chronic illnesses during childhood? _____

Hospitalizations, surgeries? _____

Pediatrician _____ Other Medical Specialists _____

Current Medications _____ Dosages _____

Past Medications _____ Dosages _____

Medications helpful? _____ In what way? _____

Childhood Illnesses _____

(please circle) meningitis encephalitis otitis media nausea dizziness allergies visual problems stomach aches recurrent headaches asthma

Has your child had any of the following evaluations? Please give the date of, reason for, and result of evaluation.

Psychological Problems _____

Psychiatric Assessment (for depression, drug or alcohol abuse, psychoses, etc.) _____

_____

Neurological Evaluations _____

Electroencephalogram (EEG) _____

CT Scan/MRI of the Brain _____

Psychotherapy/Counseling _____

Occupational Therapy_____

Speech/Language Therapy_____

Physical Therapy_____

Hearing/Vision Evaluation_____

Litigation_____

Learning Problems_____

Mental Retardation_____

Genetic_____

EDUCATIONAL BACKGROUND

Current School_____Grade_____County_____

Preschool_____Ages Attended_____

Any problems?_____

Kindergarten_____

Any problems?_____

Elementary_____

Any problems?_____

Test scores/reports available_____

Middle School_____

Any problems?_____

Test scores/reports available_____

High School_____

Any problems?_____

Test scores/reports available_____

Suspensions_____ Expulsions_____

Has your child received any of these services?	Yes	No
Early Intervention	____	____
Learning disabilities resource	____	____
Emotionally handicapped	____	____
Intellectually disordered	____	____
Self-contained	____	____

	Yes	No
Tutoring	____	____

SOCIAL HISTORY

Mother's name_____Occupation_____

Father's name_____Occupation_____

Years of formal education: Mother_____Father_____

Mother's age_____ Father's age_____

Parents are: _____Married_____Separated_____Divorced_____Single____Widowed

With whom child lives_____

Siblings_____ Age_____Grade_____

_____ Age_____Grade_____

_____ Age_____Grade_____

_____ Age_____Grade_____

Significant marital conflict?_____

Significant conflict between parents and child?_____

Unusual behaviors/tics?_____Types of discipline_____

Child's response_____

Difficulty getting along with adults_____

Hobbies_____

Peer relationships_____

Any sudden changes in behavior_____

Strengths_____

Weaknesses_____

Organizations child belongs to_____

SIGNIFICANT FAMILY INFORMATION: (including child's parents, grandparents, aunts, uncles, and cousins). Please provide as much detail as possible:

Psychological Problems_____

Psychiatric Assessment (For depression, drug or alcohol abuse, psychoses, etc.)_____

_____

Neurological Evaluations_____

Electroencephalogram (EEG)_____

CT Scan/MRI of the Brain_____

Psychotherapy/Counseling_____

Financial Stress_____

Litigation_____

Learning Problems_____

Mental Retardation_____

Genetic_____

The SNAP-IV Teacher + Parent Rating Scale

James M. Swanson, PhD, University of California, Irvine, CA 92715

Name of Child:_____

Completed by:_____

For each item, check the column that best describes the child:	Not At All	Just A Little	Quite A Bit	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks.				
2. Often has difficulty sustaining attention in tasks or play activities.				
3. Often does not seem to listen when spoken to directly.				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties.				
5. Often has difficulty organizing tasks and activities.				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort.				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books).				
8. Often is distracted by extraneous stimuli.				
9. Often is forgetful in daily activities.				
10. Often fidgets with hands or feet or squirms in seat.				
11. Often leaves seat in classroom or in other situations in which remaining seated is expected.				
12. Often runs about or climbs excessively in situations in which it is inappropriate.				
13. Often has difficulty playing or engaging in leisure activities quietly.				
14. Often is “on the go” or acts as if “driven by a motor.”				
15. Often talks excessively.				
16. Often blurts out answers before questions have been completed.				
17. Often has difficulty awaiting turn.				
18. Often interrupts or intrudes on others (e.g., butts into conversations or games).				
19. Often loses temper.				
20. Often argues with adults.				
21. Often actively defies or refuses adult requests or rules.				
22. Often does things that annoy other people.				
23. Often blames others for his or her mistakes or misbehavior.				
24. Often is touchy or easily annoyed by others.				
25. Often is angry and resentful.				
26. Often is spiteful or vindictive.				