Rebecca Farinas, M.D.
Diplomat American Board Psychiatry & Neurology
Board Certified Child, Adolescent &
Adult Psychiatrist

On the next several pages you will find a very comprehensive questionnaire. Its completion is required prior to your first appointment with me. ***Please complete and return or fax it to our office prior to your first appointment.*** The fax number is (904) 997-7057, alternately the mailing address is printed at the bottom of this page, or you are welcome to bring the completed documents to our office Monday through Friday from 9 a.m. – 5p.m. Being able to review the information you provide, ***before*** I see your child, will maximize our time together.

I apologize, in advance, for its length. Also, I realize that some of the information is very private. I will be the only person reviewing your responses. Your child's medical record is kept locked in our office at all times. A few of the questions will not apply to you or your child. If you have questions about any item, feel free to seek clarification.

Also, enclosed are a few administrative forms that our office requires to be completed. I realize your time is valuable and appreciate your collaboration with the therapeutic process. I look forward to meeting with you and your child.

Respectfully,
Rebecca Farinas, M.D.

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Comprehensive Child and Adolescent History Form

Please fill out the form to the best of your knowledge. If some questions are not applicable to your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

General Information

Date: ________________

Child's Name: ____
First Middle Last

Nickname: _______________________ Sex: ☐ Female ☐ Male

Date of Birth: ______________ Age: _________

Child lives at: ____
Address City State Zip Code

Caretakers that the child currently lives with: ______________________________

Does the child live elsewhere during the week or year? ☐ Yes ☐ No

If "Yes", please explain: ____

Does the child have any siblings? ☐ Yes ☐ No

If "Yes", please list their names and ages: ______________________________

____

Does the child live with any of the siblings? ☐ Yes ☐ No

Please describe living arrangements: ______________________________

____

Name of person completing form: ______________________________

Relationship to child: ______________________________

Child's Mother's Name: ____
First Middle Last

Mother's Address (only if different from child's address)

____
Address City State Zip Code

Telephone (Day) ___________________________ (Evening) ___________________________

Child's Father's Name: ____
First Middle Last

Father's Address (only if different from child's)

____
Address City State Zip Code

Telephone (Day) ___________________________ (Evening) ___________________________

Referral Information

Child's Pediatrician or Family Doctor:

Name: ____

Address: ____

Telephone: _____________________ Fax: _______________________

Parent / Guardian Name: ____DOB: ________________

Child's Current Mental Health Professional (*if applicable*)**:**
Name: ____
Address: ____
Telephone: _______________________ Fax: _________________________

Current Concerns

Why are you bringing your child in for psychiatric care?
____
____

What about your child concerns you?
____
____

How long has this been a problem / concern?
____
____

What have you tried to do to help your child with these concerns?
____
____

How do you hope we can help you? What are your goals?
____
____

Past Problems

Has your child ever seen a psychiatrist, psychologist or counselor before?
- ☐ No
- ☐ Yes (please tell us who and when): ____
____

Has your child ever had a psychological evaluation or testing for learning disabilities?
- ☐ No
- ☐ Yes (please explain): ____

Has your child ever taken medication to manage behavioral or emotional problems?
- ☐ No
- ☐ Yes (please list the medication and the age when your child took it): __________________
____
____

Has your child ever been in the hospital for behavioral or emotional problems?
- ☐ No
- ☐ Yes (please explain): ____
____
____

Is your child currently under care of mental health provider?
- ☐ No
- ☐ Yes (please list medication, dose, and frequency): ________________________________
____
____

Has your child ever had any bad reactions to medications for behavioral or emotional problems?
- ☐ No
- ☐ Yes (please explain): ____
____
____

Parent / Guardian Name: ____DOB: ________________

Pediatric Symptom Checklist

Please place a check mark under the heading that best describes your child

Symptoms	Never	Rarely	Sometimes	Often
1. Complains of aches or pains	☐	☐	☐	☐
2. Spends more time alone	☐	☐	☐	☐
3. Tires easily, little energy	☐	☐	☐	☐
4. Fidgety, unable to sit still	☐	☐	☐	☐
5. Has trouble with a teacher	☐	☐	☐	☐
6. Less interested in school and homework	☐	☐	☐	☐
7. Acts if driven by a motor that can't be turned off	☐	☐	☐	☐
8. Daydreams too much	☐	☐	☐	☐
9. Distracted easily	☐	☐	☐	☐
10. Is afraid of new situations	☐	☐	☐	☐
11. Feels sad, unhappy	☐	☐	☐	☐
12. Is irritable, angry	☐	☐	☐	☐
13. Feels hopeless	☐	☐	☐	☐
14. Has trouble concentrating	☐	☐	☐	☐
15. Less interested in friends	☐	☐	☐	☐
16. Fights with other children	☐	☐	☐	☐
17. Absent from school	☐	☐	☐	☐
18. School grades dropping	☐	☐	☐	☐
19. Has poor self-image	☐	☐	☐	☐
20. Visits doctor with doctor finding nothing wrong	☐	☐	☐	☐
21. Has trouble sleeping	☐	☐	☐	☐
22. Worries a lot	☐	☐	☐	☐
23. Wants to be with you more than before	☐	☐	☐	☐
24. Feels he or she is bad/blames oneself/feels worthless	☐	☐	☐	☐
25. Takes unnecessary risks	☐	☐	☐	☐
26. Gets hurt frequently	☐	☐	☐	☐
27. Seems to be having less fun	☐	☐	☐	☐
28. Acts younger than children his or her age	☐	☐	☐	☐
29. Does not listen to the rules or follow the rules	☐	☐	☐	☐
30. Does not show feelings/emotions	☐	☐	☐	☐
31. Does not understand other people's feelings	☐	☐	☐	☐
32. Teases others	☐	☐	☐	☐
33. Blames others for his or her troubles	☐	☐	☐	☐
34. Takes things that do not belong to him or her	☐	☐	☐	☐
35. Refuses to share	☐	☐	☐	☐

Parent / Guardian Name: ____DOB: ________________

36. Uses bad language	☐	☐	☐	☐
37. Has ideas that he/she cannot stop thinking about	☐	☐	☐	☐
38. Demonstrates repetitive behaviors despite attempts to stop	☐	☐	☐	☐
39. Changes in eating habits – eats more or less than before	☐	☐	☐	☐
40. Changes in eating habits – binging or purging	☐	☐	☐	☐
41. Has been hoarding things	☐	☐	☐	☐

Pregnancy

(If child was adopted, parent/guardian can skip questions pertaining to pregnancy and delivery)

Please list all of the Mother's pregnancies in order, including the patient.

If a pregnancy ended in miscarriage, state which month.

Year	Mother's Age	Length of Pregnancy	Birth Weight	Complications Yes/No

Please answer which of the following conditions may have occurred during this pregnancy and explain (month, amount, and treatment) in the space below.

Yes	No		Yes	No	
		Edema (swelling of the hands & feet)			Epilepsy
		Vaginal Bleeding			Infections (colds, flu, urinary tract, rubella, vaginal)
		Toxemia			Other illnesses
		Emotional Stress			Cigarettes Used (Avg. # per Day)
		High Blood Pressure			Alcohol Used
		X-ray Studies			Marijuana Used
		Hospitalization			Cocaine Used
		Fever			Heroine Used
		Operations (specify below)			Other Drugs Used
		Medications Used			

Please explain all "Yes" answers:

____

____

____

Parent / Guardian Name: ____DOB: ________________

Was the pregnancy of the child who is coming to the clinic planned? ☐ Yes ☐ No
How did the parents feel about this pregnancy? ____
____

How active was this baby during pregnancy? ☐ Very Active ☐ Active ☐ Not Active

Birth History

Place (City, State, Country): ____
Hours of Labor: ______________________
Was the baby delivered on time?
☐ Yes ☐ No ☐ Early, by how much time? ___________ ☐ Late, by how much time? __________

Type of Labor Onset: ☐ Induced ☐ Spontaneous
Type of Anesthesia: ☐ Gas ☐ Spinal ☐ Local ☐ None
Type of Birth: ☐ C-section ☐ Vaginal
Baby's Presentation: ☐ Breech ☐ Head

Post Delivery Period

Check which of the following problems may have occurred after the child's birth and explain the amount and treatment in the space below:

Yes	No		Yes	No	
☐	☐	Trouble breathing	☐	☐	Jaundice
☐	☐	Cord around the neck	☐	☐	Poor Feeding
☐	☐	Required a blood transfusion	☐	☐	Hemorrhage (bleeding) in brain
☐	☐	Vomiting	☐	☐	Large ventricles (fluid) in brain
☐	☐	Low Tone	☐	☐	Incubator care / premature birth
☐	☐	Cyanosis (turned blue)	☐	☐	Infection
☐	☐	Need for ventilation			

Please explain all "Yes" answers: ____
____
____
____

How many days was the infant hospitalized after delivery? ________________

Infancy

Was any of the following present in your baby to a significant degree during the first few years of life?

Yes	No		Yes	No	
☐	☐	Did not enjoy cuddling	☐	☐	Was not calmed by being held or stroked
☐	☐	Difficult to comfort	☐	☐	Excessive restlessness
☐	☐	Excessive irritability	☐	☐	Frequent head banging
☐	☐	Difficult feeding			

Parent / Guardian Name: ____DOB: ________________

Please explain all "Yes" answers above: ____
____
____
____

Temperament

Please evaluate the following behaviors your child exhibited during infancy and early childhood.

How active has your child been from an early age?
☐ Extremely active ☐ Active ☐ Not very active

How well did your child pay attention?
☐ Very well ☐ Average ☐ Not very well

How well did your child deal with changes?
☐ Very well ☐ Average ☐ Not very well

How well did your child respond to new things (places, people, food, etc.)?
☐ Very well ☐ Average ☐ Not very well

How strong are your child's feelings when happy or unhappy?
☐ Very ☐ Average ☐ Not very

What was your child's basic overall mood?
☐ Happy ☐ Average ☐ Irritable

How predictable was your child in patterns of sleep, appetite, etc.?
☐ Very regular ☐ Average ☐ Not very regular

Developmental Milestones

How old was your child when he/she did the following?
(If your child has not yet done the listed activity, please write N/A).

Sit: __________ Crawl: __________ Walk: __________
Pedal a 3-wheeler: __________ Pedal a 2-wheeler: __________
Smile in response: __________ Say 1st word other than Mama or Dada: _________
Know primary colors: __________ Sound out letters of the alphabet: __________
Print first & last name: __________ Tie shoes: __________
Use knife to spread food: __________ Cut food with knife: __________
Buttoned clothing: _________ Began to read: __________
Toilet trained to urinate: __________ Bowel movement trained: __________
Briefly describe toilet training methods: ____
____
____

Coordination

How would you rate your child's coordination? When answering this question, think about how your child walks, runs, throws, catches, plays sports in comparison to other children his/her age.

Parent / Guardian Name: ____DOB: ________________

☐ Good ☐ Average ☐ Poor

Does your child seem to have an excessive number of accidents compared to other children?

☐ No ☐ Yes If“Yes”, please explain: _____________________________________

____

____

Health History

Allergies to medications? ____

When was your child’s last physical exam? ____

Where? ____

Check which of the following your child has had and note the age, complications, and frequency below (elaborate on lines provided below):

Yes	No	
☐	☐	Hospitalizations
☐	☐	Surgeries
☐	☐	Allergies
☐	☐	Persistent high fevers
☐	☐	Coma
☐	☐	Head trauma
☐	☐	Loss of consciousness
☐	☐	Tics
☐	☐	Staring spells
☐	☐	Accidentally Poisoning
☐	☐	Ear infections (how many?__)
☐	☐	Hearing problems
☐	☐	Sleep problems
☐	☐	Colic
☐	☐	Medication for convulsions
☐	☐	Medication for hyperactivity
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Pregnancies
☐	☐	Irregular periods
☐	☐	Menstrual period (If yes, at what age?) ___________

Yes	No	
☐	☐	Vision problems
☐	☐	Falls frequently
☐	☐	Trauma (stitches or broken bones)
☐	☐	Poor coordination
☐	☐	Seizures
☐	☐	Headaches
☐	☐	Bedwetting
☐	☐	Stool soiling
☐	☐	Tremor
☐	☐	Other infections
☐	☐	Bowel problems (loose stools, constipation)
☐	☐	Excessive vomiting
☐	☐	Pica (eating non-food items such as dirt or paper)
☐	☐	Other long term medical complaints/problems
☐	☐	Medication for other illness (not for colds or ear infections)

Please explain all “Yes” answers to the previous list of questions: ________________________

____

____

____

Does your child take any medications or additional (including over-the-counter) supplements not previously listed? ☐ Yes ☐ No

If “Yes” please list medications / supplements:

Medication name	Dose	Frequency

Parent / Guardian Name: ____DOB: ________________

Lab Tests

Has your child had the following tests and what were the results?

Yes	No		Yes	No		Yes	No	
☐	☐	EEG	☐	☐	Organic Acids	☐	☐	Lead
☐	☐	Thyroid	☐	☐	Head CT	☐	☐	Amino Acids

Please explain all "Yes" answers:

____

____

____

School History

If your child does not yet attend school, write N/A on the line marked "Name of Child's School" and then please move on to the next section marked "Comprehension and Understanding."

Name of child's school: ____

Address: ____

Telephone number: ______________________

Current Grade: _______________ Teacher: ____

Special treatment (if any): ____

Has testing been completed by school? ☐ No ☐ Yes (Date): ________________

(If yes, please attach a copy of school evaluation)

May we contact the school? ☐ Yes ☐ No

Please evaluate your child's school experience related to *academic* learning:

	Good	Average	Poor
Nursery School	☐	☐	☐
Kindergarten	☐	☐	☐
Current Grade	☐	☐	☐

Has your child ever repeated a grade? ☐ No ☐ Yes (which one(s)): ________________________

Is your child currently receiving special counseling or remedial work? ☐ Yes ☐ No

If "Yes", please explain: ____

Briefly describe any *academic* school problems: ____

____

Please evaluate your child's school experience related to *behavior*:

	Good	Average	Poor
Nursery School	☐	☐	☐
Kindergarten	☐	☐	☐
Current Grade	☐	☐	☐

Is your child in a special classroom setting because of *behavior* problems? ☐ Yes ☐ No

If "Yes", please explain: ____

Parent / Guardian Name: ____DOB: ________________

Please briefly describe any behavioral school problems:

____

____

____

Comprehension and Understanding

Do you think your child understands directions and situations as well as other children his/her age?

☐ Yes ☐ No (Please explain): ____

____

____

How would you rate your child's overall intelligence compared to other children?

☐ Average ☐ Above Average ☐ Below Average

Daily Observed Behaviors

All children, to some degree, engage in the behaviors noted below. Please indicate to what degree your child has exhibited the following behaviors by checking the appropriate column for each item below:

	Not at All	Just a Little	Often	Very Often
Fidgets with hands, feet or squirms in seat	☐	☐	☐	☐
Has difficulty remaining seated when required	☐	☐	☐	☐
Is easily distracted by extraneous stimulation	☐	☐	☐	☐
Has difficulty waiting turn in games/groups	☐	☐	☐	☐
Blurts out answers to questions	☐	☐	☐	☐
Has problems following through with instructions	☐	☐	☐	☐
Has difficulty paying attention during tasks or play	☐	☐	☐	☐
Shifts from one uncompleted activity to another	☐	☐	☐	☐
Has difficulty playing quietly	☐	☐	☐	☐
Often talks excessively	☐	☐	☐	☐
Interrupts or intrudes on others (impulsively)	☐	☐	☐	☐
Does not appear to listen to what is being said	☐	☐	☐	☐
Loses things necessary for tasks or activities	☐	☐	☐	☐
Often engages in physically dangerous activities without considering consequences	☐	☐	☐	☐

Where does your child sleep?

- ☐ Bedroom other than parent(s) bedroom and not with anyone else
- ☐ Bedroom parent(s) sleep in
- ☐ Bedroom shared with 1 2 3 4 5 others (not parents)
- ☐ Room other than a bedroom

Parent / Guardian Name: ____DOB: ________________

Does your child have problems falling asleep? ☐ Yes ☐ No

If "Yes" then how long does it take for him/her to fall asleep? __________ hours

Does your child wake up in the middle of the night? ☐ Yes ☐ No

If "Yes" approximately how many times per night? __________

How long does it normally take for him/her to go back to sleep after waking up in the middle of the night? ________________

Does your child snore? ☐ Yes ☐ No Is your child restless during sleep? ☐ Yes ☐ No

Does your child experience any of the following?
- ☐ Nightmares
- ☐ Night Terrors
- ☐ Sleep walking/talking

How many hours of sleep per night does your child currently get? ______________________________

Does your child nap during the day? ☐ Yes ☐ No

If "Yes" when and how long? ____

Eating

How would you rate your child's appetite? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Do you believe any particular foods affect your child's behavior? ☐ Yes ☐ No

If "Yes" which foods and how does it affect him/her? ____

____

Friendships

How many close friends does your child have? ______________

Does your child have a best friend? ☐ Yes ☐ No. If "Yes" how old is he/she? __________________

How does your child get along with friends? ☐ Poorly ☐ Average ☐ Well

If "Poorly," please explain? ____

____

Does your child date? ☐ Yes ☐ No

Is your child sexually active? ☐ Yes ☐ No

Does your child express a desire for romantic relationships? ☐ Yes ☐ No

Discipline and Behavior

In comparison to other children, how well does your child behave at home or in public?

____

In comparison to his/her siblings, how well does your child behave at home or in public?

____

What kind of discipline do you use with your child?

____

Is there a particular form of discipline that you have found effective?

____

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? ____

____

Parent / Guardian Name: ____DOB: __________________

Major Life Experiences

Please give child's age at the time of occurrence, with a brief explanation to any "Yes" responses in the space provided after each question.

Death

Death of a family member? ☐ Yes ☐ No Seen a dead body? ☐ Yes ☐ No
Death of a friend? ☐ Yes ☐ No

____
____

Major Illness

Has your child ever been hospitalized? ☐ Yes ☐ No
Has your child ever required a medical procedure? ☐ Yes ☐ No
Has your child ever required major medical care? ☐ Yes ☐ No
Has a family member been hospitalized? ☐ Yes ☐ No
Has a family member required a medical procedure? ☐ Yes ☐ No
Has a family member under medical care? ☐ Yes ☐ No

____
____
____

Violence

Been violent to others? ☐ Yes ☐ No Witnessed family violence? ☐ Yes ☐ No
Victim of family violence? ☐ Yes ☐ No Witnessed community violence? ☐ Yes ☐ No
Victim of community violence? ☐ Yes ☐ No

____
____
____

Physical Abuse

Been abusive to others? ☐ Yes ☐ No
Has he/she ever been hit? ☐ Yes ☐ No
Visited Emergency Room for non-accidental injury? ☐ Yes ☐ No
Referred to Child Protective Services (CPS) for physical abuse? ☐ Yes ☐ No

____
____
____

Sexual Abuse

Witnessed sexual behavior? ☐ Yes ☐ No Participated in sexual intercourse?* ☐ Yes ☐ No
Been touched inappropriately? ☐ Yes ☐ No Referred to CPS for sexual abuse? ☐ Yes ☐ No

If * "Yes" , was it consensual?

____
____
____

Parent / Guardian Name: ____DOB: ________________

Neglect

Failure to thrive? ☐ Yes ☐ No Smaller than average in size? ☐ Yes ☐ No
Referred to CPS for neglect? ☐ Yes ☐ No

____

____

Self Harm

That required medical care? ☐ Yes ☐ No Abused alcohol or drugs? ☐ Yes ☐ No
Attempted suicide? ☐ Yes ☐ No Is there a substance of choice? ☐ Yes ☐ No

____

____

Domiciles

Ever placed out of home with relatives or other?* ☐ Yes ☐ No
Foster placement? ☐ Yes ☐ No If * "Yes" for how long and why?

____

____

Legal

Appeared in court? ☐ Yes ☐ No Arrested? ☐ Yes ☐ No
Charged with a crime? ☐ Yes ☐ No Convicted? ☐ Yes ☐ No

____

____

Accidents Victim ☐ Witness ☐

Motor vehicle? ☐ Yes ☐ No
Fire? ☐ Yes ☐ No
Natural disaster? ☐ Yes ☐ No

____

____

Family Psychiatric History

Please check "Yes" or "No" for each of the conditions below to show if any family members have any of the listed conditions. Please indicate whether it occurs on the Mother's (M), Father's (P), or Both (B) sides of the family.

	No	Yes	M, P, B	List all affected family members, and indicate their relationship to the child (e.g. Sibling, Grandparent, Aunt or Uncle, etc.)
Schizophrenia				
Major Depressive Disorder				
Bipolar Disorder				
Suicide Attempt				
Suicide completed				
Alcoholism				
Drug Abuse				

Parent / Guardian Name: ____DOB: ________________

Obsessive Compulsive Disorder (OCD)				
Panic Disorder				
Anxiety Disorder				
Bed Wetting after 5 yrs.				
Tics/Tourette's				
Hyperactivity				
Slowness in Walking				
Mental Retardation				
Learning Problems				
Autism				
Repeated a Grade in School				
Speech Problems				
Delinquency Problems				

Has any blood relative to your child experienced problems similar to those your child is currently experiencing? ☐ No ☐ Yes (Please explain):____
____
____

Additional Comments

Please write any additional remarks you may have regarding your child or address any area of concern we may have missed in the space provided:

____
____
____
____
____
____
____

____ Date/Time: ___________________________

Parent's signature

____ Date/Time: ___________________________

Rebecca Farinas, M.D.