Rebecca Farinas, M.D.

Diplomate American Board Psychiatry & Neurology

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. Please call us ahead of time and we'll guide you on our hours. A HIPPA secure email is available as well upon request. 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.

Phone: (904)997-7776 Fax: (904)997-7057 Website: www.RebeccaFarinasMD.com
7545 Centurion Pkwy. Suite 302, Jacksonville, FL 32256

Parent / Guardian Name: _____ DOB: _____

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 a 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 interest 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				
36. Uses bad language				
37. Has ideas that he/she cannot stop thinking about				

Parent / Guardian Name: _____ DOB: _____

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 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)?

☐ 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.

☐ Good ☐ Average ☐ Poor

Parent / Guardian Name: _____ DOB: _____

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		Yes	No	
☐	☐	Hospitalizations	☐	☐	Vision problems
☐	☐	Surgeries	☐	☐	Falls frequently
☐	☐	Allergies	☐	☐	Trauma (stitches or broken bones)
☐	☐	Persistent high fevers	☐	☐	Poor coordination
☐	☐	Coma	☐	☐	Seizures
☐	☐	Head trauma	☐	☐	Headaches
☐	☐	Loss of consciousness	☐	☐	Bedwetting
☐	☐	Tics	☐	☐	Stool soiling
☐	☐	Staring spells	☐	☐	Tremor
☐	☐	Accidentally Poisoning	☐	☐	Other infections
☐	☐	Ear infections (how many? __)	☐	☐	Bowel problems (loose stools, constipation)
☐	☐	Hearing problems			
☐	☐	Sleep problems	☐	☐	Excessive vomiting
☐	☐	Colic			
☐	☐	Medication for convulsions	☐	☐	Pica (eating non-food items such as dirt or paper)
☐	☐	Medication for hyperactivity			
☐	☐	Anemia	☐	☐	Other long-term medical complaints/problems
☐	☐	Asthma			
☐	☐	Pregnancies	☐	☐	Medication for other illness (not for colds or ear infections)
☐	☐	Irregular periods			
☐	☐	Menstrual period (If yes, at what age?) _____			

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? 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				

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.