NANCY'S PREVENTION CLINIC
PEDIATRIC INITIAL PSYCHIATRIC HISTORY

Name:		**Medication Allergies:**	**Date:**
DOB: Age: ❑ Male ❑ Female		Pediatrician:	
Historical Source		**Date of Last Physical Exam:**	
Date of Last Laboratory Test			

Symptoms: Please comment briefly. Complete every line.

Sleep ______________________________

Appetite ______________________________

Crying Often and Easily ______________________________

Easily Frustrated /Demands Must Be Met Immediately ______________________________

Inattentive/Easily Distracted ______________________________

Restless/ Overactive/ Fidgeting ______________________________

Mood Changes Quickly and Drastically ______________________________

Fails to Finish Things that He/She Starts ______________________________

Actions That He/She Cannot Stop Doing ______________________________

Excitable/ Impulsive (Acts Without Thinking) ______________________________

Disturbs Other Children______________________________

Risk Taking / Starts Fires ______________________________

Hurts Himself / Herself (Bangs His/Her Head or Threatens to Hurt Others)______________________________

Unfounded Fears or Phobias ______________________________

Hallucination (Hearing Voices, Seeing Visions)______________________________

Stressors ______________________________

Give any comments about your child that may be helpful to the provider:

____

____

____

Signature of parent/guardian ______________________ Date______________

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❑

Patient's Name:

Date:

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CHILD PSYCHIATRIC HISTORY

Presenting Problem:	❑ Easily Frustrated ❑ Ticks ❑ Sleep Problems ❑ Inattention	❑ Mood Swings ❑ Crying Easily ❑ Hyperactivity ❑ Fears/phobias	❑ OCD ❑ Drugs ❑ Hearing voices
How long has your child had this problem?	❑ Within this last month	❑ Less than 6 months	❑ Greater than a year

Describe The **Main Problem** Which Brought You Here For Treatment, Be specific.
Describe When the Problems Began and if They Have Changed Overtime.

Has the child had any prior diagnosis or treatment for the problems listed above? If yes, please list:

Has the child had any other psychiatric problems that are not listed above?

Initials__________________ Date__________________

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BIRTH HISTORY

State, Country Child Born:		Delivery Type:
Pregnancy/Delivery Problems: ❑ Rash ❑ Pregnancy Planned ❑ High Blood Pressure ❑ Swelling Legs ❑ Seizures ❑ Vaginal Bleeding ❑ Baby on Time		Post Partum Complications:
❑ Baby trouble with starting to breath? ❑ yes ❑ No ❑ Length Of Baby's Hospital Stay: Was Baby Discharged With Mother? ❑ Yes ❑ No Why?		Comments:
Birth Weight lbs. oz.	Apgar	

IMMUNIZATION HISTORY

Immunizations Current: [ ] Yes [ ] No	Comments:

GROWTH AND DEVELOPMENT

Age sat alone: Walked:	How does this child treat or get along with:
Any words by the age of 12-15 months: Age Used Sentences:	Father:
Does Child Ask Questions: what, how, where, when, who? ❑ yes ❑ no	Mother:
Does Child say he/she is: sad, bad, mad, happy, glad? ❑ yes ❑ no	Brothers:
What does this child do particularly well?	Sisters:
What things does this child like to do for fun?	Other children:

SOCIAL/CULTURAL HISTORY

Child Hobbies/ Interests	Who does the child live with?
Language Spoken At Home:	Number Of Family Members Living In Same House:
Primary caretaker of the child:	Parents marital Status: ❑ Married ❑ Divorced ❑ Single

	Name	Occupation	Age
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			

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PEDIATRIC INITIAL PSYCHIATRIC HISTORY

CHILD'S PSYCHIATRIC HISTORY	DATES
Previous Examiners	
Previous Diagnosis given	
Psychiatric Hospitalizations	
Suicide attempts	
Physical, sexual or domestic abuse: Please explain:	

PRESENT MEDICATIONS:

Name	Over the Counter

PAST MEDICATIONS:

Name	Adverse Reaction

MEDICAL HISTORY

Allergies to food, environment, medications	
Hospitalizations	
Surgeries	
Injuries/Accidents	
Significant Illnesses	

Child has had

- ❑ Headaches
- ❑ Palpitation/ Skipped beats
- ❑ Dizziness/ Fainting
- ❑ Chest Pain
- ❑ Shortness Of Breath
- ❑ Stomach Problems
- ❑ Muscle/Joint/Back pain :
- ❑ Weight Problems
- ❑ Constipation or Diarrhea
- ❑ Menstrual Problems
- ❑ Pneumonia
- ❑ Urinating problems
- ❑ Hot or cold intolerance
- ❑ Sexual Problems
- ❑ Chickenpox
- ❑ Mumps
- ❑ Measles
- ❑ TB
- ❑ Hearing Problems
- ❑ Vision Problems
- ❑ Seizures
- ❑ Anemia
- ❑ Sinus Problems
- ❑ Ear Infections
- ❑ Hay Fever
- ❑ Eczema
- ❑ Heart Murmur
- ❑ Sickle Cell Disease/Trait

Initials__________________ Date__________________

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Patient's Name:

Date:

NANCY'S PREVENTION CLINIC
PEDIATRIC INITIAL PSYCHIATRIC HISTORY

TESTS/ EVALUATIONS WHERE	DATES
EKG	
EEG	
MRI	
Psychological	
ADD/HD test	
Other:	

ACADEMIC HISTORY-Check appropriate responses for this child

School Name:	Grade In School:
Grade School	Grades: poor___ good____ excellent____ Behavior: poor___ good____ excellent____
Middle School	Grades: poor___ good____ excellent____ Behavior: poor___ good____ excellent____
High School	Grades: poor___ good____ excellent____ Behavior: poor___ good____ excellent____
Teacher's concerns:	
Individualized Education Program	Yes _____ No ______ What School?

ENVIRONMENTAL HISTORY

Exposure To Tobacco Smoke	❑ Yes	❑ No
Drug Use (Age Appropriate)	❑ Yes	❑ No
Alcohol Use (Age Appropriate)	❑ Yes	❑ No
Tobacco Use (Age Appropriate)	❑ Yes	❑ No

FAMILY PSYCHIATRIC HISTORY

Blood relative has had

❑ Alcoholism
❑ Depression
❑ Bipolar/ Manic Depression
❑ Anxiety Disorders
❑ Panic Disorders
❑ Drug Abuse
❑ Phobias
❑ Schizophrenia
❑ Obsessive-Compulsive Disorder
❑ Suicide Attempt
❑ Imprisonment
❑ Post-traumatic Stress Disorder
❑ Mental Retardation
❑ ADD/HD
❑ Giftedness
❑ Abuse ❑ Other:

FAMILY MEDICAL HISTORY

❑ Thyroid Problems
❑ Diabetes
❑ Asthma
❑ Eczema
❑ High Blood Pressure
❑ Cancer
❑ Heart Disease
❑ Seizures
❑ Deafness
❑ Birth Defects
❑ Tuberculosis
❑ Stroke
❑ Hay Fever
❑ Kidney Disease
❑ Other:

Initials__________________ Date__________________

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❑

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Date:

NANCY'S PREVENTION CLINIC
PEDIATRIC INITIAL PSYCHIATRIC HISTORY

Review of Systems

CONSTITUTION
- ❑ WNL ❑ Wide Base
- ❑ Fever ❑ Appetite
- ❑ Dyskinetic ❑ Ataxic
- ❑ Weight ❑ Stiff
- ❑ ADLs ❑

SKIN
- ❑ WNL ❑ Lesions
- ❑ Edema ❑ Dry/Scaly
- ❑ Bruises ❑ Hot/Cold
- ❑ Pale ❑ Diaphoretic

RESPIRATORY
- ❑ WNL ❑ SOB
- ❑ Wheezing ❑ Cough

CARDIOVASCULAR
- ❑WNL ❑ Chest Pain
- ❑ Heart Rate ❑ Pressure

GI/GU
- ❑ WNL ❑ Diarrhea
- ❑ Abd Pain ❑ Cramps
- ❑ Burning ❑ Urinary Ret
- ❑ Enuresis ❑ Constipation

NEUROLOGICAL
- ❑WNL ❑Confusion
- ❑ Falls ❑ Blurred vision
- ❑ Headache ❑ LOC

MUSCULOSKELETAL
- ❑ WNL ❑ ROM
- ❑ Gait/Station ❑ Stability
- ❑ Strength/tone

Subjective Clinician Notes: ____

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❑

Patient's Name:

Date:

NANCY'S PREVENTION CLINIC
PEDIATRIC INITIAL PSYCHIATRIC HISTORY

Mental Health Status

Appearance	❑ Appears Stated Age	❑ > Than Stated Age	❑ Emaciated	
	❑ < Stated Age	❑ Obese	❑ Frail	
Orientation	❑ Oriented/All Spheres	❑ Not Oriented To Place	❑ Not Oriented To Day	❑ Not Oriented To Year
	❑ Not Oriented To Person	❑ Not Oriented To Time	❑ Not Oriented To Date	
Alertness	❑ Alert	❑ Fluctuating Alertness	❑ Inattentive	❑ Stuporous
	❑ Drowsy	❑ Hyper Alert	❑ Lethargic	
Affect	❑ Appropriate	❑ Constricted	❑ Intense	
	❑ Blunted		❑ Restricted In Range	
Mood	❑ Depressed	❑ Anxious	❑ Expansive	❑ Panicky
	❑ Appropriate	❑ Euphoric	❑ Fearful	❑ Empty
	❑ Euthemic	❑ Elated	❑ Irritable	❑ Inappropriate
Eye Contact	❑ Good	❑ Poor	❑ Staring At Examiner	❑ Eyes Frequently Closed
	❑ Fair	❑ Avoids Eye Contact	❑ Gazing Vacantly	
Speech	❑ Logical And Coherent	❑ Reveals Blocking	❑ Incoherent And Illogical	❑ Slowed
	❑ Spontaneous	❑ Flight Of Ideas	❑ Loud	❑ Sparse
	❑ Animated	❑ Loosen Of Assoc.	❑ Preservative	❑ Terse
	❑ Disorganized	❑ Halting	❑ Pressured	❑ Not spontaneous
	❑ Excessive	❑ Hesitant	❑ Rapid	❑ Tangential / Circumstantial
Recent Mem	❑ Normal	❑ Mildly Impaired	❑ Mod. Impaired	❑ Severely Impaired
Remote Mem	❑ Normal	❑ Mildly Impaired	❑ Mod. Impaired	❑ Severely Impaired
Musculoskeletal	❑ NL Movements/Activity	❑ Tics Of:	❑ Fidgetiness	❑ Hyperactivity
	❑ Psychomotor Agitation	❑ Difficult Staying Seated	❑ Tremors Of:	❑ Squirming
	❑ Restlessness	❑ Slowed Reactions At Times		❑ Gait
Grooming	❑ Well Groomed	❑ Inappropriate	❑ Neat And Clean	❑ Bizarre
	❑ Disheveled	❑ Meticulous	❑ Unkempt	
Thought Content	❑ No Sig. Preoccupation	❑ Obsessions	❑ Hypochondriacal Sx	❑ Preoccupation With:
	❑ Suicidal Ideation	❑ Phobias	❑ Delusions Of:	❑ Ideas Of Reference
	❑ Open And Cooperative	❑ Hostile & Un-coop.	❑ Ingratiating	❑ Seductive
Attitude	❑ Indifferent	❑ Defensive	❑ Perplexed	❑ Suspicious & Guarded
	❑ Evasive	❑ Dramatic	❑ Sarcastic	❑ Unresponsive
Insight	❑ Aware Of Problems Consequences & Causes	❑ Partially Aware	❑ Complete Denial Of Problems	❑ Blames Physical Reas.
	❑ Is Aware But…	❑ Blames Others	❑ Blames Physical Reas.	
Disorganization	❑ Non Evident	❑ Mild	❑ Moderate	❑ Severe
Attention/Conc.	❑ Attends And Maintains	❑ Diff. Ignoring Irrelevant Stimuli	❑ Distractible	❑ Poor Attention Span
Impulse Control	❑ Reflective & Able To Resist Urges	❑ Poor Frustration Tol.	❑ Acts W/O Considering Alternatives	❑ Volatile & Unpredictable
	❑ Overly Controlled And Restrained	❑ Seeks Immediate Gratification Of Urges		
Perceptual	❑ Denies Hallucination	❑ Auditory Hallucinations	❑ Depersonalization	❑ Illusions
	❑ None Are Evidenced	❑ Visual Hallucinations	❑ De-realization	❑ Experiences Déjà Vu
Judgment	❑ Good	❑ Fair	❑ Poor	

❑ Nancy Bryant, FNP-C

❑

Patient's Name:

Date:

Assessment/Diagnosis:

Axis I: (Mental Disorders and Substance Abuse)

1.____________________________ 2.__________________________3.____________________________

`

Axis II: (Personality Disorders / Mental Retardation)

1.____________________________ 2.__________________________3.____________________________

Axis III: (Other Relevant Conditions)

1.____________________________ 2.__________________________3.____________________________

4.____________________________ 5.__________________________ 6. ____________________________

Axis IV: (Psychological and Environmental Problems)
❑ Access to Health Care ❑ Economic ❑ Education ❑ Housing
❑ Legal ❑ Primary Support Group ❑ Social Environment
❑ Other:

Axis V: Global Assessment of Functioning: __________

Plan/Treatment: ❑ *See medication sheet and instructions sheet dated* ________________

Discussed with patient in detail:

- ❒ Td-Nms
- ❒ Off Label Use
- ❒ Full Treatment Options
- ❒ Informed Consent
- ❒ Women/Child Bearing Age Treatment Options
- ❒ Verbal Contract For Safety
- ❒ Educational Materials: (See Education Form)
- ❒ Provided Full Disclosure re: Scope Of Practice And Limitations As A Family Nurse Practitioner
- ❒ Patients Comments Or Questions:

Referrals: ❑ Therapist ❑ Psychologist ❑ ADD/HD Coach ❑ Family of Origin Counselor ❑ Biofeedback/ Stress Reduction
❑ Neurologist ❑ Primary Care Provider ❑ Testing _________ ❑ Metabolic Evaluation ❑ Other ____________________

Reviewed: ❑ Past Med Hx ❑ Past Surg Hx ❑Soc/Fm Hx ❑ Outside Records ❑ Radiology ❑ Other ____________________
❑ Routine Labs ordered_________________ ❑ Copy to PCP ❑ EKG _____________ ❑ Other ____________________

Return visit: ❑ 1 week ❑ 2 weeks ❑ 3 weeks ❑ 1 month ❑ 2 months ❑ 3 months ❑ RTC date ______________________

Minutes: ❑ Initial 45-60 Initial ❑ 75-90 ❑ Family w/o pt ❑ Family w/ Patient ❑ ___________present during entire interview

❑ Nancy Bryant, FNP-C	Patient's Name:
❑	Date: