MEDICAL PSYCHOSOCIAL QUESTIONNAIRE

PHOENIX INDIAN MEDICAL CENTER

PEDIATRIC CLINIC

In order for us to serve your better, please answer the following questions **BEFORE** you come to your appointment and remember to bring this completed form with you. Feel free to add extra comments or information.

NAME OF CHILD: _____ _____ AGE: _____

DATE OF BIRTH: _____ Date form completed: _____

Person completing form: _____ Relationship to child: _____

Home Phone: _____ Cell phone: _____ Work phone: _____

Primary Care Provider: _____

CONCERNS:

What are your chief concerns about your child?

_____

_____

_____

How long has this problem been a concern?

_____

When did you first notice this problem?

_____

Who else have you seen for this problem?

_____

_____

What evaluations have been performed?

_____

_____

What has been done to treat this problem (medications, diet, counselling, etc)?

_____

_____

What seems to help the most?

_____

_____

PREGNANCY and DELIVERY HISTORY:

Exposure to drugs during pregnancy? __ yes __ no Exposure to alcohol during pregnancy? __ yes __ no

Other complications during pregnancy? _____

Was baby born at term? __ yes __ no (if premature, how many weeks_____) Birth weight_____

How was the baby delivered? __ vaginally __ forceps __vacuum __Cesarean Section __ other

Did the baby have any of the following problems?

__ anemia __eye problems __intracranial bleed __blood transfusion __phototherapy

__ apnea __infection __low blood sugar __bradycardia __problems sucking

__ birth defect __intensive care __seizure __ trouble breathing/need for oxygen/ventilator

HEALTH: Has your child had any of the following?

__coordination problem __tremors/tics __seizures __asthma __heart murmur

__ congenital heart disease __ high lead /lead poisoning __thyroid problem __bedwetting/bladder control problem

__ concussion __ head injury __broken bones __ hearing problem __vision problem

Has your child ever been hospitalized? __ yes __ no IF yes, what for/what age?

_____

_____

Has your child ever had surgery? __ yes __no IF yes, what surgery/ what age?

_____

Any suspicion of physical or sexual abuse?

_____

Current medications:

_____

Any allergies to food, medication/drugs, or other? _____

Has your child ever fainted, passed out during or after exercise, emotion or startle? __ yes __no

Has your child ever had extreme shortness of breath during exercise or extreme fatigue during exercise? __yes __ no

Has your child ever had discomfort, pain, or pressure in his/her chest during exercise? __yes __no

Are there any family members who had sudden/unexplained/unexpected death before age 50? __yes __no

Are there any family members who have unexplained seizures or fainting? __yes __no

Are there any family members with conditions such as enlarged heart, cardiomyopathy, heart rhythm problems, Long QT syndrome, Short QT syndrome, ventricular tachycardia, Marfan syndrome, heart attack before age 15, pacemaker or implanted defibrillator? __yes __no

DEVELOPMENT:

At what age did your child first demonstrate the following?

Sit up _____ Crawl _____ Walk _____ Use fork/spoon _____

First word _____ 2 word sentence _____ Toilet trained _____ Dress self _____

Speech: __normal for age __poor for age

Do you have concerns about your child's speech? _____

Motor coordination: __ good __clumsy

Do you have concerns about your child's motor development? _____

Does your child have any sleeping problems (trouble falling asleep, nightmares, sleep walking, etc.)?

_____

Previous or current therapies/evaluations:

__ None

__ Referred to Arizona Early Intervention Problem (AZEIP)

__ Receiving services through DDD (Division of Developmental Disabilities)

__ Speech/language therapy __occupational therapy __physical therapy __early intervention services

__ Special education at school __ Individual education plan (IEP)

SCHOOL HISTORY:

Did your child attend preschool? __ yes __ no Did you child attend special needs preschool? __ yes __no

Name of current school_____ Current grade _____

Classroom: __ regular __special education __ regular with resource help

What is your impression of your child's learning potential? __low __ average __above average __ gifted

Do you feel your child is performing up to their potential at school? __ yes __ no

Do you feel your child has difficulty with the following?

__Arithmetic/Math __Language/reading __Science __Writing __Other : _____

How does your child get along with others?

_____

My child is very good at

_____

_____

BEHAVIORAL HISTORY:

Has your child or any siblings received psychiatric or psychological treatment?

_____

_____

Does your child have any of the following oppositional concerns?

__often angry or resentful __often defies rules __often spiteful /vindictive __often blames others

__ often easily annoyed __often loses temper __ often argues with adults __often annoys others on purpose

Does your child have any of the following anxiety concerns?

__avoidance of being alone __marked self-consciousness __unrealistic and persistent worries

__distress with separated from you __refusal to sleep alone __unrealistic concern about future events

__excessive need for reassurance __persistent school refusal __repeat nightmares about separation from you

__ panic attacks __ unusual fears/phobias __ excessive clinging/attachment to adults

Does your child have any of the following concerns for depression/sadness?

__ depressed or irritable mood __feelings of worthlessness/guilt __diminished pleasure in activities

__feelings of hopelessness __low energy/fatigue __poor concentration/difficulty making decisions

__trouble sleeping or sleeping too much

Has your child exhibited any of the following symptoms?

__compulsive rituals __bizarre ideas/hallucinations __disorientation/confusion/spacing out

__incoherent speech __ excessive mood swings __situationally inappropriate emotions

__explosive temper with minimal provocation

FAMILY MEDICAL HISTORY

__drug/alcohol problems __epilepsy/seizures __Learning problems

__heart problems __death prior to age 50 __mental retardation/intellectual disability

__ADHD __anxiety __depression

__conduct disorder __ obsessive/compulsive disorder __ other: _____

FAMILY SOCIAL HISTORY:

Father's Name _____ Age _____ Occupation _____

Mother's Name _____ Age_____ Occupation _____

Siblings: Name Age Grade Problems

_____

_____

_____

_____

_____

Who else lives in the home with child? _____

Do any of the following family stressors apply to your family?

__change of job __death of family member or friend __financial stress __parental separation

__change of school __move to new home __pregnancy/birth of a new child

Is there other information you want to share?

_____

_____

_____

_____

_____