



COLUMBUS PSYCHIATRY  
Kristi Maroni, M.D.

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Dear Parent,

If your child is age 13 and up, please have them fill out this form on their own and check it before coming to your first appointment to make sure they have answered all of the questions. Please feel free to add information to the form (preferably in a different color pen) but do not change your child's answers.

If your child is under 13 or has difficulty reading/understanding the form, please fill it out for them but ask them for their input when filling out the symptom checklist. I look forward to working with your family. Thank you.





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Name: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

Primary Care Physician Name, Address and Phone Number: \_\_\_\_\_

Person who referred you (Name and Address): \_\_\_\_\_

Reason for your visit (Please be as detailed as possible): \_\_\_\_\_

**Medical History:** Please check all that apply to you and your family members and indicate their relationship to you:

	<u>Self</u>	<u>Family Member(s)</u>
Heart Disease	_____	_____
Stroke	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____
Thyroid Problems	_____	_____
Cancer	_____	_____
Seizure	_____	_____

Please use the space below to report any other medical problems not listed above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





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Please list any surgeries, medical hospitalizations or history of head trauma including dates:

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**Medication allergies: No Yes**

If yes please list medication and reaction: \_\_\_\_\_

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Please list **all current medications** and dosages including over the counter medication, and vitamin/herbal supplements: \_\_\_\_\_

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Please list **all past psychiatric medications**, doses and reason for discontinuing (do not include antibiotics or over the counter medicines).

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If applicable, date of last menstrual period: \_\_\_\_\_

Are you pregnant or have you ever been pregnant: \_\_\_\_\_

What form of birth control are you using, if any: \_\_\_\_\_

**Past Psychiatric History:**

Previous diagnosis: \_\_\_\_\_

Previous Outpatient Psychiatrist: \_\_\_\_\_

Previous Outpatient Therapist/Counselor: \_\_\_\_\_

Previous Psychiatric Admissions: \_\_\_\_\_

Previous Suicide Attempts: \_\_\_\_\_

Any Self Injurious Behaviors (cutting, burning, hair pulling): \_\_\_\_\_





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**Family Psychiatric History:**

Depression: \_\_\_\_\_

Bipolar: \_\_\_\_\_

PTSD: \_\_\_\_\_

Anxiety: Schizophrenia: \_\_\_\_\_

Eating Disorder: \_\_\_\_\_

ADHD: \_\_\_\_\_

Developmental Disorder: \_\_\_\_\_

Asperger's/Autism: \_\_\_\_\_

Cutting: \_\_\_\_\_

Psychiatric Hospitalization: \_\_\_\_\_

Suicide Attempt: \_\_\_\_\_

Completed Suicide: \_\_\_\_\_

Alcohol Abuse: \_\_\_\_\_

Drug Abuse: \_\_\_\_\_

**Social History:**

Where were you born? \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

Please list names and ages of all brothers and sisters:

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_





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Are your parents still alive? **Yes No**

If not, how and when did they die? \_\_\_\_\_

Are your parents \_\_\_\_ married, \_\_\_\_ not married but living together, \_\_\_\_ together but living separately, \_\_\_\_ divorced or \_\_\_\_ separated?

Do you have any children? If so, give names and ages: \_\_\_\_\_

Are you employed? **Yes No**

Where? \_\_\_\_\_ How Long? \_\_\_\_\_

Has Child Protective Services ever been involved in your care? **Yes No**

**If yes, please explain:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever drunk alcohol? **Yes No**

If yes, how old were you when you started? \_\_\_\_\_

What did/do you drink?  
\_\_\_\_\_  
\_\_\_\_\_

How often did/do you drink? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever used illegal drugs or abused prescription medications? **Yes No**

If yes, how old were you when you started? \_\_\_\_\_





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What do/have you used? \_\_\_\_\_

How often did/do you use? \_\_\_\_\_

Do you smoke? **Yes No**

If yes, how much? \_\_\_\_\_

How much caffeine do you drink in a typical day? (ex. Coffee, tea soda, chocolate, energy drinks)

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**Academic History:**

Are you in preschool or daycare? **Yes No**

Are you in school? **Yes No**

What school do you attend? \_\_\_\_\_

What grade are you in? \_\_\_\_\_

What are your grades typically in school? \_\_\_\_\_

Have you ever had to repeat a grade? **Yes No**

If yes, which grade? \_\_\_\_\_

Do you have a 504 or IEP? \_\_\_\_\_

Are you in special education classes and/or have a tutor? **Yes No**

Have you ever been suspended? **Yes No**

Have you ever been expelled? **Yes No**

