Columbus Psychiatry

Kristi Maroni, M.D.

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 you 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.

Columbus Psychiatry

Kristi Maroni, M.D.

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:

	Self	Family Member(s)
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:

____

____

____

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

____

____

____

____

Medication allergies: **No** **Yes**

If yes please list medication and reaction: ______________________________

____

____

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

____
____
____
____
____

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

____
____
____
____
____

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): _______________________

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: ____________________
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? ____
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) ____

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**