Please return completed form to: admin@katychildpsychology.com or Fax to 713-264-8607

21384 Provincial Blvd / Katy, TX 77450

# PATIENT DEMOGRAPHICS & HISTORY QUESTIONNAIRE

**Patient Name:** ______________________________ Nickname if used: ____________________

Date of Birth: ____________________ Age: __________ Current Grade: ____________________

(Optional) Race/Ethnicity and/or Religion ______________________________

Address: ______________________________

City: ______________________________ State: __________ Zip: ______________

Caregiver's name *(if not in parent's custody)* ______________________________

**Mother's name:** ______________________________ Date of Birth: ____________________

Address *(if different than above)*: ______________________________

Mother's Primary Phone: ______________________________ **Texted** appointment reminders? ❑ Yes ❑ No
Email address: ______________________________ **Emailed** appointment reminders? ❑ Yes ❑ No

**Father's name:** ______________________________ Date of Birth: ____________________

Address *(if different than above)*: ______________________________

Father's Primary Phone: ______________________________ **Texted** appointment reminders? ❑ Yes ❑ No
Email address: ______________________________ **Emailed** appointment reminders? ❑ Yes ❑ No

Contact person for scheduling ____________________ Relationship to patient __________ Phone #(if not listed above) __________

**Email** is used occasionally to send appointment information or documents. It is not a 100% secure form of communication and thus privacy cannot be guaranteed. Email will not be used for advice, treatment, or any other form of intervention with your provider.
By listing email addresses, you are acknowledging your understanding of these statements.

Mothers Occupation: ____________________ Fathers occupation: ____________________

Marital Status of Biological Parents: ❑ Married ❑ Never Married ❑ Widowed ❑ Separated ❑ Divorced
If child's parents have a divorce decree and/or custody agreement, please describe guardian/primary conservatorship.

______________________________________________________________

** It is the responsibility of the parents to follow their divorce decree/custody agreement when seeking treatment for their child. The parent scheduling an appointment must have the legal right to consent to mental health services for the patient identified above, and all parties should be notified as legally mandated.*
*KCPA requires a copy of the custody agreement to be on file. If not received prior to the scheduled appointment, the appointment may need to be rescheduled.*
*KCPA providers will not see a child whose parents are involved in an active court case. If appropriate it is preferred for both parents to attend the initial visit. **

**INSURANCE - Please complete all fields** ❑**Aetna** ❑**Cigna** (All others will be self-pay at the time of the visit, **skip to next section**)

Name of Subscriber: ______________________________ Subscriber DOB: ____________________

Subscriber ID: ______________________________ Group # ______________________________

Subscriber SSN# ____________________ Subscriber Employer: ______________________________

Phone number for Mental Health Benefits: ______________________________

**Please send a copy of the front and back of the insurance card if it is to be billed**

Who lives in the home with your child? Names/Ages/Relationship to child:

______________________________________________

______________________________________________

______________________________________________

Please check all that apply for the last 12 months:

❑ family moved ❑ parent changed job ❑ parents separated/divorced ❑ conflict in family ❑ death in family ❑ family financial problems ❑ changed school ❑ new baby at home ❑ family accident/illness ❑ repeat grade ❑ history of abuse ❑other:

Explain any indicated items marked above:

______________________________________________

______________________________________________

**REASON FOR VISIT:**

❑**EVALUATION** (Dr. Poyksy) ❑**THERAPY/COUNSELING (**Alyssa Muchaw)

What are your specific primary concerns about your child at this time? How long has this problem persisted?______________

______________________________________________

Under what conditions do the problems usually get worse? Get better? ______________________

______________________________________________

What do you hope to gain from evaluation and/or therapy? What changes do you hope to make? ______________

______________________________________________

**MENTAL HEALTH HISTORY**

Has your child been in psychotherapy before? If so, please list the therapist's name, contact information, & description of what issues that were addressed in therapy? ______________________

______________________________________________

______________________________________________

**PREVIOUS INTERVENTION/SERVICES**

❑ Educational Testing ❑ Speech/Language Therapy ❑ Neuropsychological Eval ❑ School/Classroom Modification

❑ Occupational/ Physical Therapy ❑ Psychiatric Eval ❑Special Education ❑Neurological Eval

Did you find therapy helpful? ❑ Yes ❑ No If no, please explain ______________________

______________________________________________

**MEDICAL HISTORY**

From Whom or Where does your child receive medical care? *(Please include psychiatrists)*

Physician/Clinic Name: ______________________ Phone: ______________

Physician/Clinic Name: ______________________ Phone: ______________

Is your child taking any medication? If so, please list name and dosage

Name: ______________ Dosage: __________ Reason: ______________

Name: ______________ Dosage: __________ Reason: ______________

Name: ______________ Dosage: __________ Reason: ______________

Does your child have allergies? ❑ Yes ❑ No If yes, please explain any precautions needed ______________

______________________________________________

Past Major Illness/Injuries/Operations? ______________________

Has your child experienced any of the following?

| | | | |
|---|---|---|---|
| Vision problems | ❑ Yes ❑ No | Head trauma | ❑ Yes ❑ No |
| Hearing Problems | ❑ Yes ❑ No | Loss of consciousness | ❑ Yes ❑ No |
| Asthma | ❑ Yes ❑ No | Coma | ❑ Yes ❑ No |
| Allergies | ❑ Yes ❑ No | Seizures | ❑ Yes ❑ No |
| Stomachaches | ❑ Yes ❑ No | Frequent falls | ❑ Yes ❑ No |
| Sleep problems | ❑ Yes ❑ No | Tics | ❑ Yes ❑ No |
| Bed wetting | ❑ Yes ❑ No | Staring spells | ❑ Yes ❑ No |
| Stool Soiling | ❑ Yes ❑ No | Tremor | ❑ Yes ❑ No |
| Chronic ear infections | ❑ Yes ❑ No | Anemia | ❑ Yes ❑ No |
| Hospitalization | ❑ Yes ❑ No | Broken bones/stitches | ❑ Yes ❑ No |
| Persistent high fever | ❑ Yes ❑ No | | |
| Headaches | ❑ Yes ❑ No | Other____________________________ | |

**PRENATAL HISTORY**

Check Yes/No for the items below which may have occurred during pregnancy:

| | | | |
|---|---|---|---|
| Edema (swelling) | ❑ Yes ❑ No | Accidents/injuries | ❑ Yes ❑ No |
| Vaginal bleeding | ❑ Yes ❑ No | Breathing difficulties | ❑ Yes ❑ No |
| Toxemia | ❑ Yes ❑ No | Alcohol used | ❑ Yes ❑ No |
| Emotional stress | ❑ Yes ❑ No | Cigarettes used | ❑ Yes ❑ No |
| High blood pressure | ❑ Yes ❑ No | Abnormal weight gain | ❑ Yes ❑ No |
| Infections | ❑ Yes ❑ No | Pre-term labor | ❑ Yes ❑ No |
| Fever | ❑ Yes ❑ No | Hospitalizations | ❑ Yes ❑ No |

Was the baby on time? ❑ Yes ❑ No If No, ❑ early? ❑ Late? By how many weeks?_________________

Explain other Yes answers:

_____________________________________________________________________________________

**DEVELOPMENTAL HISTORY** ❑ No Birth/Developmental History Known

Child's birth weight: ____________ Mother's age at birth: ___________ Did mother receive prenatal care? ❑ Yes ❑ No

How many days did the child stay in the hospital after birth? ________

Check Yes/No for the items below which may have occurred during the days following the child's birth:

| | | | |
|---|---|---|---|
| Difficulty breathing | ❑ Yes ❑ No | Infection | ❑ Yes ❑ No |
| Need for ventilation | ❑ Yes ❑ No | Jaundice | ❑ Yes ❑ No |
| Blood transfusion | ❑ Yes ❑ No | Poor feeding | ❑ Yes ❑ No |
| Bleeding in the head | ❑ Yes ❑ No | Vomiting/Reflux | ❑ Yes ❑ No |
| Water on the brain | ❑ Yes ❑ No | Floppy muscle tone | ❑ Yes ❑ No |
| Turned blue | ❑ Yes ❑ No | Neonatal ICU (NICU) | ❑ Yes ❑ No |
| Fever | ❑ Yes ❑ No | Other___________________________________ | |

Explain Yes answers: ___________________________________________________________________________

Check Yes/No for the items below which may have occurred during the days following the child's infancy:

| | | | |
|---|---|---|---|
| Difficult to comfort | ❑ Yes ❑ No | Sleep difficulties | ❑ Yes ❑ No |
| Excessive irritability | ❑ Yes ❑ No | Excessive restlessness | ❑ Yes ❑ No |
| Extremely passive | ❑ Yes ❑ No | Frequent head banging | ❑ Yes ❑ No |
| Difficulty feeding | ❑ Yes ❑ No | Other___________________________________ | |

Explain Yes answers: ___________________________________________________________________________

**DEVELOPMENTAL MILESTONES** (Please check correct time range if it is appropriate for your child's age)

| | | | |
|---|---|---|---|
| Smiled in response (social smile) | ❑2-3 months | ❑4-6 months | ❑over 6 months |
| Sat up without support | ❑3-6 months | ❑7-12 months | ❑over 12 months |
| Crawled | ❑6-12 months | ❑13-18 months | ❑over 18 months |
| Walked without assistance | ❑under 1 year | ❑12-18 months | ❑18 months or more |
| Said "mama" or "dada specifically | ❑9-13 months | ❑14-18 months | ❑19-24 months or more |
| Said next word after "mama/dada" | ❑9-13 months | ❑14-18 months | ❑19-24 months or more |
| Put two words together | ❑14-18 months | ❑19-24 months | ❑25-36 months or more |
| Could be understood 100% | ❑14-18 months | ❑19-24 months | ❑25-36 months or more |
| Knew colors | ❑under 3 years | ❑3-4 years | ❑5 years or more |
| Knew numbers | ❑under 3 years | ❑3-4 years | ❑5 years or more |
| Potty Trained (urine) | ❑under 3 years | ❑3-4 years | ❑5 years or more |
| Potty Trained (bowel) | ❑under 3 years | ❑3-4 years | ❑5 years or more |
| Printed first & last name | ❑3-4 years | ❑5-6 years | ❑7 years or more |
| Tied shoes | ❑4-5 years | ❑6-7 years | ❑8 years or more |
| Snap, button clothing | ❑4- 5 years | ❑6-7 years | ❑8 years or older |
| Began to read | ❑3-5 years | ❑6-7 years | ❑8 years or older |

Has your child been diagnosed with a developmental disability or delay? ❑ Yes ❑ No If yes, please explain ______________

______________________________________________________________________________

**EDUCATIONAL HISTORY**

Does your child attend school? ❑ Yes ❑ No (If No, skip to Home Life section)
Did your child attend Preschool? ❑ Yes ❑ No If Yes, name of school: ______________________________
Were there adjustment problems in preschool? ❑ Yes ❑ No
If Yes, Explain______________________________________________________________
Were you concerned about your child's success in preschool? ❑ Yes ❑ No
If Yes, Explain______________________________________________________________
Did your child receive services through ECI or PPCD? ❑ Yes ❑ No
If Yes, Explain______________________________________________________________
Name of child's current school: ______________________School District: ______________
Address of school: ______________________________School Phone #______________
Child's grade: ________Child's Teacher: ______________________________
Class placement: ❑ regular class ❑ESL ❑ bilingual ❑special class
Do you feel your child is performing at the same level as his/her peers? ❑ Yes ❑ No
If No, Explain______________________________________________________________
Does your child currently receive educational interventions or modifications (e.g., extended time on assignments, distraction free environment for testing, resource room, etc.)? ❑ Yes ❑ No
If Yes, Explain______________________________________________________________
Has testing been completed by the school? ❑ Yes ❑ No If Yes, when? ______________________
Does your child have an IEP? ❑ Yes ❑ No If Yes, please bring a copy to appointment.
How often is your child absent from school? ❑ Never ❑ Often ❑ Seldom
Explain usual reason for absence: ______________________________________________
Has your child ever been retained? ❑ Yes ❑ No If Yes, what grade? ____________Why? ______________
Has your child ever been: Suspended from school ❑ Yes ❑ No Expelled from School: ❑ Yes ❑ No

## HOME LIFE

What are your child's favorite activities?

______________________________________________

What are your child's least favorite activities?

______________________________________________

How often must you discipline your child?

______________________________________________

What forms of discipline are used?

______________________________________________

Describe your child's typical mood:

______________________________________________

What about your child makes you proud?

______________________________________________

How does your child get along with peers? ❑Great ❑ Fair ❑ Poor
Explain: ______________________________________________

Does your child have any close friends? ❑ Yes ❑ No
Explain: ______________________________________________

Does your child get along best with: ❑ older children ❑same age children ❑ younger children
Explain: ______________________________________________

Do you have concerns about your child's sleep habits? ❑ Yes ❑ No
Explain: ______________________________________________

Do you have concerns regarding your child's eating habits? ❑ Yes ❑ No
Explain: ______________________________________________

Has a family member struggled with any of the following problems?

| | | | | |
|---|---|---|---|---|
| Learning Disabilities | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| Attention Deficit/Hyperactivity | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| Medical Problems | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| Psychiatric Problems | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| Depression | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| Anxiety | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| OCD | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| Schizophrenia | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| Bipolar | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| Substance/Alcohol abuse | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |
| Legal problems | ❑ Mother | ❑Father | ❑ Sibling | ❑ Other family member__________ |

## ANYTHING ELSE?

Is there additional relevant information we should know about your child? ______________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Who can we thank for referring you to Katy Child Psychology Associates?

❑ Friend/Family ❑Pediatrician or other doctor (name)______________________________

❑ Psychology Today ❑ Internet search ❑ Other______________________________