



21384 Provincial Blvd / Katy, TX 77450

PATIENT DEMOGRAPHICS & HISTORY QUESTIONNAIRE

Patient Name: _____ Prefers to be called: _____

Date of Birth: _____ Age: _____ Identifying Gender: _____ Current Grade: _____

(Optional) Race/Ethnicity and/or Religion _____

Address: _____

City: _____ State: _____ Zip: _____

Caregiver's name (if not in parent's custody) _____

Parent 1 name: _____ Date of Birth: _____

Address (if different than above): _____

Primary Phone: _____ **Texted** appointment reminders? Yes No

Email address: _____ **Emailed** appointment reminders? Yes No

Parent 2 name: _____ Date of Birth: _____

Address (if different than above): _____

Primary Phone: _____ **Texted** appointment reminders? Yes No

Email address: _____ **Emailed** appointment reminders? Yes No

Contact person for scheduling _____ 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.

Parent 1 Occupation: _____ Parent 2 occupation: _____

Marital Status of Biological Parents: Married Never Married Widowed Separated Divorced

Child is adopted

Is there a divorce decree or custody agreement regarding parental rights for this patient? Yes No

* 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 divorce decree/custody agreement to be on file. If not received prior to the scheduled appointment, the appointment may need to be rescheduled. If appropriate it is preferred for both parents to attend the initial visit. KCPA providers do not provide services for court cases. *

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 provide 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 currently? 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Head trauma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of consciousness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomachaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent falls | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sleep problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tics | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bed wetting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Staring spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stool Soiling | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tremor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic ear infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hospitalization | <input type="checkbox"/> Yes <input type="checkbox"/> No | Broken bones/stitches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Persistent high fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |

PRENATAL HISTORY

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

- | | | | |
|-----------------------|--|--|--|
| Edema (swelling) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Accidents/injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Vaginal bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breathing difficulties | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Toxemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol used | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emotional stress | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cigarettes used | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal weight gain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pre-term labor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hospitalizations | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was the baby on time? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If No, <input type="checkbox"/> early? <input type="checkbox"/> 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Need for ventilation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Poor feeding | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding in the head | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vomiting/Reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Water on the brain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Floppy muscle tone | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Turned blue | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neonatal ICU (NICU) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever | <input type="checkbox"/> Yes <input type="checkbox"/> 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep difficulties | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive irritability | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive restlessness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Extremely passive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent head banging | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty feeding | <input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> 2-3 months	<input type="checkbox"/> 4-6 months	<input type="checkbox"/> over 6 months
Sat up without support	<input type="checkbox"/> 3-6 months	<input type="checkbox"/> 7-12 months	<input type="checkbox"/> over 12 months
Crawled	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> 13-18 months	<input type="checkbox"/> over 18 months
Walked without assistance	<input type="checkbox"/> under 1 year	<input type="checkbox"/> 12-18 months	<input type="checkbox"/> 18 months or more
Said "mama" or "dada specifically	<input type="checkbox"/> 9-13 months	<input type="checkbox"/> 14-18 months	<input type="checkbox"/> 19-24 months or more
Said next word after "mama/dada"	<input type="checkbox"/> 9-13 months	<input type="checkbox"/> 14-18 months	<input type="checkbox"/> 19-24 months or more
Put two words together	<input type="checkbox"/> 14-18 months	<input type="checkbox"/> 19-24 months	<input type="checkbox"/> 25-36 months or more
Could be understood 100%	<input type="checkbox"/> 14-18 months	<input type="checkbox"/> 19-24 months	<input type="checkbox"/> 25-36 months or more
Knew colors	<input type="checkbox"/> under 3 years	<input type="checkbox"/> 3-4 years	<input type="checkbox"/> 5 years or more
Knew numbers	<input type="checkbox"/> under 3 years	<input type="checkbox"/> 3-4 years	<input type="checkbox"/> 5 years or more
Potty Trained (urine)	<input type="checkbox"/> under 3 years	<input type="checkbox"/> 3-4 years	<input type="checkbox"/> 5 years or more
Potty Trained (bowel)	<input type="checkbox"/> under 3 years	<input type="checkbox"/> 3-4 years	<input type="checkbox"/> 5 years or more
Printed first & last name	<input type="checkbox"/> 3-4 years	<input type="checkbox"/> 5-6 years	<input type="checkbox"/> 7 years or more
Tied shoes	<input type="checkbox"/> 4-5 years	<input type="checkbox"/> 6-7 years	<input type="checkbox"/> 8 years or more
Snap, button clothing	<input type="checkbox"/> 4- 5 years	<input type="checkbox"/> 6-7 years	<input type="checkbox"/> 8 years or older
Began to read	<input type="checkbox"/> 3-5 years	<input type="checkbox"/> 6-7 years	<input type="checkbox"/> 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 is 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	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
Attention Deficit/Hyperactivity	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
Medical Problems	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
Psychiatric Problems	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
Depression	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
Anxiety	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
OCD	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
Schizophrenia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
Bipolar	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
Substance/Alcohol abuse	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other family member _____
Legal problems	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> 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 _____