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: ____ 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	❑ 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 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	❑ 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___