Summit
MENTAL HEALTH SERVICES

Pediatric New Patient Assessment

Demographic Information

Date:_____
Patient Name:_____
Name of person completing form:_____
Relationship to patient if other than patient:_____
Patient Date of Birth:_____ Age:____
Patient Social Security Number:_____
Home Address:_____
_____
Phone: _____(home)
_____(Cell)
_____(Parent Cell or work)
Email: _____ (Patient)
_____ (Parent)

Referred by:_____

Insurance/Billing Information

Insurance Company Name:_____
Policy or ID number:_____
Group or Account number:_____
Name of Policy Holder:_____
Address and Phone Number of Policy Holder (if different from above):
_____
_____
Social Security Number of Policy Holder:_____
Policy Holder's Date of Birth:_____

Emergency Information

Name of Emergency Contact:_____
Relationship to Patient:_____
Daytime phone number(s) for contact:_____
Evening phone number (s) for contact:_____

Authorization

My signature below attests to the fact that the above information is true to the best of my knowledge. I approve payment be made to Summit Mental Health Services for services that I receive. I understand that I may be responsible for payment in the event that my benefits do not cover the services provided. I authorize Summit Mental Health Services to release required information to my insurance company to justify services being covered by my insurance provider.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient

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Parent Consent

In cases where parents of a patient are divorced, both parents must consent to treatment at the start of treatment. No further sessions will be held unless both parents consent to the patient receiving treatment at Summit Mental Health Services, in accordance with Florida law.

_____ _____
Mother's signature Date

_____ _____
Father's signature Date

Patient History

Please state the presenting problem:

_____
_____
_____
_____

How long has this problem existed: _____

Social History

Please name the people who live in your home and their ages:

Name	Age	Occupation

Where was the patient born? _____

Please list the places that the patient has lived in his/her life:

_____
_____

Who has had responsibility for raising the patient? _____

Social History (cont.)

Has the patient ever suffered abuse? Yes No
If so, what kind? Physical Sexual Neglect
If so, was the abuse ever reported to authorities? Yes No
Has the patient ever witnessed domestic violence in the home? Yes No
Is domestic violence currently occurring in the child's home? Yes No
Does the patient believe their childhood has been happy? Yes No

What extracurricular activities does the patient engage in at this time?

_____

In the past, what extracurricular activities has the patient enjoyed?

_____

If the patient is a teenager, has he or she ever been employed? Yes No
Please list name of employer and dates of employment:_____
Does the patient have a history of sensory issues? Yes No
How much physical activity does the patient engage in daily? _____
Please describe the patient's eating habits:_____

_____

Please list the time the patient normally falls asleep _____
Please list the time the patient normally wakes in the morning _____
Does the patient report issues with falling or staying asleep? Yes No

Educational History

Does your child qualify for a PLSA (Personal Learning Scholarship Account), If so, which?
{ } AAA scholarship { } Step up for Kids.

Please list all schools that the patient has attended and the grades they attended for each school:

School Name	Grade attended
_____	_____
_____	_____
_____	_____
_____	_____

Current Grade: _____
Please list any grades repeated by the patient:_____

Behavioral difficulties? Yes No If yes, please describe:

_____

Difficulties with academics? Yes No If yes, please describe:

_____

Educational History (cont.)

History of psycho educational testing? Yes No If yes, please list the results of testing and the name of the provider who completed the testing. *If test results are available, please speak to the therapist about providing them to this office.*

Provider Name Results

_____ _____

_____ _____

Does the patient have an Individualized Education Plan (IEP)? Yes No

If yes, do you know the reason for the IEP (i.e. learning disability):_____

Medical History

Patient's birth weight and height: _____

Was the patient adopted? Yes No

Method of delivery: Vaginal Cesarean

Complications at birth: Yes No

If yes, please explain:_____

Did the patient meet developmental milestones on time: Yes No

Comment:_____

_____

Describe the patient's temperament as an infant (i.e. easy to comfort, quiet, level of activity and irritability)

_____

Describe the patient's early sleeping and eating habits:_____

Current medical concerns: _____

Current medications: _____

Primary Care Doctor Name: _____

History of chronic or ongoing medical concerns: _____

History of strep throat diagnoses? Please list dates:_____

Psychiatric History and Symptom Inventory

List the patient's three most stressful issues as reported by the patient:

1. _____
2. _____
3. _____

Does the patient have a history of receiving mental health counseling, behavioral therapy, inpatient psychiatric care, or outpatient medication management by a psychiatrist or neurologist?

Yes No

If so, please list the provider's name and dates of service below:

Name of Provider Dates of Service

_____ _____

_____ _____

_____ _____

Psychiatric History (cont.)

Family psychiatric history:

_____

_____

_____

Psychiatric medication history: Please list below the medications that the patient has been prescribed for psychiatric reasons. Place and asterisk (*) next to those that the patient is currently taking.

Medication	Dosage	Duration on medicine
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the patient ever attempted to commit suicide? Yes No

If yes, please describe: _____

Is the patient currently experiencing suicidal thoughts? Yes No

If yes, please describe: _____

Please circle the column that most applies below, cross out if the item does not apply:

Symptom	Rarely	Somewhat	Frequently
Irritability	Rarely	Somewhat	Frequently
Sadness/depressed	Rarely	Somewhat	Frequently
Self-Injury	Rarely	Somewhat	Frequently
Suicidal thoughts	Rarely	Somewhat	Frequently
History of running away	Rarely	Somewhat	Frequently
Loss of appetite	Rarely	Somewhat	Frequently
Weight loss/gain	Rarely	Somewhat	Frequently
Difficulty sleeping	Rarely	Somewhat	Frequently
Fatigue	Rarely	Somewhat	Frequently
Loss of interest in activities	Rarely	Somewhat	Frequently
Unmotivated	Rarely	Somewhat	Frequently
Changes in grades	Rarely	Somewhat	Frequently
Poor self esteem	Rarely	Somewhat	Frequently
Needs lots of reassurance	Rarely	Somewhat	Frequently
Perfectionistic	Rarely	Somewhat	Frequently
Easily embarrassed	Rarely	Somewhat	Frequently
Sensitive to criticism	Rarely	Somewhat	Frequently
Fidgety	Rarely	Somewhat	Frequently
Unable to sit still	Rarely	Somewhat	Frequently
Unable to follow directions	Rarely	Somewhat	Frequently
Quick to startle	Rarely	Somewhat	Frequently
Fear of dying	Rarely	Somewhat	Frequently
Trouble breathing	Rarely	Somewhat	Frequently
Chest pain	Rarely	Somewhat	Frequently

Hot or cold flashes	Rarely	Somewhat	Frequently
Nausea, diarrhea, or other abdominal issues	Rarely	Somewhat	Frequently
Answers out of turn	Rarely	Somewhat	Frequently
Fire setting	Rarely	Somewhat	Frequently
Destroys property	Rarely	Somewhat	Frequently
Hurts animals	Rarely	Somewhat	Frequently
Anger issues	Rarely	Somewhat	Frequently
Risk taking behavior	Rarely	Somewhat	Frequently
History of fighting	Rarely	Somewhat	Frequently
Stealing	Rarely	Somewhat	Frequently
Trouble falling asleep	Rarely	Somewhat	Frequently
Distressing dreams	Rarely	Somewhat	Frequently
Bedwetting	Rarely	Somewhat	Frequently
Panic	Rarely	Somewhat	Frequently
Inability to concentrate	Rarely	Somewhat	Frequently
Recurrent mention or thoughts of past events	Rarely	Somewhat	Frequently
Avoiding stressful situations/items	Rarely	Somewhat	Frequently
Decreased interest in preferred activities	Rarely	Somewhat	Frequently
Ritualistic behaviors	Rarely	Somewhat	Frequently
Phobias	Rarely	Somewhat	Frequently
Unrealistic fears	Rarely	Somewhat	Frequently
Racing thoughts	Rarely	Somewhat	Frequently
Rapid mood shifts	Rarely	Somewhat	Frequently
Auditory hallucinations	Rarely	Somewhat	Frequently
Visual hallucinations	Rarely	Somewhat	Frequently
Sexually inappropriate behavior	Rarely	Somewhat	Frequently
Bizarre behavior	Rarely	Somewhat	Frequently
Self injury	Rarely	Somewhat	Frequently
Frequent lying	Rarely	Somewhat	Frequently
School refusal	Rarely	Somewhat	Frequently
Drug or alcohol use	Rarely	Somewhat	Frequently
Impairment in Communication	Rarely	Somewhat	Frequently
Impairment in social interaction	Rarely	Somewhat	Frequently
Repetitive patterns of behavior, interest, and activities	Rarely	Somewhat	Frequently
Stutters	Rarely	Somewhat	Frequently
Tics or other uninitiated movements	Rarely	Somewhat	Frequently
Fine or gross motor skill issues	Rarely	Somewhat	Frequently
Sensitivity to cloths (tags, socks, shoes, straps, fabrics)	Rarely	Somewhat	Frequently
Sensitivity to noise	Rarely	Somewhat	Frequently
Sensitivity to food textures	Rarely	Somewhat	Frequently
Chews clothing	Rarely	Somewhat	Frequently

Please describe symptoms and list those not listed in the table above:

Legal History

Has the patient ever been involved in any type of legal proceeding, or ever been arrested?
Yes No
If yes, please explain:

_____

_____

Substance Abuse History

Does the patient have a history of any substance abuse? Yes No
If so, please list the substances abused and the patient's treatment history:

_____

_____

_____