Parents, please complete to the best of your ability.

SILVER LAKE PEDIATRICS
33017 PROFESSIONAL DRIVE
LEESBURG FL 34788
352-314-2275

MEDICAL HISTORY FORM

Person completing this form:_____ Date_____

Relationship to child:_____ Child's primary language:_____

Child's Name:_____ Sex:_____ Date of Birth:_____

Mailing Address_____

City_____ County_____ State_____ Zip_____

Home Phone ( )_____

Child's Primary Care Physician (PCP) Name:_____

Mailing Address_____

City_____ County_____ State_____ Zip_____

Office Phone ( )_____ Who referred you to this clinic_____

Specific Concerns

What specifically concerns you about your child? Describe your concerns and what you hope to gain from the evaluation?

_____

_____

_____

_____

_____

_____

When were you first aware of this problem?

_____

Has your child been previously evaluated? By whom? What were you told about your child's problem?

_____

_____

_____

Composition of Family in which child currently resides:

Mother's Name_____ Age_____

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ _____

Education:_____

Occupation:_____

Address of Employment:_____

Home Phone ( )_____ Work Phone:( )_____

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income?_____

Father's Name_____ Age_____

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ _____

Education:_____

Occupation:_____

Address of Employment:_____

Home Phone (__) _____ Work Phone:(__) _____

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income?_____

Who is the child's legal guardian?_____

Persons residing in the home with child:

Name	Age	Sex	Relationship

If parent works, who cares for child?_____

Events In Family:

Have any of the following events occurred in the child's immediate family in the past year?

Family moved?	Yes ☐	No ☐
Death, divorce, separation, loss of family member?	Yes ☐	No ☐
Marriage, reconciliation, pregnancy, a new family member?	Yes ☐	No ☐
Serious injury or illness, problems with aging relatives?	Yes ☐	No ☐
Loss of work, change jobs, retirement?	Yes ☐	No ☐
Frequent serious arguments or fights?	Yes ☐	No ☐
Money problems?	Yes ☐	No ☐
Sex problems?	Yes ☐	No ☐
Drug or drinking problems?	Yes ☐	No ☐
Involvement with social services?	Yes ☐	No ☐
Out of home placement of the child?	Yes ☐	No ☐
Serious trouble with the law?	Yes ☐	No ☐
Mental illness?	Yes ☐	No ☐
Some other serious problem? (If yes, what?_____)	Yes ☐	No ☐

Agency involved:_____ Caseworker:_____

Explanation of items marked "yes":_____

Family History

Is there any history on either side of the child's biologic parents' family of the following? If yes, indicate FATHER'S or MOTHER'S side and explain WHO in remarks section showing the item number.

Item	Item Description	No	Yes	Mother's	Father's	Remarks
1	Psychological/psychiatric emotional					
2	Mental Retardation					
3	Learning Problems					
4	Birth Defects (C.P., etc...)					
5	Seizures/Convulsions					
6	Tuberculosis					
7	Neurological Disease					
8	Diabetes					
9	Cancer					
10	Allergies/asthma					
11	Gland disorders/thyroid					
12	Hearing disorders					
13	Vision					
14	Hyperactivity					
15	Miscarriages					
16	Slow development					
17	Speech problems					
18	Other diseases in family					

All Pregnancies (include patient, deceased or miscarriages) in order:

No.	Birth Weight	Current Age	Current Grade	Health or Developmental Problems/Comments

Concerning the child being evaluated:

Did you receive prenatal care? Yes ☐ No ☐

During which month did you start prenatal care?_____

Did you smoke cigarettes during your pregnancy? Yes ☐ No ☐ If yes, how many per day?_____

Did you drink alcohol during your pregnancy? Yes ☐ No ☐ If yes, number of drinks per week?_____

Did you use any narcotic or prescription drugs during or before your pregnancy? Yes ☐ No ☐

If yes, which ones?_____ How often?_____

Did any of the following occur during pregnancy? (Check those which DID occur)

☐	decreased fetal movement	☐	morning sickness	☐	swelling
☐	high fever	☐	amniocentesis	☐	stressful events
☐	x-rays	☐	hospitalization	☐	significant trauma
☐	ultrasound	☐	operations	☐	special diet
☐	stress test	☐	accidents	☐	vaginal bleeding
☐	diabetes	☐	toxemia	☐	unusual worries
☐	high blood pressure	☐	premature labor	☐	any other problem(s)

Please explain the items you checked: _____

_____

_____

Child's Birth

At birth of child - Mother's age:_____ Father's age_____

Place of child's birth: Hospital name_____

Address_____

Physician's Name_____

Was the baby born on time?_____ Late?_____ Early?_____ How many weeks?_____

Any problems with labor or delivery? Yes ☐ No ☐ Explain _____

_____

_____

Type of anesthesia/pain relief/sedation_____

Delivery was by: vaginal/natural . C-section ____ planned _____ emergency ____breech _____ forceps_____

How many days in hospital?_____

Infant's condition at birth and in nursery:_____

Birth weight: _____ Birth length: _____ Head Circumference: _____

APGAR scores: _____

Please explain anything additional or exceptional about the birth or newborn period of your child: _____

_____

_____

Developmental History

Developmental Milestones: State the age when your child first did each of the following. Say "No" if your child has not yet done it. If you do not remember, leave it blank.

Smiled _____

Held head erect _____

Rolled over _____

Sat alone _____

Crawled _____

Walked alone _____

Rode tricycle _____

Rode bicycle _____

Ate unaided with spoon _____

Separated easily from mother _____

Buttoned clothes _____

Dressed self _____

Imitated sound _____

Said "mama", "dada" _____

Said other single words _____

Said 2-3 word phrases _____

Followed simple directions _____

Knew colors _____

Started counting _____

Recited total alphabet _____

Did you feel your child developed quickly? _____ or slowly? _____

Temperament

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity level - How active was your child? _____ How distractible? _____

_____

_____

Adaptability - How well did your child deal with transition and change? _____

_____

_____

Approach/Withdrawal - How well did your child respond to new places, people, and things? _____

_____

_____

Intensity - Was your child happy or unhappy? _____ Do adults notice how your child is feeling? _____

_____

Mood - What was your child's basic mood? (Check one) Happy? ☐ Sad? ☐ Angry? ☐ Quiet? ☐

Regularity - Was your child predictable in patterns of sleep, appetite, etc...?

Child's Medical History

We need as complete a medical history of your child as possible. Please complete this part. Explain any items checked "YES" in the explanation space and include as much information as possible about the item. Use more paper if necessary.

Has child ever been treated for or had a history of:

No.	Item Description	No	Yes	Explanation
1	Abdominal pain/bowel problems			
2	Allergies, including foods or drugs			
3	Anemia			
4	Birth Defects			
5	Concussion/significant head injury			
6	Dental problems			
7	Drooling			
8	Ear Infections			
9	Eating problems			
10	Headaches			
11	Hearing loss			
12	Heart condition			
13	Hemorrhaging or blood disorders			
14	Hormone problems			
15	Ingesting toxins/poisons			
16	Joint or bone problems			
17	Muscular problems			
18	Seizures or convulsions			
19	Significant accidents			
20	Skin diseases			
21	Tics (eye blinking, any non-purposeful repetitive movement)			
22	Urinary problems or infections			
23	Lung or breathing problems			
24	Visual/eye problems			
25	Other			

Hospitalizations: List any hospitalizations, operations or accidents of child._____

_____

_____

Medications: List medication child currently takes:_____

_____

_____

Current Weight _____ Current Height _____

Has child been immunized? Yes ☐ No ☐ Up to date?_____

Educational History

List pre-schools and schools this child has attended:

School: Dates:

_____ _____

_____ _____

_____ _____

_____ _____

Has this child ever repeated one or more grades? If so, which grade(s)? _____

Has this child ever been in special education, or received resource room help or tutoring?

When Where What kind?

_____ _____ _____

_____ _____ _____

Describe any current school problems:_____

_____

_____

Has this child ever received any developmental evaluations or testing in the past?

What type? Where What kind?

_____ _____ _____

_____ _____ _____

Briefly describe this child's attitude toward school:

_____

_____

_____

Other Information: Please list other items that you may feel are relevant to your child behavior?

_____

_____

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Name: _____

Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When I feel frightened, it is hard to breathe.	○	○	○
2. I get headaches when I am at school.	○	○	○
3. I don't like to be with people I don't know well.	○	○	○
4. I get scared if I sleep away from home.	○	○	○
5. I worry about other people liking me.	○	○	○
6. When I get frightened, I feel like passing out.	○	○	○
7. I am nervous.	○	○	○
8. I follow my mother or father wherever they go.	○	○	○
9. People tell me that I look nervous.	○	○	○
10. I feel nervous with people I don't know well.	○	○	○
11. I get stomachaches at school.	○	○	○
12. When I get frightened, I feel like I am going crazy.	○	○	○
13. I worry about sleeping alone.	○	○	○
14. I worry about being as good as other kids.	○	○	○
15. When I get frightened, I feel like things are not real.	○	○	○
16. I have nightmares about something bad happening to my parents.	○	○	○
17. I worry about going to school.	○	○	○
18. When I get frightened, my heart beats fast.	○	○	○
19. I get shaky.	○	○	○
20. I have nightmares about something bad happening to me.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. I worry about things working out for me.	○	○	○
22. When I get frightened, I sweat a lot.	○	○	○
23. I am a worrier.	○	○	○
24. I get really frightened for no reason at all.	○	○	○
25. I am afraid to be alone in the house.	○	○	○
26. It is hard for me to talk with people I don't know well.	○	○	○
27. When I get frightened, I feel like I am choking.	○	○	○
28. People tell me that I worry too much.	○	○	○
29. I don't like to be away from my family.	○	○	○
30. I am afraid of having anxiety (or panic) attacks.	○	○	○
31. I worry that something bad might happen to my parents.	○	○	○
32. I feel shy with people I don't know well.	○	○	○
33. I worry about what is going to happen in the future.	○	○	○
34. When I get frightened, I feel like throwing up.	○	○	○
35. I worry about how well I do things.	○	○	○
36. I am scared to go to school.	○	○	○
37. I worry about things that have already happened.	○	○	○
38. When I get frightened, I feel dizzy.	○	○	○
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	○	○	○
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	○	○	○
41. I am shy.	○	○	○

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher that 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: _____

Date: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe.	○	○	○
2. My child gets headaches when he/she is at school.	○	○	○
3. My child doesn't like to be with people he/she doesn't know well.	○	○	○
4. My child gets scared if he/she sleeps away from home.	○	○	○
5. My child worries about other people liking him/her.	○	○	○
6. When my child gets frightened, he/she feels like passing out.	○	○	○
7. My child is nervous.	○	○	○
8. My child follows me wherever I go.	○	○	○
9. People tell me that my child looks nervous.	○	○	○
10. My child feels nervous with people he/she doesn't know well.	○	○	○
11. My child gets stomachaches at school.	○	○	○
12. When my child gets frightened, he/she feels like he/she is going crazy.	○	○	○
13. My child worries about sleeping alone.	○	○	○
14. My child worries about being as good as other kids.	○	○	○
15. When he/she gets frightened, he/she feels like things are not real.	○	○	○
16. My child has nightmares about something bad happening to his/her parents.	○	○	○
17. My child worries about going to school.	○	○	○
18. When my child gets frightened, his/her heart beats fast.	○	○	○
19. He/she gets shaky.	○	○	○
20. My child has nightmares about something bad happening to him/her.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 2 of 2 (To be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her.	○	○	○
22. When my child gets frightened, he/she sweats a lot.	○	○	○
23. My child is a worrier.	○	○	○
24. My child gets really frightened for no reason at all.	○	○	○
25. My child is afraid to be alone in the house.	○	○	○
26. It is hard for my child to talk with people he/she doesn't know well.	○	○	○
27. When my child gets frightened, he/she feels like he/she is choking.	○	○	○
28. People tell me that my child worries too much.	○	○	○
29. My child doesn't like to be away from his/her family.	○	○	○
30. My child is afraid of having anxiety (or panic) attacks.	○	○	○
31. My child worries that something bad might happen to his/her parents.	○	○	○
32. My child feels shy with people he/she doesn't know well.	○	○	○
33. My child worries about what is going to happen in the future.	○	○	○
34. When my child gets frightened, he/she feels like throwing up.	○	○	○
35. My child worries about how well he/she does things.	○	○	○
36. My child is scared to go to school.	○	○	○
37. My child worries about things that have already happened.	○	○	○
38. When my child gets frightened, he/she feels dizzy.	○	○	○
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)	○	○	○
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	○	○	○
41. My child is shy.	○	○	○

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

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A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Office use only: **Severity score:** _____

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0

asQ
Ask Suicide-Screening Questions

Ask the patient:

(1) In the past few weeks, have you wished you were dead? YES NO

(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO

(3) In the past week, have you been having thoughts about killing yourself? YES NO

(4) Have you ever tried to kill yourself? YES NO

If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

(5) Are you having thoughts of killing yourself right now? YES NO

If yes, please describe: _____

Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. doi:10.1001/archpediatrics.2012.1276

Provide resources to all patients: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
24/7 Crisis Text Line: Text "HOME" to 741-741

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐