wasatch pediatrics

Cottonwood
5770 South. 250 East, #290
Murray, UT 84107
(801) 747-8700

Draper
114 E. 12450 South Suite #100
Draper, UT 84020
(801) 523-3001

Southpoint
9071 South 1300 West, Ste. 301
West Jordan, UT 84088
(801) 565-1162

WELCOME TO THE MENTAL HEALTH PROGRAM AT WASATCH PEDIATRICS INC!

We are requesting that you complete the enclosed patient history form in order to schedule your consultation

It is our goal to make your visit as pleasant and useful as possible. The initial evaluation is specifically designed to use the information you will provide about your child to determine how we can best help your family. As you are the expert when it comes to your child. This will allow our providers assist you the best they can.

Please be aware that the Mental Health Program at Wasatch Pediatrics ***does not*** provide forensic psychology services. In other words, we do no conduct custody evaluations or provide intervention services such as testifying in court for legal or divorce purposes.

Please bring relevant paperwork along with you to the visit. Things we find particularly helpful include written reports from school (especially those pertaining to testing the school has completed), recent report cards, test results from previous evaluations, and information regarding serious medical conditions. If you are divorced, **you must** bring a copy of the divorce decree to allow us to confirm conservator ship (i.e., whether the parent has the right to consent to psychological assessment/treatment for the child). If you are not a biological or adoptive parent, we will need proof of guardianship.

Parents should be aware that if you and your child arrive later than 15 minutes after the scheduled time of your appointment, your appointment will be rescheduled.

We would like to take this opportunity to inform you about what will happen when you visit the Mental Health Program for the first time.

- After you have checked in, you will be asked to complete a questionnaire(s) that will take approximately 10-15 minutes. Afterwards, you and your child will be taken to a private exam room where you will meet with one of our providers. We will discuss your concerns as well as your child's strengths. Much of the conversation will likely revolve around information you have already provided through the information packet and questionnaires. This gives us a place to start.

- In addition, with time permitting, our team will meet with your child individually to observe your child. During this observation period, they will play with and/or talk with you child depending on his or her age. Your child may also be asked to draw pictures, write their name, answer questions, or identify letters, numbers, or words.

- Based on the information you have provided and our interaction with the child, a tentative plan will be formulated and discussed with you on the day of your visit. Please note, that in some circumstances, additional testing and follow-up will be scheduled before a final treatment plan is made. You are an integral member of the planning and treatment team and in collaboration with you a treatment plan will be made. Once a plan is agreed upon, we will help you take the steps necessary to get the plan in motion.

Please feel free to contact us with any concerns regarding this appointment. Please plan on about 1 hour for your initial visit. We look forward to working with your family.

Sincerely,

The Staff of the Wasatch Pediatrics' Mental Health Program

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Patient History and Environmental Assessment

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

GENERAL INFORMATION:

Child's name: _____ Date: _____
First Middle Last

Form completed by: _____ Relationship to child: _____

(If child is adopted, please state child's age at adoption and date of adoption: _____ International adoption? Y / N)

Gender of child: ☐ Male ☐ Female Birth date of child: _____ Age: _____

Usual language of child: _____ Religion / Spiritual affiliation: _____

Name of child's current school: _____Grade: _____

REFERRAL INFORMATION:

Current Pediatrician or Family Doctor:

Name: _____ Telephone: _____

Child's Current Mental Health Professional: (if applicable)

Name: _____ Telephone: _____

CURRENT CONCERNS:

What is the main reason for your child's referral to the Wasatch Pediatrics Mental Health Program?

_____

_____

_____

_____

How long has your child had these problems? or How long have you been concerned about your child's difficulties?

_____

_____

Where does your child exhibit these problems? (Check all that apply)

☐ Home ☐ School ☐ Other (specify):_____

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PAST MEDICAL HISTORY:

Please check which of the following your child has had and note the age, any complications, and frequency below:

Yes	No		Yes	No	
☐	☐	Hospitalizations	☐	☐	Vision problems (date of last exam:_____)
☐	☐	Surgery	☐	☐	Hearing problems (date of last exam:_____)
☐	☐	Trauma (stitches / broken bones)	☐	☐	Asthma/Respiratory Difficulties
☐	☐	Head trauma/Concussion	☐	☐	Endocrine / thyroid problems
☐	☐	Loss of consciousness	☐	☐	Allergies (list: _____)
☐	☐	Seizures	☐	☐	Stomach aches
☐	☐	Tics (motor / vocal)	☐	☐	Pica (eating nonfood items)
☐	☐	Staring spells	☐	☐	Diabetes
☐	☐	Tremor	☐	☐	Gastrointestinal difficulties
☐	☐	Poor muscle tone/Falls frequently	☐	☐	Chronic ear infections (PE tubes: Y / N)
☐	☐	Anemia	☐	☐	Elevated lead levels
☐	☐	Headaches (migraines: Y / N)	☐	☐	Cancer
☐	☐	Cardiovascular / heart disease	☐	☐	Other medical problems

Please explain all "Yes" answers from prior Past Medical History Checklist:

_____

_____

_____

SERVICES / INTERVENTION SOUGHT PREVIOUSLY:

☐ Medical Evaluation	☐ Brain Scan (CT / MRI)	☐ Occupational/Physical Therapy	☐ School Modifications
☐ Psychiatric Exam	☐ Laboratory Test (EEG,EKG)	☐ Educational Testing	☐ Neuropsychological Assessment
☐ Medication	☐ Genetic/Chromosome Test	☐ Special Education	☐ Psychological Counseling or Therapy
☐ Neurological Exam	☐ Speech/Language Therapy	☐ Tutoring	☐ Other

What else have you tried to do to help your child with these problems?

_____

_____

_____

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MEDICATION HISTORY:

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

ALLERGIES:

Does your child have any allergies to drugs? If so, please indicate the reaction.

Medication	**Reaction**

PRE-NATAL HISTORY:

Please answer which of the following conditions may have occurred during this pregnancy and explain (month, amount, treatment, etc.) in the space below:

Yes	No		Yes	No	
☐	☐	Vaginal bleeding / spotting (when?_____)	☐	☐	Methamphetamines
☐	☐	Toxemia	☐	☐	Alcohol used
☐	☐	Emotional stress	☐	☐	Marijuana used
☐	☐	High blood pressure	☐	☐	Cocaine / crack used
☐	☐	Hospitalization	☐	☐	Other drugs used
☐	☐	Fever	☐	☐	Injuries
☐	☐	Operations (specify below)	☐	☐	Limited prenatal care
☐	☐	Medications used (specify below)	☐	☐	Anemia
☐	☐	Preterm labor	☐	☐	Malnutrition and/or dehydration
☐	☐	Epilepsy (seizure)	☐	☐	Preeclampsia / Eclampsia
☐	☐	Cigarettes used (average #/Day)	☐	☐	Other

Please explain all “Yes” answers:

_____

_____

_____

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BIRTH HISTORY:

Was the baby on time? ☐ Yes ☐ No Weight of child at birth: _____

If No, was he/she ☐ Early or ☐ Late and by how many weeks? _____

Age of mother at birth: _____

Age of father at birth: _____

Complications during delivery: ☐ Yes ☐ No

Please specify (e.g., emergency c-section; breech birth, etc).____

_____

_____

CHILD'S POST DELIVERY PERIOD:

Number of days infant stayed in the hospital after delivery:_____

Please check the following problems that may have occurred after the child's birth and explain the treatment in the space below:

Yes	No		Yes	No	
☐	☐	Trouble breathing / Hypoxia	☐	☐	Infection
☐	☐	Cord around the neck	☐	☐	Fever
☐	☐	Knot in cord	☐	☐	Underdeveloped lungs
☐	☐	Hemorrhage (bleeding) in head	☐	☐	Irregular heart rate
☐	☐	Hydrocephalus (water on the brain)	☐	☐	Sepsis / lumbar puncture
☐	☐	Cyanosis (turned blue)	☐	☐	Congenital anomalies / defects
☐	☐	Need for ventilation	☐	☐	Required resuscitation
☐	☐	Jaundice (Phototherapy: Y / N)	☐	☐	Neonatal intensive care (NICU)
☐	☐	Incubator care	☐	☐	Other (please specify below)

Please explain all "Yes" answers:

_____

_____

EARLY INFANCY & CHILDHOOD:

Please check the following problems that may have been present to a significant degree during the first few years of life:

Yes	No		Yes	No	
☐	☐	Did not enjoy cuddling	☐	☐	Was not calmed by being held or stroked
☐	☐	Difficult to comfort	☐	☐	Excessive restlessness
☐	☐	Excessive irritability	☐	☐	Frequent head banging
☐	☐	Difficult feeding / reflux	☐	☐	Sleeping difficulties
☐	☐	Extremely passive	☐	☐	Colic
☐	☐	Poor feeding	☐	☐	Floppy Muscle Tone

Please explain all "Yes" answers:

_____

_____

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DEVELOPMENTAL MILESTONES:

Were you or your pediatrician concerned about your child's development such as talking, walking, and progressing as a child?

☐ Yes ☐ No If yes, make sure to complete below.

Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.

Age:		Age:	
_____	Smile in response (social smile)	_____	Tie shoes
_____	**Walk independently**	_____	Snap, zip, button clothing
_____	**Say 1st word other than "mama" or "dada"**	_____	Toilet trained (urine)
_____	You understood 100% of what your child said	_____	Toilet trained (bowel)

FAMILY STRESSORS OR EVENTS:

Have any of the following events occurred within the past 12 months?

☐ Parents divorced or separated	☐ Parent changed job	☐ New baby at home	☐ Child changed schools
☐ Family accident or illness	☐ Death in family	☐ Conflict in family	☐ Child repeated a grade
☐ Family financial problems	☐ Family moved	☐ Family changes	☐ Other: _____

FAMILY HISTORY:

Has anyone in your family experienced the following: **(Biological Relationship to the Child)**

Medical Condition	Yes / No	Immediate Family			Father's Relatives	Mother's Relatives
		Dad	Mom	Sibling		
Learning Problems	☐ Yes ☐ No					
Attention-Deficit/Hyperactivity Disorder	☐ Yes ☐ No					
Intellectual Disability	☐ Yes ☐ No					
Autism / Asperger's	☐ Yes ☐ No					
Speech Delay	☐ Yes ☐ No					
Tourette's Syndrome – Tic Disorder	☐ Yes ☐ No					
Neurological Disorders	☐ Yes ☐ No					
Epilepsy/Seizure Disorder	☐ Yes ☐ No					
Bipolar Disorder (Manic Depression)	☐ Yes ☐ No					
Depression	☐ Yes ☐ No					
Panic Attacks	☐ Yes ☐ No					
Anxiety	☐ Yes ☐ No					
Obsessive Compulsive Disorder	☐ Yes ☐ No					
Schizophrenia	☐ Yes ☐ No					
Alcoholism/Substance Abuse	☐ Yes ☐ No					
Genetic Syndromes	☐ Yes ☐ No					
Endocrine/Hormonal Problems	☐ Yes ☐ No					
Hypertension or Cardiac Disease	☐ Yes ☐ No					
Diabetes/Hypoglycemia	☐ Yes ☐ No					
Cancers	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

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Have any blood relatives to your child experienced problems similar to those your child is currently experiencing? ☐ Yes ☐ No

If yes, please describe: _____

_____

FAMILY STATUS:

Marital Status of Parents:

☐ Married for _____ years ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed

▶ **If parents are divorced, who has primary conservatorship of this child (who has the right to consent to psychological services)?**

_____

A COPY OF THE DIVORCE DECREE IS REQUIRED IN ORDER FOR US TO SEE YOUR CHILD

Child currently lives with: *(Please check all that apply)*

☐ Natural Mother ☐ Natural Father ☐ Stepmother ☐ Stepfather

☐ Adoptive Mother ☐ Adoptive Father ☐ Foster Mother ☐ Foster Father

☐ Grandmother ☐ Grandfather ☐ Other (Specify) _____

Mother's History:

Mother's name: _____ Highest grade completed: _____
First Middle Last

Occupation: _____

Father's History:

Father's name: _____ Highest grade completed: _____
First Middle Last

Occupation: _____

FAMILY MEMBERS:

Names of Household Members	Age	Gender M / F	Relationship to Child

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SOCIAL:

How many close friends does your child have? _____

Does he/she have a best friend? □ Yes □ No (If yes, how old is he/she? ____ How long have they been friends? ____)

How easily does your child make friends?

□ Better than average

□ Average

□ Worse than average (explain:_____)

How well does your child get along with friends?

□ Better than average

□ Average

□ Worse than average (explain:_____)

Does your child get along best with: □ Older children □ Children of the same age □ Younger children

Does your child have problems keeping friends? □ Yes □ No (if yes, please explain: _____)

Is your child teased/bullied? □ Yes □ No (if yes, for what: _____; how often_____)

Does your child tease or bully others? □ Yes □ No (if yes, how: _____; how often_____)

Is your child physically or verbally aggressive with their peers? □ Yes □ No (if yes, how often: _____)

EATING HABITS:

How would you rate your child's appetite? □ Poor □ Fair □ Good □ Excellent

Is your child a picky eater? □ Yes □ No (if yes, please describe: _____)

SLEEP HABITS:

How many hours total sleep does your child currently sleep at night?_____

Where does your child sleep?

□ Own bedroom

□ Shared bedroom (with whom:_____)

□ Room other than a bedroom (describe:_____)

Does your child currently experience:

Snoring	□ Yes	□ No	
Restlessness	□ Yes	□ No	
Difficulty falling asleep	□ Yes	□ No	(if yes, how long does it take? _____)
Waking in the night	□ Yes	□ No	(if yes, how many times per night? _____ how long to fall back asleep? _____)
Nightmares	□ Yes	□ No	(if yes, how often? _____)
Night Terrors	□ Yes	□ No	(if yes, how often? _____)
Sleep Walking/Talking	□ Yes	□ No	(if yes, how often? _____)

Does your child nap? □ Yes □ No

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EMOTION AND BEHAVIOR:

Please describe briefly any emotional or behavioral problems at *home*:

_____

_____

Please describe briefly any emotional or behavioral problems at *school*:

_____

_____

Has your child ever been suspended/expelled from school? ☐ Yes ☐ No

if yes, how many times? _____ why? _____

Please check any of the following behaviors your child has displayed frequently or intensively within the last 6 months:

☐ Separation anxiety	☐ Anxiety	☐ Low frustration tolerance	☐ Physical aggression
☐ Unhappiness	☐ Unusual fears	☐ Impulsivity	☐ Stealing
☐ Shy / timid	☐ Avoidance	☐ Hyperactivity	☐ Skipping school
☐ Social Isolation	☐ Obsessive-compulsive behaviors	☐ Attention seeking	☐ Quick change of emotions
☐ Lack of confidence / Low self-esteem	☐ Stereotyped / repetitive behaviors	☐ Irritability	☐ Destructiveness
☐ Concern with weight	☐ Poor concentration / Distractibility	☐ Temper tantrums	☐ Cigarette use / Vaping
☐ Sleep problem	☐ Short attention span	☐ Oppositional behavior / noncompliance	☐ Alcohol / substance use
☐ Homicidal thoughts	☐ Suicidal thoughts	☐ Lying	☐ Poor social skills
☐ Other:			

Please provide additional information about any of the above you feel would be helpful: _____

_____

_____

_____

DISCIPLINE:

Types of discipline you use with your child:

☐ Rewards

☐ Verbal reprimands / verbal demands

☐ Time out (isolation)

☐ Removal of privileges

☐ Ignoring behavior

☐ Physical punishment

☐ Giving in to child

☐ Other (please specify)_____

Which form(s) of discipline has proven most effective? _____

_____

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EDUCATIONAL HISTORY:

Has your child received DDI (Developmental Disabilities Intervention) services? ☐ Yes ☐ No

if yes, from when to when? _____

Has your child received PPCD (Preschool Program for Children with Disabilities) services? ☐ Yes ☐ No

if yes, from when to when? _____

Were there any adjustment problems in preschool or school? ☐ Yes ☐ No

if yes, please explain: _____

Were you concerned about your child's ability to succeed in preschool or school? ☐ Yes ☐ No

if yes, please explain: _____

Present class placement: ☐ Regular class
☐ Special class (specify: _____)
☐ Bilingual
☐ English as a Second Language (ESL)
☐ Advanced placement (e.g., ALPS, SALTA, Morningside)

Has IEP testing been completed by school? ☐ Yes ☐ No Date:_____

If so, please attach a copy of the school evaluation

How often is your child absent from school? ☐ Often ☐ Seldom ☐ Never Usual reason for absence:_____

Has your child ever been retained? ☐ Yes ☐ No (if yes, what grade? _____ why? _____)

Briefly describe you child's current academic difficulties:

_____

_____

When were these problem first noticed? _____

ACADEMIC PERFORMANCE:

Please list your child's current grades (if applicable):

Math:	_____	Science:	_____
Reading:	_____	Other: _____	_____
Spelling	_____	Other: _____	_____
Social Studies:	_____	Other: _____	_____
Language Arts:	_____	Other: _____	_____

Does your child have an IEP or 504 plan? ☐ Yes ☐ No

Has your child ever been in any of the following educational programs, and if so, how long?

☐ Resource Room Services	☐ Alternative Academics	☐ Self-Contained Class
☐ Life Skills Class	☐ Behavior/Emotion Disorders Class	☐ Speech & Language Therapy
☐ Occupational Therapy	☐ Counseling (school based)	☐ Alternative School Placement

☐ Other: _____

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PERSONAL:

What are your child's main hobbies and interests?

_____

_____

What about your child are you most proud of?

_____

_____

What does your child enjoy doing most?

_____

_____

What does your child dislike doing most?

_____

_____