

## Hattiesburg Clinic Connections Initial Visit Intake Questionnaire

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Reason for initial visit (check all that apply):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Depression                | <input type="checkbox"/> Behavior problems            |
| <input type="checkbox"/> Academic concerns | <input type="checkbox"/> Attention/focus struggles | <input type="checkbox"/> Hyperactivity or impulsivity |
| <input type="checkbox"/> Autism concerns   | <input type="checkbox"/> Developmental delay       | <input type="checkbox"/> Learning difficulties        |
| <input type="checkbox"/> Other: _____      |  |   |

**Has patient ever been admitted to (or evaluated by) an *inpatient* mental health facility or rehabilitation center?**

- No  Yes (If yes, please briefly list approximate dates, name of the hospital/facility, and reason for hospitalization)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list any previously prescribed mental health medications for the patient along with approximate duration that each was taken:**

- None/Not applicable

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Has patient received therapy, counseling, or behavioral intervention?**

- No  Yes (If yes, please briefly list approximate dates and name of clinic or therapist)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Has patient been evaluated by a psychologist, psychometrist, or psychiatrist (either privately or through school)?**

- No  Yes (If yes, please briefly list approximate date and name of clinic or clinician)

\_\_\_\_\_  
\_\_\_\_\_

**Please list all previous diagnoses related to mental health, development, or school performance:**

\_\_\_\_\_

**Has the patient ever received special education services or other accommodations at school (select all that apply)?**

- No  Yes, 504 Plan  Yes, IEP  Yes, Behavior Modification  Yes, Gifted Programming

**If yes, please** provide the following:

Date/school year of initial school evaluation: \_\_\_\_\_

Eligibility ruling (IEP/special education services): \_\_\_\_\_

Therapies provided through school (e.g., speech therapy, OT, etc.): \_\_\_\_\_

### Review of Systems

(Please mark if any of these have been a **significant** problem for the patient):

- |   |   |   |   |                                      |
|---|---|---|---|--------------------------------------|
| <input type="checkbox"/> Recurrent Fevers                         | <input type="checkbox"/> Excessive Fatigue                      | <input type="checkbox"/> Double or Blurry Vision            | <input type="checkbox"/> Other Vision or Eye Problems |                                      |
| <input type="checkbox"/> Recurrent Nosebleeds                     | <input type="checkbox"/> Chronic Nasal Stuffiness               | <input type="checkbox"/> Hearing Problems                   | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Ear Pain    |
| <input type="checkbox"/> Recurrent Headaches                      | <input type="checkbox"/> Significant Head Injury                | <input type="checkbox"/> Recurrent Strep Throat             | <input type="checkbox"/> Snoring                      | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Difficulty Swallowing                    | <input type="checkbox"/> Recurrent Mouth Ulcers                 | <input type="checkbox"/> Problems with Exercise Tolerance   | <input type="checkbox"/> Asthma                       |                                      |
| <input type="checkbox"/> History of Heart Murmur                  | <input type="checkbox"/> High Blood Pressure                    | <input type="checkbox"/> Heart Palpitations or Fainting     | <input type="checkbox"/> Chest Pain                   |                                      |
| <input type="checkbox"/> Other Heart Problem                      | <input type="checkbox"/> Chronic Cough                          | <input type="checkbox"/> Recurrent Lung Infections          | <input type="checkbox"/> Recurrent Vomiting           |                                      |
| <input type="checkbox"/> Chronic Constipation                     | <input type="checkbox"/> Recurrent Abdominal Pain or Discomfort | <input type="checkbox"/> Food Intolerance                   |   |                                      |
| <input type="checkbox"/> Chronic Diarrhea                         | <input type="checkbox"/> Bedwetting                             | <input type="checkbox"/> Urinary Frequency                  |   |                                      |
| <input type="checkbox"/> Recurrent Bladder or Kidney Infections   | <input type="checkbox"/> Daytime Bladder Incontinence           |   |   |                                      |
| <input type="checkbox"/> Recurrent Broken Bones                   | <input type="checkbox"/> Joint Problems                         | <input type="checkbox"/> Muscle Weakness                    | <input type="checkbox"/> Thyroid Problems             |                                      |
| <input type="checkbox"/> Hot/Cold Intolerance                     | <input type="checkbox"/> Tics (Repetitive Muscle Movements)     | <input type="checkbox"/> Seizures or Staring Spells         |   |                                      |
| <input type="checkbox"/> Sleep Problems                           | <input type="checkbox"/> Rapid Weight Change                    | <input type="checkbox"/> Menstrual Problems (if applicable) |   |                                      |
| <input type="checkbox"/> Obsessive Thoughts or Compulsive Actions | <input type="checkbox"/> Anxiety                                | <input type="checkbox"/> Depression                         |   |                                      |

### Birth History

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Any Complications with Pregnancy      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Any Medicines During Pregnancy        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Any Alcohol/Drug Use During Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Any Complications with Labor/Delivery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Birth History Unknown/Adopted         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### Growth & Development

Were milestones (e.g., walking/talking) met at appropriate ages in the first few years of the child's life?

Yes  No If no, please explain:

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Any history of speech, physical, or occupational therapy?  Yes  No If yes, please explain:

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Please list any concerns with sleep or appetite.

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**Family Mental Health History**

Please place an X if any of the **patient's** family members have been diagnosed or treated for any of the following conditions. If more than one in a family category has the condition, please write the number of family members in that category with that condition in the box. Please note that these are **close family members only**. Do not include great-grandparents, great aunts/uncles, or distant cousins. Only biological "blood" relatives, so do not include adoptive or step-family members. Please include any half-siblings as siblings.

Relationship <u>to the Patient</u>	Mother	Father	Sibling(s)	Grandmother	Grandfather	Aunt	Uncle	First Cousin
School Problems (Repeated Grades, etc.)								
Learning Disability (such as Dyslexia)								
ADHD or ADD								
Autism								
Anxiety								
Depression								
Obsessive Compulsive Disorder								
Bipolar Disorder								
Schizophrenia								
Tourette's Syndrome/Tics								
Addiction Problems								

**Cardiovascular Family History**

- Family History of sudden or unexplained death or an event requiring resuscitation in children or young adults?  
 No  Yes \_\_\_\_\_
- Family history of heart problems in close relatives younger than 50 years, or of specific heart conditions (i.e., Wolff-Parkinson-White syndrome, hypertrophic cardiomyopathy, long QT syndrome, Marfan syndrome, or clinically important arrhythmias)?  
 No  Yes \_\_\_\_\_

**Social History**

- Please list members of patient's primary residence/household: (e.g. Mom, Dad, 2 Sisters): \_\_\_\_\_
- Parents' status:  Married  Divorced  Never Married  Separated  Other: \_\_\_\_\_
- Recent significant stressors for the patient?  No  Yes \_\_\_\_\_
- Frequent Relocations/Moves in the last 3 years?  No  Yes \_\_\_\_\_
- Any loss of loved ones in the family in recent years?  No  Yes \_\_\_\_\_

## School/Social History

1. What school does patient attend? \_\_\_\_\_
2. Current Grade: \_\_\_\_\_
3. Does the patient have behavioral problems in school? Have teachers reported any difficulties? \_\_\_\_\_  
\_\_\_\_\_
4. Does the patient have any academic difficulties? If so, in what specific areas (e.g., reading, writing, etc.)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Has the patient ever received tutoring or academic intervention? \_\_\_\_\_  
\_\_\_\_\_
6. Does the patient make and keep friends easily?     No     Yes \_\_\_\_\_
7. Are there any concerns for any of the following (check all that may apply):
  - Eye contact (poor, fleeting)                       Flat affect/Lack of facial expression
  - Repetitive/Stereotyped behaviors               Social immaturity
  - Odd play behaviors                                       Social avoidance
  - Narrow range of interests                               Difficulty with change
  - Sensory issues (please list): \_\_\_\_\_