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Bell Patient Information Form

Updated: 2/2016

Date of Initial Consultation: _____

This form is to be completed by the parent/legal guardian of the child to be seen by Dr. Bell. If you have questions about any part of this form, please call 205-822-7348.

_____ _____
Name of legal guardian completing form Relationship to patient

Best phone number:_____

Child/Patient Name:_____ Date of Birth: _____ Patient age: ___ Sex: ☐ Male ☐ Female

_____ _____ _____ _____ _____
Address (if different from legal guardian) City State Zip County

_____ _____
Name of person/Doctor/Therapist who referred you for treatment Phone

Patient's Chief Problems as You See Them	When did Problem Begin
Example: *My child is aggressive and gets into fights about weekly at school. He has been suspended 4 times for fighting at school this year.*	*Two years ago*
1.	
2.	
3.	
4.	

Clinician use only. Do not write in this space._____

_____

_____

_____

_____

_____

_____

Sleep:_____

_____

_____

Problem List

Check any boxes that apply to your child. **Please do not write in the shaded areas:**

☐	Can't concentrate / pay attention	Clinician use only. **Do not write in this space.**
☐	Restless or hyperactive	Duration:
☐	Talks too much / talks out of turn	Settings: Home / School
☐	Impulsive or acts without thinking	Teacher complaints since:
☐	Trouble staying seated	Attention span estimate:
☐	Makes careless mistakes	
☐	Fails to finish things he/she starts	
☐	Daydreams / Gets lost in thought	
☐	Inattentive / Easily distracted	
☐	Has trouble following directions	
☐	Forgetful / Often loses things	

☐	Angry / Resentful	Clinician use only. **Do not write in this space.**
☐	Does not mind / Argues	Duration:
☐	Annoys others purposely	Settings: Home / School
☐	Bullies / Threatens / Intimidates others	
☐	**Physical Aggression**	
☐	**Homicidal/Threats to kill others**	
☐	Destroys property	
☐	Temper tantrums / Loses temper easily	
☐	Lies / Blames others for own misbehavior	Details aggression:
☐	Cruel to animals	
☐	Has set fires	
☐	Violates curfew / Has run away	
☐	Suspected smoking / alcohol / drug use	Details substance:
☐	Inappropriate sexual behaviors	
☐	Suspected sexual activity	
☐	School suspensions / alternative school	

Danger/safety:

☐	Frequent sadness or irritability	Clinician use only. **Do not write in this space.** *Vegetative/Depressive Symptoms:* Sleep: Interest/pleasure: Energy: Somatic Complaints: Appetite/weight change: Irritability/anger:
☐	Tearful / Cries easily	
☐	Low energy level	
☐	**Suicidal thoughts, threats, or actions**	
☐	Low self-esteem or guilt	
☐	**Cuts, burns or intentionally causes harm to self**	
☐	Loss of interest in favorite activities	
☐	Has trouble making and keeping friends	
☐	Feelings hurt easily	
☐	Severe changes in mood when compared to peers	
☐	Talks too much, too fast, changes topics quickly, cannot be interrupted	
☐	Thoughts racing	
☐	Increased goal-directed activities	

☐ Unrealistic highs in self-esteem	
☐ Worries about safety of self or others	Nightmares?
☐ Unusual worries or fears	
☐ Panic attacks	Avoidance of triggers / Palpitations / trembling or shaking / sweating / sensation of smothering / chest pain / shortness of breath / nausea / feeling lightheaded or dizzy / fainting / paresthesias / hot or cold flashes / feelings of impending doom
☐ Panics or tantrums when separated from parent	
☐ Obsessive thoughts	
☐ Unusual behaviors that must be preformed , such as dressing, bathing, mealtime, or counting rituals	
☐ Nervous tics or other repetitive, abrupt nervous movements or vocal noises	

☐ Sees or hears things that are not real	Clinician use only. **Do not write in this space.**
☐ Confused thinking or beliefs	☐ Auditory hallucinations
☐ Feels people are "out to get" him or her	☐ Visual hallucinations
☐ Unable to care for hygiene, nutrition, or basic needs	☐ Tactile hallucination
☐ Odd or bizarre thoughts or behavior	☐ Olfactory hallucinations

☐ Behaves like a younger child	Clinician use only. **Do not write in this space.**
☐ Has trouble communicating	
☐ Avoids or seems obsessed with certain things	
☐ Makes repetitive sounds or body movements	
☐ Fascinated with odd objects or parts of toys	
☐ Uses people as objects	
☐ Lack of imaginary or pretend play	
☐ Does not seek to share interests	
☐ Does not make friends / in his or her "own world"	
☐ Does not keep eye contact	
☐ Has rituals or routines that must be followed	
☐ Problems with wetting or soiling self	

Please describe any stressful event or circumstance that may have contributed to these problems:

_____

_____

_____

_____

Has your child ever witnessed or been exposed to domestic violence? ☐No ☐Yes If yes, please explain:_____

_____

Clinician use only. Do not write in this space._____

_____

_____

_____

_____

Custody Information

Are there any current custody issues? ☐No ☐Yes If yes, please explain_____
_____
_____

Is there a history of physical abuse, sexual abuse, or neglect involving this child or a family member? ☐No ☐Yes

Name	Child or Adult	Victim or Perpetrator	Relationship to this child	Reported to DHR?

Has the Department of Human Resources (DHR) ever been involved with this child? ☐No ☐Yes
If yes, please list any situation requiring DHR, Family Court, or Juvenile Probation involvement:
Social worker / Case worker:_____Phone:(___)_____
Dates of involvement:_____ Reason for involvement:_____
_____
_____
_____

Clinician use only. Do not write in this space. _____
_____
_____
_____

Family Data

Please list **ALL** individuals living in the child's household:

Name	Age	Relationship	Known to child as	Occupation
Example: *Jane Dow*	*32*	*Mother*	*"Mommy"*	*homemaker*

Please list all OTHER family/caregivers **NOT** currently residing with the patient (this may include biological parents, step parents, siblings, step siblings, etc.)

Name	Age	Relationship	Known to child as	Occupation
Example: *Ashley Smith*	*30*	*Grandmother*	*"Nanny"*	*sales*

Marital Status of Biological parents:

☐ Married/ Remarried ☐ Divorced ☐ Living Together
☐ Single/Never Married ☐ Legally Separated ☐ Widow

If parents are separated or divorced, how old was patient at time of separation?_____

Housing/Living Situation:

☐Adequate for needs ☐Inadequate (i.e. living in a shelter, living with relatives/friends)
☐ Moved more than 2 times in past 12 months ☐ Moved more than 3 times in past 12 months

Are there transportation problems that may make it difficult to keep appointments? _____

Please describe any information regarding family that may contribute to stress for the child including visitations, step parents, foster care, adoption, or other custody issues: _____
_____
_____
_____

Clinician use only. Do not write in this space. _____

Developmental History

Biological mother's age at child's birth_____ If child was adopted, child's age at adoption____
If not a biological child of parent, is the child aware of this? ☐Yes ☐ No
Planned Pregnancy: ☐Yes ☐No _____

Check the corresponding box if the biological mother used the following during pregnancy:

☐ Alcohol ☐ Cigarettes
☐ Over-the-counter medications ☐ Antibiotics
☐ Prescription Medicines
☐ Recreational/Street drugs (Examples: cocaine, marijuana, amphetamines, heroin etc.)
☐ Other_____

Please list any problems experienced by the mother during pregnancy: (Examples: high blood pressure, Diabetes, bed rest ordered etc. _____
_____

Were there any complications at birth? ☐No ☐Yes If yes, please specify:_____
_____

Was the baby premature? ☐No ☐Yes If yes, how early was the baby? _____

What was your child's birth weight? _____

What was your child's personality from age 0 to 1 year:

☐ 1) Easy going ☐ 2)Slow to warm up to others ☐3) Demanding and difficult to please
☐Other _____

At what age did your child first do the following:

Sit up _____ Say single words _____
Crawl _____ Say 2 or more words together _____
Walk _____ Become toilet trained _____

Clinician use only. Do not write in this space. _____
_____
_____
_____
_____
_____
_____
_____

Medical History

Who is your child's pediatrician? _____Phone (___)_____
When was your child's last hearing screening? _____ Normal? ☐No ☐Yes
When was your child's last vision screening? _____Normal? ☐No ☐Yes
Are your child's immunizations up to date? ☐No ☐ Yes
Has your child ever had any of the following? If so, give dates and brief description.

☐ Broken Bones_____
☐ Speech problems_____
☐ Lead Poisoning_____
☐ Seizures or convulsions_____
☐ Head Injury _____
☐ Hospitalization_____
☐ Surgery_____
☐ EKG or EEG_____
☐ Heart Problems_____

Please list any **current** health problems (Ex: Asthma/Allergies, Diabetes, heart condition, etc.):

_____ _____
_____ _____
_____ _____

Please list any **current** medications and the Dr. who prescribes them:

_____ _____
_____ _____
_____ _____

Please list any **past** health problems: _____
_____ _____
_____ _____

Does your child have any allergies to foods, medications, or latex? ☐No ☐Yes

If yes, please list with reaction: _____
_____
_____

Clinician use only. Do not write in this space. _____

Please note if your child has ever taken any of the following medications:

Medication / Dose	Beneficial Effects	Side Effects	Duration	Reason Stopped
Example: Abilify *-20 mg at bedtime*	*Helps him to not hear voices*	*Headaches*	*7/03 - Present*	*Didn't work*
Abilify (aripiprazole)				
Adderall / Adderall XR (amphetamine salts)				
Anafranil (clomipramine)				
Atarax (hydroxyzine)				
Ativan (lorazepam)				
Aventil (nortriptyline)				
BuSpar (buspirone)				
Benadryl (diphenhydramine)				
Catapres (clonidine) tablets / patches				
Celexa (citalopram)				
Cogentin (benztropine)				
Concerta (methylphenidate)				
Cymbalta				
DDAVP (desmopresin)				
Daytrana Patch (Methylphenidate)				
Depakene (valproic acid)				
Depakote (divalproex sodium)				
Desyrel (trazodone)				
Dexedrine, Dextrostat (dextroamphetamine)				
Effexor / Effexor XR (venlafaxine)				
Elavil (amitriptyline)				
EMSAM				
Eskalith (lithium carbonate)				
Evekeo				
Focalin (dexmethylphenidate)				
Geodon (ziprasidone)				
Haldol (haloperidol)				

Medication / Dose	Beneficial Effects	Side Effects	Duration	Reason Stopped
Klonopin (clonazepam)				
Lamictal (phenyltriazine)				
Lexapro (escitalopram oxalate)				
Lithobid, Lithonate, Lithotabs (lithium)				
Luvox (fluvoxamine)				
Mellaril (piperidine phenothiazine)				
Metadate ER / Metadate CD (methylphenidate)				
Methylin				
Norpramin (desipramine)				
Pamelor (nortriptyline)				
Paxil (paroxetine)				
Prozac (fluoxetine)				
Quillivant				
Risperdal (risperidone)				
Ritalin / Ritalin LA (methylphenidate)				
Seroquel (quetiapine)				
Serzone (nefazodone)				
Sinequan (doxepin)				
Stelazine(trifluoperazine)				
Strattera (atomoxetine)				
Tegretol (carbamazepine)				
Tenex (guanfacine)				
Thorazine (chlorpromazine)				
Tofranil (imipramine)				
Topamax				
Trileptal (dibenzazepine)				
Valium (diazepam)				
Remeron (mirtazapine)				

Medication / Dose	Beneficial Effects	Side Effects	Duration	Reason Stopped
Vivactil (protriptyline)				
VYVANSE				
Wellbutrin (bupropion)				
Xanax (alprazolam)				
Zoloft (sertraline)				
Zyprexa (olanzapine)				
Other:				

Past Psychiatric History

If your child has had prior counseling, psychiatric care, psychiatric hospitalizations, or testing please list:

Hospital or doctor's name	Phone #	Dates Seen	Recommendations

Clinician use only. Do not write in this space.

_____

_____

_____

_____

_____

Biological Family Medical / Psychiatric History

Please write which family member had these problems if appropriate:

Past or Present diagnosis or symptoms	Biological siblings	Biological Mother	Biological Father	Biological mother's family	Biological father's family	Others living in the home
1. ADHD						
2. Oppositional/Defiant						
3. Obsessive/Compulsive Disorder						
4. Antisocial behavior						
5. Learning disability / Special Education						
6. Mental Retardation						
7. Autism /Asperger's Disorder / PDD						
8. Psychosis / Schizophrenia						
9. Bipolar Disorder / Manic Depression						
10. Depression						
11. Suicide or suicide attempts						
12. Anxiety / Phobias						
13. Eating Disorders						
14. Tics/Tourette' s Syndrome						
15. Aggression or behavior problems						
16. Murdered or attempted to kill others						
17. Been arrested or spent time in jail						
18. Alcohol abuse						
19. Drug abuse						
17. Other psychiatric problem						
18. Heart Problems						
19. Seizures/Epilepsy						
20. Other medical problem						
21. Outpatient therapy						
22. Hospitalizations						

Clinician use only. Do not write in this space._____

Educational History

Name of current school:_____ Grade:_____

Teachers:_____

Current Placement: ☐Regular ☐Alternative school ☐ Special education :
☐ for behavior only ☐ for learning difficulties ☐Both ☐Other:_____

How many schools has your child attended this school year? ☐One (current) ☐2-3 ☐3 or more

Any prolonged absences from school? ☐No ☐Yes When_____ How long_____

Has your child repeated any grades? ☐No ☐Yes Which one(s)_____

Has your child been suspended **this school year**? ☐No ☐Yes How many times?_____ Please list reason for suspension:_____

Has your child been tested for special education placement by the school? ☐No ☐Yes
When?_____ **Please bring copies of testing and IEP's if available**.

Specific educational difficulties: ☐Spelling ☐Math ☐Reading ☐All Subjects

Current Academic Performance:
☐Very Good (All A's & B's)
☐Fair (C's & D's)
☐Poor (Mostly F's)

Past Academic Performance:
☐Very Good (All A's & B's)
☐Fair (C's & D's)
☐Poor (Mostly F's)

Peer relationships:
☐Aggressive/Social Conflict ☐Friendly/Good Social function
☐Has no or few friends ☐Teased/Bullied by others

Work History if applicable (attendance, relationship with boss):

Clinician use only. Do not write in this area

_____

_____

_____

_____

_____

Initial

This concludes parent information form!

Clinician use only. Do not write in this area

Mental Status Exam:

Appearance and Behavior:

Race: African–American / Asian / Caucasian / Latino / other
In relation to age: equal / older / younger
Build: *normal / obese / overweight / muscular / thin / frail / gaunt*
Grooming: *clean / meticulously groomed / unkempt /dirty /messy hair / foul odor*
Dress: *appropriate / disheveled / bizarre* / inappropriate for weather / young for age / old for age / seductive
Make-up: *appropriate / none / heavy / bizarre*
Eye contact: *appropriate / poor / fleeting / excessive / variable*
Manner: *pleasant / unpleasant / alert / angry / evasive / glib / spontaneous / guarded / tearful / imperturbable / hostile / exhibitionistic / sullen / depressive*
Activity level: *hyperactive / agitated / restless / excessive movement / calm / lethargic*
Abnormal Movements: *grimaces /vocal tics / motor tics / stereotypies / rituals / echopraxia*

Speech:

Rate: *normal / slow / fast / hesitant*

Rhythm: *normal / sing-song / choppy / stuttering*
Volume: *normal / soft / loud / whispering*
Articulation: *normal / abnormal / slurred / mumbling / running together of words / lisping*
Spontaneity: *normal / talkative / verbose / pressured / paucity / silent*
Language: *names objects*
Repeating phrases:

Mood and Affect:

Attitude toward interviewer: *cooperative / open / defensive / fearful / hostile / evasive / suspicious / reticent / guarded / friendly / playful / negativistic / irritable / shy*
Mood: *euthymic / anxious / apathetic / depressed / humor / guilty / irritable / frightened / euphoric / helpless / paranoid*
Range: *normal / flat / blunted / labile*
Depression: *hopeless / sad / guilty / worthless*
Given 5 moods to choose from: *happy / sad / mad / worried / scared*

Additional Notes as needed:

Intellectual:

Oriented: *time / place / person*
Est. intellectual functioning: *average / below average / above average*
Memory: Recent: *intact / impaired*
Remote: *intact / impaired*
Digits forward: *able to repeat / unable to repeat*
Subtraction: Serial 3's*: able to perform / minor problems / unable to perform*
Concentration: *sufficient / deficient / easily distractible / short span of attention / poor concentration*

Thought Content:

Themes: *externalizing blame / rivalry / rejection / phobias / obsessions / compulsions*

Delusions: *control / grandiose / mind-reading / persecution / ideas of reference / nihilistic /somatic / thought / broadcasting / thought insertion*

Hallucinations:
Visual: *present / denied*
Auditory: *present / denied*
Tactile: *present / denied*
Olfactory: *present / denied*
Intrusive thoughts or images*: present / denied*
Compulsive behavior: *present / denied / noted*
Self esteem: *elevated / good / normal / low / poor*

Notes:

Suicidal thoughts: *none* / *occasional / frequent / continuous*
Suicide plans: *none / vague / clear*
Specify Plan:
Means:
Commitment to safety:

Notes:

Homicidal thoughts: *none* / *occasional / frequent / continuous*
Homicidal plans: *none / vague / clear*
Specify Plan:
Means:
Commitment to safety:

Notes:

Thought Process:

Clarity: *goal-directed / coherent / incoherent / cloudy / confused / vague / clear / unclear in meaning or associations*
Associations: *logical / tangential / circumstantial / clang / loose*
Rate of thoughts: *lack of spontaneity / slow to respond to questions / doubting and indecision / flight of ideas / thought blocking / thought insertion / thought withdrawal / circumstantiality / tangentiality / perserveration / poverty of thought / echolalia / word salad / clang associations*
Abstract reasoning:

Proverb: "*When it rains it pours" /*

Similarities: *apple / banana*

Insight and Judgment:

Recognized illness: *yes / no / somewhat*
Judgment in: Social situations: *good / impaired / impulsive*
Everyday activities: *good / impaired / impulsive*

Strengths and Liabilities:

Socioeconomic: *poor / fair / good*
Family support*: poor / fair / good*
Insight: *poor / fair / good*
Motivation: *poor / fair / good*

Assessment:

Diagnosis:

Primary:

Social Factors:

Treatment Plan / Referrals:

1.

2.

3.

4.

5.

6.

7.

____Informed consent obtained

____Confidentiality Reviewed

____ Discuss Child age < 14

____ Response to Referral

____ Limits of Confidentiality
HI, SI, Abuse

____Emergency Services

____ Fees Discussed

____Training / Background

_____ _____

Stephen K. Bell, Ph.D.
Licensed Psychologist

DOS

Print Form Clear Form