Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Person Completing the Form: ________________________ Date:____________

Who referred you to Dr. Burritt: ____

Child's Name: __________________________ Date of Birth:____________ Age:_________

Mother's Name: __________________________ Father's Name: ________________________

Family Address: ____

Home Telephone: _____________________ Child's cell phone: ______________________

Mother's cell phone: _____________________ Father's cell phone: _____________________

Please provide the following information about each person living in the home including the child, parents, siblings, and any other children or adults living in the home:

Name	Date of Birth	Birthplace	Highest Grade or Degree Reached

Are there any extended family members or other important persons in the child's life who are not living in the home?

____
____
____
____

Please fill in the following information:

	Mother	Father
Number of brothers:	______	______
Number of sisters:	______	______
Which child were you:	______	______

Occupation of Mother: _________________ ___________________
Occupation of Father: _________________ ___________________

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Please fill in the following information:

	Mother	Father
Type of work:	____________________	____________________
Place of work:	____________________	____________________
Hours of work:	____________________	____________________

What concerns you about your child?

How long have you been concerned about the above problem(s)?

When and how do you feel these difficulties developed?

Do you feel that your child is aware of the problem(s)? If yes, how much?

What concerns, if any, do you feel your child's school system has about your child?

In doing this evaluation, what questions would you like answered for you?

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Child's Medical History

Pediatrician: ________________________ Office phone: ________________________
Office address: ____
Affiliation with a healthcare system (Dupont, CHOP, etc): __________________________
Current insurance provider: ____

Is there an additional physician or healthcare professional involved in your child's care? No ____
Name: ________________________ Office phone: ________________________
Office address: ____

Please check which of the following immunizations your child has had:

Haemophilis Influenza B (HiB)___	Hepatitis B (HepB)___	Heptatis A (HepA)___
Polio (IPV)___	Measles, Mumps, Rubella (MMR)___	Smallpox___
Diptheria, Tetanus, Pertussis (Dtap)___	Varicella (VAR)___	Human Pappilomavirus (HPV)___
Meningococcal B (MenB) ___	Pneumococcal (PCV)___	Rotavirus (RV)___

Has your child ever been tested for tuberculosis? Yes___ No___ Results? ________

Has your child ever been hospitalized? (If yes, please include when, why, how long, and where)
____
____
____

Please check if your child has ever had any of these childhood illnesses:

Chickenpox ___	Scarlet Fever ___	Measles___	German Measles (Rubella) ___	
Whooping Cough___	Rheumatic Fever___	Mumps___	Diptheria___	Other _______________

What is the highest fever your child has ever had? ___ When? ______________

Has your child ever been seen by a specialist for consultation? If so, please provide the name, specialty, reason, and results.
____
____
____

Has your child ever had medical testing or imaging? Examples could include MRI or CT (brain/head imaging), EKG (heart rhythm testing), EEG (brain wave testing). What were the results?
____
____
____

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Past and current medical conditions:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

To assist your in remembering past or current medical problems please review the questions below:

Nervous System: Has your child had headaches or migraines, dizziness, or seizures?

____

Eyes: Has your child had visual problems? Does he or she wear glasses or contacts?

____

Ears: Has your child had hearing difficulty or ear infections?

____

Nose and throat: Does your child get frequent colds, sore throat, strep infections, or hoarseness?

____

Lungs: Has your child had breathing difficulty, asthma, pneumonia, or other lung problems? Has he or she ever required intubation (“breathing tube”)?

____

Heart: Has your child have any heart problems, racing or pounding heart beat, fainting, or chest pain?

____

Digestive System: Has your child had stomach problems, indigestion or heart burn, nausea, constipation, or diarrhea?

____

Urinary System: Has your child had problems urinating, urinary infections, or urinary accidents?

____

Muscle/Skeleton System: Has your child had problems with muscle strength or activity or bone fractures?

____

Menstruation: At what age was your daughter's first menses? Has there been difficulty with menstruation? Examples could include cramping, heavy blood loss, or missed menses. Is she on a form of contraception such as an oral birth control pill or depot injection?

____

Family Medical History

Do any illnesses run in your family? (diabetes, heart disease, cancer, allergies, emotional illness, etc)

____
____
____
____

Please note age and illnesses or cause of death

Maternal grandmother:

____

Maternal grandfather:

____

Paternal grandmother:

____

Paternal grandfather:

____

Do you feel as a child you had emotional problems or learning disabilities?

Mother____

Father ____

Do you feel that any of your other children have emotional problems or learning disabilities?

____
____
____
____
____

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Developmental History

Location of Birth: ____

Which pregnancy was this? ____

Was it a wanted pregnancy? ____

How did you feel emotionally during pregnancy? _______________________________________

How was your health during this pregnancy?____

Did you have difficulty with previous pregnancies?______________________________________

Was delivery natural, via Caesarean ("C-section"), or breech? ______________________________

At how many weeks did the delivery occur? ____

Was it a single or multiple birth? ____

What was the duration of labor?____

What type of anesthesia was used?____

Were forceps used?____

Were there any complications during the delivery? _____________________________________

Birth weight:________ Birth length:________

Was the child jaundiced (If so, for how long)?____

Was a blood transfusion required? ____

Was oxygen required immediately after birth?____

If your child was adopted please write the age of adoption and any information that you know about the circumstances of birth and the child's biological parents.

____
____
____
____

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

During the first months of life did your child have difficulty with:

Sucking ______________________________

____

Chewing ______________________________

____

Swallowing ______________________________

____

Crying ______________________________

____

Feeding (please note whether breast or bottle fed)______________________________

____

____

____

____

Sleeping______________________________

____

____

____

____

Did you child appear to enjoy body contact or did you child seem not to enjoy or dislike body contact?

____

____

____

____

Did your child appear to be overly responsive or sensitive to sounds or noise? ____________________

____

____

Did your child have any food dislikes, allergies, or idiosyncrasies? ______________________________

____

____

____

____

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Motor and Muscle Development
To the best that you can remember, at what age did your child:

Hold head up_______Smile when played with_______Sit without support_______
Stand without support_______Crawl_______Walk by self_______Run with ease_______
Button clothing_______Tie shoes_______Ride a tricycle_______Ride a bicycle_______

Have you ever been concerned about your child's ability to use or play with toys?_______
Please elaborate____

Which hand does your child prefer when: Eating_______Writing_______Throwing_______
Has your child ever preferred a different hand for tasks?_______ Please elaborate
____

Are languages other than English used in the home today?_______In the past?_______ If yes, what language and to what extent? ____
____

At what age did your child begin to: Babble_______Mimic Sounds_______Say first word_______
Use language to communicate_______Speak clearly_______
Has your child ever had a hearing test?_______ What were the results and recommendations?
____

Do you feel your child may have or has had a speech problem? This may include stuttering, stammering, lisping, or other articulation problems. ____
____

Does anyone in the family have any speech or hearing problems including articulation problems but also deafness, hearing loss, or voice disorders? ____
____

Do you feel your child may have a language problem? (For example, knowing what he or she wants to say but unable to find the right word or get it out.) ____
____

How does your child respond to sounds?
____

How does your child respond to speech? (Does your child understand everything that is said? Does he or she just imitate sounds? Does he or she respond appropriately to questions? Is there inconsistency?)
____
____

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Academic and Educational Development

Name of current school ____________________________ Current Grade _______
Teacher's name: ___________________________________ Principal name: ______________________
Who knows your child best? ______________________
Is your child in regular education, special education, or in advanced classes?

____

Does your child have an Individualized Educational Program(IEP) or 504B plan? _______
If so, please provide a copy and below describe the major goal of the plan: ________________________
____
____

At this time, at what grade level do you feel you child is functioning?
Reading_______ Writing _______ Math _______ School adjustment _______

At what age did your child begin to:
Name objects in the home_______ Name colors _______ Know name and address _______
Name letters of the alphabet_______ Use adjectives such as big or little _______ Read _______
Print _______ Use cursive _______ Type _______

For each program/grade please give the age your child began and describe the experience (positive/negative/problems)

Daycare prior to school ____
____
Nursery School ____
____
Kindergarten ____
____
First Grade____
Second Grade ____
Third Grade____
Fourth Grade____
Fifth Grade ____
Sixth Grade____
Seventh Grade____
Eight Grade____
Ninth Grade____
Tenth Grade____
Eleventh Grade ____
Twelfth Grade ____

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Social and Psychological Development

To the best that you can remember, at what age did your child:

Begin to be afraid of strangers _______ Comfortably separate from mother _______
Give up breast or bottle feeding completely _______ Feed self independently _______
Become bladder trained _______ Become bowel trained _______

How was bladder and bowel training accomplished?____
____
____
____

Since the age of 5, has your child ever had a problem with bed wetting or daytime accidents? ______
If so, please elaborate and indicate if your child was evaluated for this and what, if any, methods were used to stop this. ____
____
____

Does your child sleep through the night? ____
Does your child snore or stop breathing while sleeping?______________________________________

Does your child now have or ever had any fears? _______ If yes, please explain.
____

Does your child now or ever had problems with:
Nightmares _______ Eating _______ Sneaking/Hoarding food _______ Tantrums _______
Fighting with peers _______ Stealing _______ Fire setting _______ Hurting animals _______
If yes to any of the above, please elaborate:____
____

Does you child get along with his siblings? ____
____

Has your child ever had psychological testing? _______ If yes, when, by whom, and what were the results? ____
____

Has your child ever had emotional problems? If yes, when was this evaluated and treated, by whom, and what were the recommendations? ____
____

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

General Sexual Development

At what age did your child begin to:
Show curiosity about sex? _______ Show modesty? _______ Begin to masturbate? _______
Does your child prefer privacy in the bathroom? _______ In the bedroom? _______

Has your child developed adult sexual characteristics? ____
____
Is your child concerned about his or her appearance? ____
____
Do you feel that your child has any concerns or difficulties in the area of sex? _______
If yes, please elaborate:____
____

Current Status

Does your child have chores? _______ If yes, what?_______________________________________
Get an allowance? _______ How much? ____
Dress self? _______ If no, to what degree? ____
At what time does your child usually:
Go to bed _______ Fall asleep _______ Wake up_______ Go to school _______ Return home _______

Is your child a discipline problem? _______ If yes, please elaborate ____________________________
____

Does you child have a problem with accepting limits? ____ Authority figures?_____ Please elaborate.
____

How does your child get along with babysitters?____
____

Does your child attend religious services and/or religious school? _______ If so, please elaborate.
____

What age group does your child prefer to play with?____

What type of play does your child prefer? (active, sedentary, formal sports, team sports, fantasy alone)
____
____

Are there neighborhood children or do you schedule play dates? _______________________________
____

Christopher Burritt D.O.
Child and Adolescent Psychiatry

Introductory Information

Does your child have any hobbies or special interests? ____
____
____

Does your child belong to any clubs or organizations such as Scouts, Little League, or a youth group?
____

Does your child play well with others? ____ If no, please elaborate. ____________________________
____

Do other children reject or pick on your child? ____ If yes, please elaborate.______________________
____

How much time does your child spend watching television on a typical day? ____ Weekend day? ____

How much time does your child spend playing on a tablet, phone, or with video game consoles:
On a typical day? ____ On a weekend day?_____

Does the family live in a house ____ apartment ____ If a home: rent ____ buying ____

How long have you lived in your current home? _________________________________

Does your child have his or her own room? ____ If shared, with whom?_________________________

Are there any problems related to the neighborhood? ____
____

For The Future

What future plans or goals do you have for your child?____
____

For your family? ____
____

For mother?____
____

For father?____
____

Please use the back of this page to add any significant information that was not yet discussed.