LAWRENCE V. TUCKER, MD, PLLC

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ADOLESCENT PATIENT INTRODUCTION

We're grateful that you've chosen to entrust your care to us here at the clinic. We look forward to getting to know you and serving your needs. Please read carefully both parts in this packet of information.

Part 1: contains information about you that will be kept in your file.

Part 2: is the patient information that you give us. We ask that you thoroughly fill out these forms as well. This information may take up to a couple of hours to complete so please don't wait until the last minute to start working on it. Again, we realize these forms are lengthy and time consuming, but we feel that the more we know about you the better we can help you.

We want to make your experience here the best it can be. If you have any questions or concerns please feel free to call us at any time.

Warmest Regards,

Lawrence V. Tucker, M.D.

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PART 1

PATIENT INFORMATION

Patient's Name: _____

SS# _____-_____-_____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Age: _____

Home Address: _____

City/State/Zip_____

Phone: (home)_____(cell)_____

School:_____

Employer: _____Work Phone: (_____)_____

Employer/Address: _____

Your E-mail Address:_____

Pharmacy Phone #:_____

RESPONSIBLE PARTY

Responsible Party: _____ SS#_____-_____-_____Date of Birth: _____

Home Address: _____

Phone: _____Occupation:_____

Employer: _____

Employer Address:_____

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PART 2

Adolescent Intake Questionnaires

Parents, in order for us to be able to fully evaluate your adolescent, we request that you fill out the following intake form and questionnaires (as they pertain to your child) to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your child's medical chart it is ok to refrain from putting it in this information. Thank you!

PATIENT IDENTIFICATION

Name _____ First Appointment Date _____

School _____ Grade _____

Natural Mother _____

Natural Father _____

Who is the adolescent current living with? _____

REFERRAL SOURCE _____ Phone #_____ Fax # _____
Do we have your permission to release information to the referring professional when it is appropriate? _____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What do you want this clinic to do for your child, yourself or your family?

_____

_____

_____

PSYCHIATRIC MEDICATIONS/SUPPLEMENTS (Please list all medications/supplements taken including dosages, effectiveness and any side-effects.) *If you need more room please attach a separate sheet.*

Date Taken	**Medication** ***Individual or Combinations*** ***Dosage(s) and time(s) taken per day***	**Effectiveness**	**Side-Effects/Problems**
Ex: 2/2000-5/2004	**Example** • *Ritalin 5 mg BID* • *Prozac 10mg QAM*	**Example** *Improved concentration in morning, still moody*	**Example** *Felt very unfocused in evening; hyperactive in evenings; dry mouth*

PSYCHIATRIC HISTORY

(Please list any psychiatrists/psychologists/therapists that you have seen previously:

Name: Dates Seen:

_____

_____

_____

_____

_____

MEDICAL HISTORY

Current medical problems:_____

_____

_____

_____

_____

Current non-psychiatric medications/supplements:_____
_____
_____
_____
Past medical problems: _____
_____
_____
_____
Other doctors/clinics seen regularly: _____
_____
Any history of head trauma? (describe): _____
_____
Ever any seizures or seizure like activity? _____
Prior hospitalizations (place, cause, date, outcome): _____
_____
Prior abnormal lab tests, X-rays, EEG, etc: _____
Allergies/drug intolerances (describe): _____
Present Height _____ *Present Weight* _____

CURRENT LIFE STRESSES (please list current factors that are a source of stress for your family)
_____
_____

FAMILY HISTORY
Family Structure (who lives in the current household):
_____
_____

Current Marital Situation/Satisfaction of Parents _____
_____
_____

Family Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, etc.)_____
_____

Natural Mother's History: age_____ occupation _____
School: highest grade completed _____
Marriages: _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____
_____
Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Mother's alcohol/drug use history _____
Have any of mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
_____
_____

Natural Father's History: age_____ occupation _____
School: highest grade completed _____
Marriages: _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc)_____
_____
Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Father's alcohol/drug use history _____
Have any of father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
_____
_____

Siblings (names, ages, problems, strengths, relationship to patient) _____
_____
_____

ADOLESCENT'S DEVELOPMENTAL HISTORY

Prenatal events:
Parents' attitude toward pregnancy _____
Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)
_____
Physical/Sexual Abuse: _____
Social development: (please write in age, parentheses are approximate normal limits)
quality of attachment to mother _____ quality of attachment to father _____
relationships to family members _____
early peer interactions _____
current peer interactions _____
special interests/hobbies _____

Behavioral/Discipline: compliance vs. non-compliance _____
lying/stealing _____ rule breaking _____ methods of discipline _____
other problems _____

Emotional development: early temperament _____
current personality _____
mood _____ fears/phobias _____
habits _____

Drug/Alcohol History: _____
_____
_____
_____

School History: current grade _____ school contact _____
number of schools attended _____ average grades _____
homework problems _____
specific learning disabilities _____
what have teachers said about the child _____

Ethnicity:_____
Religious Preference:_____
Overall Strengths – as viewed by Parents _____
_____
Overall Strengths – as viewed by Adolescent _____
_____

Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well rate you. List other _____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Parent/Adolescent

____ ____ 1. Problems sustaining attention to detailed tasks
____ ____ 2. Procrastinates or turns in assignments late
____ ____ 3. Problems following through and finishing tasks
____ ____ 4. Restless and fidgety
____ ____ 5. Problems setting and attaining goals
____ ____ 6. Uses caffeine to help focus
____ ____ 7. Uses nicotine to help focus
____ ____ 8. Acts impulsively
____ ____ 9. Interrupts others
____ ____ 10. Lack of forethought (says or does things before thinking about the implications)
____ ____ 11. Shows little empathy for others
____ ____ 12. Becomes fixated on thoughts (often negative)
____ ____ 13. Worries
____ ____ 14. Has difficulty getting over things (may hold a grudge)
____ ____ 15. Becomes upset if things do not go your way
____ ____ 16. Becomes upset if things are messy or out of place
____ ____ 17. Likes to follow a certain routine
____ ____ 18. Does not like change
____ ____ 19. Experiences obsessive thoughts
____ ____ 20. Experiences compulsive behaviors
____ ____ 21. Experiences addictive behaviors
____ ____ 22. Tends to be argumentative
____ ____ 23. Trouble shifting attention
____ ____ 24. Tendency to be oppositional
____ ____ 25. Feels sad
____ ____ 26. Is pessimistic and negative
____ ____ 27. Energy level is low
____ ____ 28. Less interested in activities that are usually fun
____ ____ 29. Crying episodes
____ ____ 30. Low self-esteem
____ ____ 31. Isolates socially
____ ____ 32. The future seems hopeless

____ ____ 33. Thoughts of wishing you were dead
____ ____ 34. Feelings of guilt
____ ____ 35. Problems concentrating
____ ____ 36. Problems sleeping—too little or too much
____ ____ 37. Feeling nervous
____ ____ 38. Headaches
____ ____ 39. Muscle tension (sore neck, jaw, etc…)
____ ____ 40. Easily startled
____ ____ 41. Social anxiety
____ ____ 42. Hyper vigilance (feeling keyed up or on edge)
____ ____ 43. Tendency for excessive motivation
____ ____ 44. Avoids conflict
____ ____ 45. Experiences thoughts going fast
____ ____ 46. Experiences panic attacks
____ ____ 47. Tendency to predict the worst
____ ____ 48. Problems turning off brain at night to go to sleep
____ ____ 49. Periods of significant irritability
____ ____ 50.Sensitivity to slights—misinterpreting comments as negative when they are not
____ ____ 51. Experiences paranoia (feeling that others are out to get you or cause you harm)
____ ____ 52. Becomes angry quickly (short fuse)
____ ____ 53. Problems with memory
____ ____ 54. Difficulty finding the right word to say
____ ____ 55. Significant mood swings
____ ____ 56. Dark thoughts (urges to hurt self or others)
____ ____ 57. Experiences déjà vu (feeling that you been somewhere or done something before that you haven't)
____ ____ 58. Hears audible voices that others don't
____ ____ 59. Sees shadows or other images moving out of the corners of your vision
____ ____ 60. Sloppy handwriting
____ ____ 62. Messy, disorganized
____ ____ 62. Clumsy (poor balance, coordination, or accident prone)
____ ____ 63. Sensitive to noise
____ ____ 64. Sensitive to touch or texture
____ ____ 65. Sensitive to light
____ ____ 66. Oversensitivity to environment
____ ____ 67. Problems keeping up in conversations
____ ____ 68. Slower than others in learning new tasks
____ ____ 69. Slow or slurred speech
____ ____ 70. Feel sleepy or the need to take a nap during the day
____ ____ 71. Mental sluggishness—brain fog
____ ____ 72. Difficulty losing weight (even on low calorie diet)
____ ____ 73. Irregular menstrual periods or heavy periods lasting longer than 5-7 days
____ ____ 74. Feeling fatigued even after significant sleep (8-10 hours)
____ ____ 75. Losing weight without dieting
____ ____ 76. Periods of a racing heartbeat while at rest
____ ____ 77. Crave sweets during the day

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General
- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other_____

Neurological
- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other_____

Respiratory
- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other_____

Chest and Cardiovascular
- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure

Head, Eye, Ear, Nose, & Throat
- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other_____

Gastrointestinal and Hepatic
- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other_____

Musculoskeletal
- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other_____

Skin, Hair
- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other_____

Genitourinary
- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other_____

Females
- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other_____

Males
- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other_____

Explanation

_____
_____
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