Houston Family Psychiatry - Abigail Nodler, M.D.
CHILD and ADOLESCENT PATIENT INFORMATION

_____
PATIENT'S NAME (First, Middle, Last)

_____ _____
DATE OF BIRTH SOCIAL SECURITY #

_____
LEGAL GUARDIAN (if applicable)

_____
HOME ADDRESS (Street AND Zip Code)

_____ _____
HOME TELEPHONE NUMBER CHILD'S CELL PHONE#

_____
RESPONSIBLE FINANCIAL PARTY

_____
MAILING ADDRESS (if different from Patient)

_____
MOTHER'S NAME

_____ _____
MOTHER'S HOME PHONE # MOTHER'S BUSINESS PHONE#

_____ _____
MOTHER'S CELLULAR PHONE # MOTHER'S EMAIL ADDRESS

_____
FATHER'S NAME

_____ _____
FATHER'S HOME PHONE # FATHER'S BUSINESS PHONE #

_____ _____
FATHER'S CELLULAR PHONE # FATHER'S EMAIL ADDRESS

Houston Family Psychiatry – Abigail Nodler, MD
PERSONAL DATA SHEET – CHILDREN/ADOLESCENTS

Please fill out the following as completely as possible. In order for us to provide the best evaluation, it is essential that we have complete information.

PATIENT'S NAME : _____NICKNAME: _____
DATE: _____ AGE: _____ DOB: _____
REFERRED BY: _____

BIRTHPLACE: _____ CITIZENSHIP: _____ RACE: _____
RELIGION: _____
ADOPTED: _____ Yes _____ No If YES, date of legal adoption _____

FAMILY SURNAME: _____HOME PHONE NUMBER: _____
HOME ADDRESS: _____

MOTHER'S NAME: _____ DATE OF BIRTH: _____
EDUCATION: _____ LIVING AT HOME?: _____
OCCUPATION: _____ FULLTIME ____PARTTIME ____
WORK PHONE: _____

FATHER'S NAME: _____ DATE OF BIRTH: _____
EDUCATION: _____ LIVING AT HOME?: _____
OCCUPATION: _____ FULLTIME ____PARTTIME ____
WORK PHONE: _____

STEPMOTHER'S NAME: _____ DATE OF BIRTH: _____
EDUCATION: _____ LIVING AT HOME?: _____
OCCUPATION: _____ FULLTIME ____PARTTIME ____

STEPFATHER'S NAME: _____ DATE OF BIRTH _____
EDUCATION: _____ LIVING AT HOME?: _____
OCCUPATION: _____ FULLTIME ____PARTTIME ____

LEGAL GUARDIAN'S NAME: _____
RELATIONSHIP: _____
PHONE : _____

ALLERGIES: _____

PEDIATRICIAN: _____ PHONE: _____
ADDRESS: _____

SIBLING NAMES	GENDER	AGE	OCCUPATION	LIVING IN HOME?

OTHER'S LIVING IN HOME	GENDER	AGE	OCCUPATION	RELATIONSHIP

FAMILY INFORMATION

DESCRIBE EACH FAMILY MEMBER'S RELATIONSHIP WITH THE CHILD.

MOTHER: _____
_____
_____
_____
_____

FATHER: _____
_____
_____
_____
_____

SIBLINGS: _____
_____
_____
_____
_____

OTHER EXTENED FAMILY: _____
_____
_____

OTHER IMPORTANT RELATIONSHIPS: _____
_____
_____
_____

HAVE THERE BEEN ANY RECENT STRESSES SUCH AS MOVES, BIRTHS, DEATHS, CHANGES IN SCHOOL, OR RELATIONSHIPS? (Including ones you believe the child in unaware of): _____

ARE THERE ANY CHRONIC STRESSES? (Including ones you believe the child in unaware of):

_____
_____

HOW LONG HAVE PARENTS BEEN MARRIED? _____

WAS EITHER PARENT MARRIED PREVIOUSLY? ☐ YES ☐ NO

MOTHER: _____
FATHER: _____

IF APPLICABLE, HOW LONG HAVE PARENTS BEEN DIVORCED? _____
IF APPLICABLE, WHEN DID EACH PARENT REMARRY?
MOTHER: _____
FATHER: _____

DOES CHURCH/RELIGION/SPIRITUALITY PLAY AN IMPORTANY ROLE IN YOUR CHILD OR YOUR FAMILY'S LIFE?
☐ YES ☐ NO

IF SO, PLEASE EXPLAIN: _____
_____
_____
_____

ANY OTHER IMPORTANT FAMILY INFORMATION:
_____
_____
_____
_____
_____

CURRENT BEHAVIOR/CONCERNS:

DESCRIBE THE PROBLEM OR SITUATION THAT LED YOU TO SEEK OUR SERVICES AT THIS TIME (feel free to write on the back of the page if necessary).

_____
_____
_____

HAS THIS OCCURRED BEFORE? ☐ YES ☐ NO

.

If so, when? _____

WHAT ARE YOU HOPING TO GAIN FROM THIS EVALUATION?

_____
_____
_____
_____

HAS THE CHILD BEEN EXPOSED TO EMOTIONAL, PHYSICAL, OR SEXUAL ABUSE? _____
_____
_____

PLEASE CHECK ANY OF THE FOLLOWING PROBLMES/SYMPTOMS THAT ARE AFFECTING THE PATIENT'S LIFE:

- ☐ Conflict with parents
- ☐ Conflict between parents
- ☐ Separation or divorce
- ☐ Friendship problems
- ☐ School Problems
- ☐ Drug-Alcohol problems
- ☐ Chronic illness
- ☐ Recent illness
- ☐ Illness of a family member
- ☐ Sleep problems
- ☐ Bed wetting
- ☐ Soiling
- ☐ Sadness/Depression
- ☐ Irritability
- ☐ Anger
- ☐ Withdrawal
- ☐ Tearfulness
- ☐ Appetite changes
- ☐ Energy changes
- ☐ Change in interests
- ☐ Self harm, thoughts
- ☐ Self harm, behavior
- ☐ Harming others, thoughts
- ☐ Harming others, behavior
- ☐ Nervousness/Anxiety
- ☐ Obsessions/Compulsions
- ☐ Excessive rituals or rigid routines
- ☐ Counting or checking
- ☐ Inattention
- ☐ Memory problems
- ☐ Eating disorders
- ☐ Family violence
- ☐ Physical abuse
- ☐ Sexual abuse

CHILD'S PAST MENTAL HEALTH HISTORY

PLEASE LIST ALL EVALUATIONS YOUR CHILD HAS HAD IN THE PAST, INCLUDING MEDICAL, PSYCHIATRIC, EDUCATIONAL, PSYCHOLOGICAL, SPEECH/HEARING, ETC. (Please send or bring copies of any evaluations with you)

EVALUATION	CLINIC/PROFESSIONAL	PHONE #	DATE

IS/HAS THE CHILD BEEN IN PSYCHOTHERAPY? ☐ YES ☐ NO

If so, with whom, for how long, and for what issues?

_____
_____
_____
_____

CURRENT PSYCHOTROPIC MEDICATIONS	DOSAGE	DURATION

PAST PSYCHOTROPIC MEDICATIONS	DOSAGE	DURATION	AGE

CHILD'S SOCIAL DEVELOPMENT

DOES YOUR CHILD HAVE A VARIETY OF FRIENDS?

☐ YES ☐ NO

DOES YOUR CHILD HAVE A BEST FRIEND?

☐ YES ☐ NO

HAS YOUR CHILD EVER HAD DIFFICULTIES MAKING OR KEEPING FRIENDS?

☐ YES ☐ NO

CHILD'S HOBBIES: _____
_____
_____

CHILD'S INTERESTS: _____
_____
_____

CHILD'S TALENTS: _____
_____
_____
_____

CHILD'S STRENGTHS: _____
_____
_____
_____

SCHOOL/VOCATION

DID YOUR CHILD ATTEND NURSERY SCHOOL?

☐ YES ☐ NO

NAME OF SCHOOL: _____

KINDERGARTEN?

☐ YES ☐ NO

NAME OF SCHOOL: _____
DESCRIBE ANY PROBLEMS? _____
_____
_____

FROM FIRST GRADE TO DATE, GIVE THE FOLLOWING SCHOOL INFORMATION:

SCHOOL YEAR	GRADE	AGE	NAME OF SCHOOL	PASSED/RETAINED

WHAT ARE YOUR CHILD'S MOST RECENT GRADES? _____

HAS THIS CHANGED OVER THE PAST YEAR?

□ YES □ NO

CURRENT SCHOOL NAME, ADDRESS, AND PHONE NUMBER:

_____

_____

NAME OF CURRENT TEACHER/ADVISOR:

_____

CURRENT SCHOOL DISTRICT (EVEN IF PRIVATE SCHOOL): _____

DESCRIBE ANY DIFFICULTIES IN SCHOOL, INCLUDING AGE AND GRADE:

_____

_____

_____

_____

_____

LIST ANY JOBS YOUR CHILD HAS HAD:

JOB	LOCATION	DATES

PREGNANCY, LABOR, AND DELIVERY

MOTHER'S HEALTH DURING PREGNANCY: GOOD ___ FAIR: ___ POOR: ___
ANY PHYSICAL PROBLEMS? YES/NO IF SO, PLEASE DESCRIBE: _____
_____

HOW DID PARENTS FEEL ABOUT THIS PREGNANCY? _____
_____

HAS THE MOTHER HAD ANY MISCARRIAGES OR CHILDREN WHO DIED AFTER BIRTH? ☐ YES ☐ NO

IF SO, WHEN AND CAUSE:
_____
_____

WERE ANY DRUGS OR MEDICATIONS PRESCRIBED DURING PREGNANCY?

☐ YES ☐ NO

IF SO, PLEASE SPECIFY: _____

HOW LONG DID LABOR LAST? _____ DIFFICULTIES? _____

WAS DELIVERY SPONTANEOUS? _____ INDUCED? ____ CAESARIAN? ____

INSTRUMENTS? _____ WHICH PART OF BABY WAS BORN FIRST? _____

WAS THE BABY FULLTERM? _____ IF NOT, HOW EARLY? _____

LIST ANY INJURIES OR DEFORMITIES AT BIRTH: _____
_____

DID THE BABY HAVE DIFFICULTIES BREATHING? _____

WAS OXYGEN USED? _____ HOW LONG DID BABY STAY IN THE HOSPITAL? _____
DID THE BABY HAVE ANY DIFFICULTIES IN THE FIRST TWO WEEKS: _____
_____

DID THE MOTHER EXPERIENCE ANY DIFFICULTIES AFTER CHILDBIRTH?
_____

WAS THE BABY BREAST FED? _____ BOTTLEFED? _____ BOTH? _____

DESCRIBE ANY DIFFICULTIES WITH FEEDING OR FORMULA: _____
_____

AT WHAT AGE WAS THE BABY COMPLETELY WEANED? _____

DESCRIBE BABY'S ACTIVITY LEVEL (ACTIVE, RESTLESS, EASY, FUSSY, ETC.) _____

WAS EITHER PARENT AWAY FROM HOME FOR MORE THAN THREE DAYS DURING THE BABY'S FIRST YEAR? _____

DESCRIBE ANYTHING UNUSUAL OR STRESSFUL IN THE FAMILY DURING THE BABY'S FIRST YEAR: _____
_____
_____

DID ANYONE HELP MOTHER WITH THE BABY?

□ YES □ NO

IF SO, WHO?_____

EARLY CHILDHOOD

AT WHAT AGE DID YOUR CHILD GET HIS/HER FIRST TOOTH? _____
SIT ALONE? _____
CRAWL? _____
WALK ALONE? _____
EAT WITH A SPOON? _____
SAY FIRST WORDS? _____
SAY TWO WORD SENTENCES? _____

AT WHAT AGE WAS TOILET TRAINING COMPLETED?
BOWEL: DAY_____ NIGHT _____
BLADDER: DAY_____ NIGHT _____
WERE THERE ANY RELAPSES? □ YES □ NO

IF SO, AT WHAT AGE AND CIRCUMSTANCES?
_____

AT WHAT AGE DID HE/SHE SHOW CURIOUSITY ABOUT SEX? _____
HOW WAS THAT DEALT WITH? _____
_____

HOW DID YOUR CHILD REACT TO FRUSTRATION AND DISAPPOINTMENT?
_____
_____

DID HE/SHE HAVE TEMPER TANTRUMS? □ YES □ NO

IF SO, PLEASE EXPLAIN _____

WHO USUALLY DISCIPLINED YOUR CHILD?_____
WHAT METHODS WERE USED? _____
_____

DID HE/SHE HAVE FEARS (E.G. DARKNESS, ANIMALS, ETC.)?

☐ YES ☐ NO

IF SO, PLEASE EXPLAIN _____

DID/DOES HE/SHE SHARE A ROOM WITH ANYONE? ☐ YES ☐ NO

IF SO, PLEASE EXPLAIN _____

DID THE CHILD EVER SHARE A BED WITH SOMEONE? ☐ YES ☐ NO

IF SO, PLEASE EXPLAIN _____

DESCRIBE ANY SLEEP DISTURBANCES: _____
_____
_____
_____

DESCRIBE ANY EATING PROBLEMS:_____
_____
_____
_____

HAVE THERE EVER BEEN ANY SUDDEN CHANGES IN SLEEPING OR EATING HABITS? ☐ YES ☐ NO

IF SO, PLEASE DESRIBE, INCLUDING AGE(S): _____
_____
_____
_____
_____
_____

COMMMUNICATION

HAVE YOU EVER QUESTIONED YOUR CHILD'S ABILITY TO HEAR NORMALLY? ☐ YES ☐ NO

HAS HIS/HER HEARING BEEN TESTED? ☐ YES (When) _____ ☐ NO

DID YOUR CHILD REPEAT SONGS, RHYMES, TV COMMERCIALS?

☐ YES ☐ NO

DID YOUR CHILD BEGIN TO BABBLE OR TALK AND THEN STOP?

☐ YES ☐ NO

HAS YOUR CHILD EVER BEEN IN SPEECH THERAPY? ☐ YES ☐ NO

IF SO, PLEASE EXPLAIN _____

OTHER INFORMATION ABOUT YOUR CHILD'S COMMUNICATION: _____
_____
_____

CHILD'S MEDICAL HISTORY

HAS YOUR CHILD EVER BEEN UNCONSCIOUS, BLACKED OUT, OR HAD A SEIZURE? ☐ YES ☐ NO

HAS HE/SHE EVER BEEN HIT IN THE HEAD OR EAR? ☐ YES ☐ NO

DOES YOUR CHILD HAVE VISION PROBLEMS? ☐ YES ☐ NO

DOES HE/SHE HAVE HEARING PROBLEMS? ☐ YES ☐ NO

DOES HE/SHE HAVE COORDINATION PROBLEMS? ☐ YES ☐ NO

HAS YOUR CHILD EVER HAD PHYSICAL THERAPY? ☐ YES ☐ NO

IF SO, PLEASE EXPLAIN _____

HAS YOUR CHILD REACHED PUBERTY? ☐ YES ☐ NO

CHILD'S PHYSICAL HEALTH

GENERAL HEALTH: ____ Excellent ____ Good ____ Fair ____Poor

WHEN WAS YOUR CHILD'S MOST RECENT PHYSICAL EXAM?: _____

PLEASE COMPLETE THE FOLLOWING:

ILLNESS	AGE	MILD/MODERATE/SEVERE	COMPLICATIONS
Measles			
Chicken Pox			
Whooping Cough			
Diphtheria			
Scarlet fever			
Mumps			
Flu			
Pneumonia			
High Fever			
Tonsillitis			
Sinusitis			
Frequent colds			
Epilepsy			
Encephalitis			
Meningitis			
Ear Infections			
Polio			
Rubella			
3 day measles			
Migraines			
Other			
Other			

OPERATIONS	AGE	LENGTH OF HOSPITALIZATION	COMPLICATIONS

OTHER HOSPITALIZATIONS: _____

_____

ACCIDENTS: _____

_____

ILNESSSES: _____

_____

CURRENT MEDICATIONS	DOSAGE	DURATION	AGE

DOES THE PATIENT TAKE ANY STREET DRUGS? ☐ YES ☐ NO

If so, which ones, how much and for how long?

_____
_____
_____

FAMILY MEDICAL HISTORY

HAVE ANY FAMILY MEMBERS HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS LISTED BELOW?

CONDITION	RELATIONSHIP	DESCRIPTION
Congenital defects	_____	_____
Mental retardation	_____	_____
Cerebral palsy	_____	_____
Muscular disorders	_____	_____
Psychiatric problems	_____	_____
Emotional problems	_____	_____
Nervous conditions	_____	_____
Depression	_____	_____
Anxiety	_____	_____
Bipolar disorder	_____	_____
Schizophrenia	_____	_____
Heart disease	_____	_____
Eye disorders	_____	_____
Lung/respiratory disease	_____	_____
Allergies	_____	_____
RH negative blood type	_____	_____
Down's syndrome	_____	_____
Physical deformities	_____	_____
Learning problems	_____	_____
ADHD	_____	_____
Alcoholism	_____	_____
Drug dependence	_____	_____
Infant death	_____	_____
Diabetes	_____	_____
Migraine headaches	_____	_____
Thyroid disorder	_____	_____

PLEASE LIST ANY OTHER FAMILY MEDICAL INFORMATION THAT YOU BELIEVE MAY BE IMPORTANT: _____

_____
_____
_____

HIPAA Notice of Privacy Practices
Houston Family Psychiatry - Abigail Nodler, MD
2211 Norfolk St., Suite 500
Houston, Texas 77098

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information.
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected information may be provided to a physician or other health care provider to whom you have been referred to insure that the physician or other health care provider has the necessary information to diagnose or treat you.

Payment
Your protected health care information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital stay.

Healthcare Operations
We may use or disclose, a needed, your protected health information in order to support the business activity of you physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging other business activities. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, and workers' compensation. Under the law, we must make disclosures to you and when required to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures
These will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, exept to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. YOUR RIGHTS

You have the right to inspect your protected health information.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding; and protected health information that is subject t o law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means that you may ask us not to use or disclose any part of you protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification proposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request or receive confidential communication from us by alternative means or an alternative location.

You have a right to receive a paper copy of this notice from us.

You have the right to have your physician amend your protected health information.
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made of any of your protected health information.
We reserve the right to change the terms of this notice and will inform you of any such changes. You then have the right to object or withdraw as provided in this notice.

Complaints.
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

This notice becomes effective on/or before April 13, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with HIPAA Officer in person or by phone at the main office

By signing below, you acknowledge the accuracy of these forms and understanding of the HIPAA Notice of Privacy Practices.

_____ _____

Responsible Party Signature Title
(Patient or guardian if under 18 as applicable)