



**Cedar Crest  
Hospital, RTC & Clinic**

*Cedar Crest Hospital & RTC - Patient Questionnaire*

Place Label Here

*Patient Questionnaire*

Patient Full Name: \_\_\_\_\_ M/F Date \_\_\_\_\_ Time \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

City/State \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

**Emergency Notification:** \_\_\_\_\_

**Emergency Phone Number:** \_\_\_\_\_

**Supporting Documents Obtained:** Birth Cert., SS Card, Custody Papers, 2085 & 2085A, Power of Atty.

(1) Parent, Name \_\_\_\_\_

Guardian, Relationship/Agency \_\_\_\_\_

Caseworker Address: \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Work Ph. \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_

Fax #: \_\_\_\_\_ email: \_\_\_\_\_

(2) Parent, Name \_\_\_\_\_

Guardian, Relationship/Agency \_\_\_\_\_

Caseworker Address: \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Work Ph. \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_

Fax #: \_\_\_\_\_ email: \_\_\_\_\_

**Medicaid** \_\_\_\_Y \_\_\_\_N # \_\_\_\_\_

**Who Referred you to Cedar Crest:** Name \_\_\_\_\_ Phone \_\_\_\_\_

**ADMISSIONS STAFF TO COMPLETE:**

PHYSICIAN/CLINICIAN:

PROGRAM: ACUTE RTC Cottage # \_\_\_\_\_ Admission Date \_\_\_\_\_ Time \_\_\_\_\_

Religious Preference \_\_\_\_\_ Race \_\_\_\_\_

Place Label Here

**DEVELOPMENTAL/SOCIAL/MEDICAL HISTORY – “PARENT’S REPORT”**

Child’s Name \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

Your Name and Relationship to Child: \_\_\_\_\_

*Instructions: Please read each question, mark an “X” in the appropriate box and add comments where needed.*

Mother’s Pregnancy with Child: If information for this section is unknown mark here: \_\_\_\_\_

Delivery:  Vaginal  C-Section Labor Induced:  Y  N Forceps used:  Y  N

Were there complications?  Y  N If Yes,  Diabetes  Premature Labor  Toxemia  Preeclampsia

Full Term Pregnancy:  Y  N If “No”, at how many weeks was your child born? \_\_\_\_\_

How much did your child weigh? \_\_\_\_\_ How long did your child remain in the hospital after giving birth? \_\_\_\_\_

Were tobacco, alcohol, or street drugs used during pregnancy?  Y  N If “yes”, explain: \_\_\_\_\_

**DEVELOPMENTAL DELAYS:** If information for this section is unknown mark here: \_\_\_\_\_

Mobility- Crawling, Walking: \_\_\_\_\_

Speech- 2 words 3-6 words together: \_\_\_\_\_

Potty trained (Out of diapers)  1½-2  2 ½ - 3 yrs  3-3 ½ years  older than 3 ½ yrs

**SOCIAL:** Does your child talk easily with others?  Y  N Does your child play well with other children?  Y  N

Does your child have friends?  Y  N Is your child sexually active?  Y  N

(comments): \_\_\_\_\_

**Support System:**

Does your child have supportive relationships?  Parents  Grandparents  Siblings  Aunts/Uncles  
 Close Friends  Boyfriend/Girlfriend  Guardians  Church Family  Other \_\_\_\_\_

**RELIGION & SPIRITUAL ORIENTATION:** If information for this section is unknown mark here: \_\_\_\_\_

Religious Preference: \_\_\_\_\_

Does your child attend church/synagogue/mosque?  Y  N \_\_\_\_\_

How important is your child’s faith in his/her everyday life? (rate on a scale of 1-10 with 10 – highest) \_\_\_\_\_

Is there a spiritual issue troubling your child?  Y  N \_\_\_\_\_

**MEDICAL REVIEW OF SYSTEMS - "PARENT'S REPORT"**

Check if problems are:  = Current or  = Past

Place Label Here

**Sleeping:** How many hours does your child sleep? \_\_\_\_\_ How long does it take your child to fall asleep? \_\_\_\_\_  
 If your child wets the bed, how often does this occur? \_\_\_\_\_

**When was your child's last physical exam?** \_\_\_\_\_ **Last dental exam?** \_\_\_\_\_

<u>Has your child ever had the following tests:</u>	<u>Date</u>	<u>Results</u>
Hearing tests/Vision tests <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____
EEG (Brain wave tests)? <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____
CAT scan/MRI (Brain Scan) <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____
EKG (heart test)? <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____
Neurological Evaluation <input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____

**Does your child have a history of head trauma?**  Y  N At what age? \_\_\_\_\_ Was there a loss of consciousness?  Y  N

If yes, please explain: \_\_\_\_\_

**Past or Present medical condition?**  Y  N If yes, list year and the reasons: \_\_\_\_\_

**Medical hospitalizations?**  Y  N If yes, list year and the reasons: \_\_\_\_\_

**Surgeries/operations?**  Y  N If yes, list year and the reasons: \_\_\_\_\_

**Immunizations Received:**  Up-to-date, details unknown

Hepatitis B <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	Polio (OVP) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?
Diphtheria/Tetanus/Pertussis (DTP) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	Measles/Mumps/Rubella (MMR) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?
Hemophilus Influenza (HIB) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	Chicken Pox (VARICELLA) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?

Has your child ever had Chicken Pox?  Y  N If yes, when and at what age? \_\_\_\_\_

Please list upcoming appointments for: Medical, Dental, Therapy, Psychiatrist, Psychological testing or school testing : \_\_\_\_\_

**Family Medical History:** Has the patient's parents, brothers, sisters or children ever had (check boxes and indicate):

If information for this section is unknown mark here: \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Seizures _____               | <input type="checkbox"/> Lung Problems _____    |
| <input type="checkbox"/> Psychological Problems _____ | <input type="checkbox"/> Stomach Problems _____ |
| <input type="checkbox"/> Thyroid _____                | <input type="checkbox"/> Arthritis _____        |
| <input type="checkbox"/> Heart Problems _____         | <input type="checkbox"/> Cancer _____           |
| <input type="checkbox"/> High Blood Pressure _____    | <input type="checkbox"/> Kidney Problems _____  |
| <input type="checkbox"/> Diabetes _____               |   |

Place Label Here

**MEDICATION RECORD – “PARENT’S REPORT”** Parents, please CIRCLE the medications taken in the PAST and indicate

the maximum dose taken and why the medication was stopped.

<b>ANTI-DEPRESSANTS</b>	<b>Maximum Dose and Reason Stopped</b>	<b>STIMULANTS</b>	<b>Maximum Dose and Reason Stopped</b>
Anafranil (Clomipramine)		Adderall	
Celexa (Citalopram)		Adderall XR	
Desyrel (Trazodone)		Ritalin LA	
Effexor XR (Velafaxine)		Concerta	
Luvox (Fluvoxamine)		Dexedrine (Dextroamphetamine)	
Paxil (Paroxetine)		Dexedrine Spansule	
Prozac (Fluoxetine)		Metadate CD	
Remeron (Mirtazapine)		Ritalin (Methylphenidate)	
Serzone (Nefazadone)		Ritalin SR	
Tofranil (Imipramine)			
Wellbutrin (Bupropion)		<b>ANTI—PSYCHOTICS</b>	
Wellbutrin SR		Geodon (Ziprasidone)	
Wellbutrin XL		Haldol (Haloperidol)	
Zoloft (Sertaline)		Orap (Pimozide)	
Lexapro		Risperdal (Risperidone)	
		Seroquel (Quetiapine)	
<b>MOOD STABILIZERS</b>		Thorazine (Chlorpromazine)	
Depakote (Divalproex Sodium)		Zyprexa (Olanzapine)	
Depakote ER		Mellaril (Thioridazine)	
Lithium		Abilify	
Lithobid			
Eskalith		<b>BENZODIAZEPINES</b>	
Neurontin (Gabapentin)		Ativan (Lorazepam)	
Tegretol (Carbamazepine)		Klonopin (Clonazepam)	
Topamax (Topiramate)		Xanax	
Trileptal			
Lamictal		<b>ADDITIONAL MEDS</b>	
		Ambien (Zolpidem)	
<b>OTHER MEDS</b>		Benadryl (Diphenhydramine)	
Strattera		Clonidine	
Sonata (Zaleplon)		Cogentin (Benztropine)	
Tenex			
Vistaril (Hydroxyzine)			

**CURRENT NON-PRESCRIPTION MEDICATION/HERBAL SUPPLEMENTS – VITAMINS (Used Regularly)**

Medication Name

Dose/Frequency

Date Started

Date of Last Dose

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Place Label Here

**BEHAVIOR CHECKLIST – “PARENT’S REPORT”** (Parents please check “Y” or “N” for all behaviors)

**Attention Deficit/Hyperactivity Behavior** (Check those that occurred before age 7)

(Staff Comments: Indicate INTENSITY and DURATION of symptoms, if applicable)

- Y N Restless, fidgets, short attention span, cannot remain seated \_\_\_\_\_
- Y N Excessive energy, acts as if driven by a motor \_\_\_\_\_
- Y N Talks excessively, cannot play quietly, interrupts others \_\_\_\_\_
- Y N Avoids tasks which take time and effort/has difficulty organizing tasks \_\_\_\_\_
- Y N Frequently loses things, often forgetful \_\_\_\_\_

**Oppositional/Defiant Behavior**

- Y N Angry, resentful, blames others for own mistakes \_\_\_\_\_
- Y N Frequently tries to get back at others/vengeful \_\_\_\_\_
- Y N Often loses temper \_\_\_\_\_
- Y N Frequent use of obscenities \_\_\_\_\_
- Y N Refuses to comply with adult requests/will argue with adults \_\_\_\_\_

**Conduct Problems/Criminal Behavior**

- Y N Has used a weapon \_\_\_\_\_
- Y N Cruel to animals \_\_\_\_\_
- Y N Cruel to people \_\_\_\_\_
- Y N Has deliberately set fires \_\_\_\_\_
- Y N Destructive to property, broken into homes, business, cars \_\_\_\_\_
- Y N Stealing: money or objects \_\_\_\_\_
- Y N Lies to obtain favors or objects \_\_\_\_\_
- Y N Has forced someone into sexual activity \_\_\_\_\_
- Y N School detentions, suspensions, truant, runaway \_\_\_\_\_

**CURRENT SERVICES**

Place Label Here

<b>PSYCHIATRIC MEDICATION MANAGEMENT</b>	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
<b>OUTPATIENT THERAPIST</b>	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
<b>FAMILY PHYSICIAN (PCP) OR PEDIATRICIAN</b>	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
<b>CHILD PROTECTIVE SERVICES</b>	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
<b>COUNTY MH-MR</b>	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
<b>SCHOOL CONTACT</b>	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
<b>PROBATION OR PAROLE OFFICER</b>	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
<b>SUBSTANCE ABUSE TREATMENT</b>	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____
<b>(OTHER)</b>	Name/Relationship: _____ Last Seen: _____ Next Appt. _____	Phone: _____ City: _____ Duration: _____

Questionnaire Completed by: (X) \_\_\_\_\_ (Signature of parent/guardian and relationship) \_\_\_\_\_ (date and time)

Questionnaire Reviewed by: (X) \_\_\_\_\_ (Staff signature and title) \_\_\_\_\_ (date and time)