BRIGHTSTAR
Child and Adolescent Psychiatry

681 Morganton Square Drive
Maryville, TN 37801-4763
Phone (865) 724-1590
Fax (865) 724-1591

CHILD/TEEN REGISTRATION

Dear Parent/Guardian, the information you provide by completing this form will help your provider identify your child's needs. Please use additional sheets if more room is needed.

Child's Name:_____Birth Date:_____Age:_____

Child's Address: _____

If teen is age 18 or older, please provide Social Security number: _____

This form was completed by:_____Date:_____

Who has legal custody of this patient? (Who can legally make medical decisions about the child's care)

_____

Who referred you to our office? _____

FAMILY DEMOGRAPHICS

FATHER or MALE CAREGIVER'S INFORMATION

Name:_____Age:_____Occupation:_____

Social Security number: _____

Living in home? Yes ☐ No ☐ If not, address_____

Relationship: Biological Father ☐ Adoptive Father ☐ Stepfather ☐ Other ☐

Marital status:_____

Telephone: (home)_____(work)_____(cell)_____

MOTHER or FEMALE CAREGIVER'S INFORMATION

Name:_____Age:_____Occupation:_____

Social Security number: _____

Living in home? Yes ☐ No ☐ If not, address _____

Relationship: Biological Mother ☐ Adoptive Mother ☐ Stepmother ☐ Other ☐

Marital status:_____

Telephone: (home)_____(work)_____(cell)_____

MAIN CONCERNS / REASON FOR REFERRAL

Please list your primary concerns about your child: _____

_____

_____

How long have you had these concerns? _____

What are your goals of treatment for your child? _____

_____

_____

Does your child have problems with activities of daily living (dressing, feeding, grooming, bathing)?

_____

_____

Please check if your child has exhibited any of the following behaviors:

BEHAVIOR	PAST CONCERNS	PRESENT CONCERNS
Has trouble hearing		
Is overly sensitive to sounds		
Has visual problems		
Tilts his/her head to look at items		
Has daytime toileting accidents		
Flaps or spins repeatedly		
Has poor eye contact		
Does not play with other children		
Is preoccupied with interests		
Cannot tolerate a change in routine		
Is very sensitive to textures		
Stares into space as if in a trance		
Is easily frustrated		
Has frequent tantrums		
Rarely smiles, giggles, or laughs		

BEHAVIOR	PAST CONCERNS	PRESENT CONCERNS
Has problems sleeping		
Has unusual fears		
Has nightmares		
Sleepwalks		
Eats things that are not food		
Goes on diets		
Is aggressive toward other people		
Is cruel to animals		
Runs away from home		
Shoplifts/steals		
Lies frequently		
Is depressed/sad		
Isolates/withdraws socially		
Is irritable/angry		
Has rapid/intense mood swings		
Has explosive outbursts		
Has had significant weight change		
Has had appetite changes		
Worries excessively/is anxious		
Has declining school grades		
Refuses to attend school		
Exhibits paranoid thinking		
Has sudden, recurring movements (blinking, head jerking, shrugging)		
Has sudden vocalizations (chirping, sniffing, snorting, coughing)		
Uses sexually inappropriate language		
Exhibits sexually inappropriate behavior		
Has “melt downs”		
Has lost interest in doing fun things		

CHILD'S PAST PSYCHIATRIC HISTORY

Please list your child's past psychiatric and psychological evaluations and therapy or counseling provided by school, physicians, clinics, counselors, or psychologists (include phone number if possible).
Please note the **date**, **location, and results** of the testing and therapy. ***PLEASE BRING EVALUATIONS TO FIRST APPOINTMENT.***

Has your child ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No Please explain:

Has your child attempted suicide? ☐ Yes ☐ No Please explain:

Has your child engaged in self-injurious behaviors? ☐ Yes ☐ No Please explain:

Has your child been abused? ☐ None ☐ Physical ☐ Sexual ☐ Emotional Please explain:

Was Child Protective Services involved? ☐ Yes ☐ No Please explain:

Has your child used or abused alcohol, marijuana, opioid medications, or other recreational substances?

☐ Yes ☐ No Please explain:

Has the child ever misused or taken more medication than prescribed? ☐ Yes ☐ No Please explain:

Are there any substances you fear that your child may be abusing? ☐ Yes ☐ No Please explain:

Has your child used medication that was prescribed for someone else? ☐ Yes ☐ No Please explain:

Has your child ever received counseling for substance abuse? ☐ Yes ☐ No Please explain:

Please list any **past** psychiatric medications your child has taken:

Medication	Reason for med	How long taken	Reason stopped	Side effects

Please list any **current** psychiatric medications your child is taking: _____

_____

_____

Please list any medication side effects your child is experiencing: _____

_____

_____

CHILD'S MEDICAL HISTORY

Child's primary healthcare provider's name: _____

Date of last comprehensive physical exam: _____

Child's current weight: _____ Child's current height : _____

Child's medication allergies: _____

Has your child seen medical specialists (cardiologists, neurologists, etc.)? ☐ Yes ☐ No Please explain:

_____

_____

Has your child been hospitalized for medical reasons? ☐ Yes ☐ No Please explain:

_____

_____

Has your child ever required surgery? ☐ Yes ☐ No Please explain:

_____

_____

List any seizures, head injuries, concussions, loss of consciousness, or neurological evaluations:

_____

Has your child experienced physical trauma or injuries? ☐ Yes ☐ No Please explain:

_____

Does your child have food or environmental allergies? ☐ Yes ☐ No Please explain:

_____

Please check any of the following medical illnesses or problems your child has had:

Frequent ear infections	☐	Shortness of breath	☐
Hearing problems	☐	Fainting	☐
Eye problems	☐	Heart defect	☐
Swallowing problems	☐	Prior EKG	☐
Thyroid disease	☐	Encephalitis	☐
Headaches	☐	Meningitis	☐
Ear Tubes	☐	Low blood count/anemia	☐
Cardiac arrhythmias	☐	Accidents	☐
Heart murmurs	☐	Broken bones	☐

Other: _____

Please list any medication your child is currently taking including over-the-counter medication, herbal supplements, diet pills, etc.:

Medication For how Long? Reason for taking medication

_____

_____

To the best of your knowledge is your child sexually active? ☐ Yes ☐ No Other relevant information:

_____

If child is a female, has menstrual cycle begun? ☐ Yes ☐ No Age of onset? _____

What is your child's gender identity? ☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Nonconforming

What was your child's assigned sex at birth? ☐ Male ☐ Female

NUTRITIONAL HISTORY

Does your child have any problems with chewing, swallowing, choking, feeding? ☐ Yes ☐ No Please explain:

_____

Does your child have any food allergies or intolerance? ☐ Yes ☐ No Please explain:

_____

_____

Has your child gained or lost 10 lbs or more of weight in the past 6 months? ☐ Yes ☐ No Please explain:

_____

Are there any concerns that your child may have an eating disorder? Vomiting? Excessive dieting? Excessive exercising?

Low caloric intake? ☐ Yes ☐ No Other concerns: _____

_____

PREGNANCY AND BIRTH HISTORY

Prenatal history (*questions refer to the pregnancy of the child who is being evaluated.)*
Please recall the best you can:

Did the mother during pregnancy …	Yes	No	Comments
Take any medications?			
Smoke tobacco			
Drink alcohol			
Use any other drugs			
Experience physical or emotional abuse			

Please explain if there were any complications during the pregnancy: _____

_____

Labor history:

Was the baby full term? ☐ Yes ☐ No Please explain: _____

Were there any problems with delivery? ☐ Yes ☐ No Please explain: _____

_____

What was the birth weight of the child? _____

Length of stay in hospital: Mother: _____ days Child: _____ days

Any problems shortly after birth? _____

_____

DEVELOPMENTAL AND SKILL PROFILE

Between the ages of 0 and 2-years-old, was your child:

	Yes	No
Extremely sensitive to slight changes in touch, sound level, lighting, etc.?		
Unable to develop a regular sleeping pattern?		
Impossible or very difficult to soothe or calm self when distressed/upset?		
Unable to separate from parents without extreme distress		
Unable to show affection?		

Check the boxes as appropriate to describe developmental milestones.

Milestone	On time	Early	Late	Don't know
Walked alone				
Said first words				
Daytime toileting				
Bladder training				
Bowel training				
Tied shoelace				
Wrote name				

What are your child's strengths?_____

_____

Please list your child's leisure time activities (sports, clubs, internet use, social networking sites):

_____

_____

Please list any problems with use of TV, internet, or cell phone:

_____

_____

What is your family's religious or spiritual affiliation? _____

Does your child have religious, spiritual, or cultural practices your provider needs to be aware of during treatment? _____

_____

_____

EDUCATIONAL HISTORY

Name of current school:_____ Location:_____

Grade: _____

Teacher's name:_____ Phone #:_____

Counselor's name:_____ Phone #_____

How many schools has your child attended? _____

What are the average grades your child receives? _____

Has child repeated a grade or subject? ☐ Yes ☐ No What subject or grade? _____

Please list any subjects your child is currently failing, if any: _____

Has child been suspended or expelled? ☐ Yes ☐ No Please explain: _____

_____

Has your child received special education services or other academic support like an IEP or 504 plan? If yes, please briefly describe below and bring a copy of the plan to your child's first appointment: _____

_____

Any history of occupational therapy, speech therapy, or counseling in the school setting? Please explain: _____

_____

Please indicate any problems your child has in school:

Reading	☐	Spelling	☐
Writing	☐	Math	☐
Does not get along with teachers	☐	Does not get along with students	☐

Other: _____

FAMILY SOCIAL & MEDICAL HISTORY

If your child has other parents or stepparents, please provide the information below:

Name Relationship to this child Location (city, state)

_____

_____

_____

_____

Please list everyone living in household:

Name (last, first) Age Relationship

_____

_____

_____

_____

_____

_____

Please list siblings not living with your child:

Name (last, first) Age Relationship

_____

_____

_____

_____

Who is the child's primary healthcare provider? _____

How many hours per day is your child in a school or child-care setting? _____

If child is not living with biological parents, please state the reason: _____

_____

Please check any significant stressors your family has experienced in the past year:

Death in the family	☐	Military deployment	☐
Divorce or separation	☐	Work stressors	☐
Significant illness or injury	☐	Financial problems	☐
Child or spouse abuse	☐	Legal problems	☐

Please circle to what extent you and your spouse agree on how to discipline your child:

Never agree				Always agree
1	2	3	4	5

What methods of discipline do you typically use?

Time out	☐	Ground	☐
Take privileges (phone, games, etc.)	☐	Spank or hit	☐
Give rewards for doing well	☐	Yell	☐
"1-2-3 Magic" or other behavior course	☐	Talk to child	☐

Other methods used:_____

Please indicate below child's biological family with a history the problems listed:

	Child's father	Father's family	Child's mother	Mother's family	Child's siblings
Attention difficulty					
Hyperactivity					
Intellectual disability					
Autism spectrum disorder (Asperger's)					
Autism					
Substance abuse					
Seizures					
Heart problems					
Tourette's syndrome					
Eating disorder					
Anxiety or nervousness					
Schizophrenia					
Bipolar disorder					
Nervous breakdown					
Mental health hospitalization					
Depression					
Self-harm					
Suicide attempt					
Death by suicide					
Sudden death					
Incarceration					
Extreme mood swings					

Other:_____

_____

_____

_____

_____

RISK ASSESSMENT

	Yes	No
Are there firearms in any homes where your child resides?		
Is there any history of violence in the home?		
Has the family ever been referred to Child Protective Services?		
Does your child have a history of suicidal thoughts or behaviors?		
Does your child have current suicidal thoughts or behaviors?		
Does your child have a history of homicidal thoughts or behaviors?		
Does your child have current homicidal thoughts or behaviors?		
Does your child drive a vehicle?		
Does your child wear a seat belt while driving a vehicle?		
Does your child talk on the phone or text while driving?		
Does your child wear a seat belt while riding in a vehicle?		
Do you have any safety concerns at this time?		

Please explain: _____

ADDITIONAL INFORMATION

Please use this space to add any information you consider important to the child's evaluation: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you