

Tampa General Hospital Behavioral Health Hub

Telepsychiatry Mental Health Background Information:

Demographics:

Name of the person completing this form:	
Relationship to the child:	
Phone #:	Email:
Child's full legal name:	Child prefers being called:
Child's Date of Birth:	Age:
Race:	Ethnicity:
Gender:	Religion:
Child's Primary Care Provider:	

Household info: Please list who lives in the same household as the child:

Name	Sex	Age	Relationship to Child

Psychiatric History:

What are the main concerns that you have about the child's behavior or emotions? _____

How long have you had these concerns?

Has the child ever attempted suicide? Yes No describe:

Does the child engage in any self-harm behaviors (like cutting)? Yes No describe: _____

Has the child ever been violent? Yes No describe:

Has the child ever been aggressive? Yes No describe:

Does the child use alcohol? Yes No describe:

Does the child use tobacco or vape? Yes No describe:

Does the child use illegal drugs? Yes No describe:

Has the child ever seen a psychiatrist or therapist/counselor before? Yes
 No

Name of provider	Dates seen	Reason

Has the child ever been admitted to a psychiatric hospital? Yes No

Name of psychiatric hospital	Dates admitted	Reason

Family History: Please identify any known psychiatric illnesses in blood relatives of the child.

Diagnosis	Child's Mother	Child's Father	Childs Siblings	Mothers familial side	Fathers Familial side
Anxiety					

Attention Deficit/Hyperactivity Disorder					
Autism					
Bipolar Disorder					
Depression					
Eating Disorder					
Intellectual Disability of learning problems					
Psychosis					
Schizophrenia					
Substance Misuse (alcohol, drugs)					
Suicide					

Social History:

Name of current school:	
Current grade:	List grades repeated or NA:
IEP or 504 plan <input type="checkbox"/> Yes <input type="checkbox"/> No	ESE or special needs classes <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe school issues (behavioral and academic):	

Development History:

Has anything significant occurred during the child's developmental years? (delayed, delayed, etc.):

Testing History:

Any history of IQ or achievement testing? Yes No

Ever been tested for hearing abnormalities? Yes No

Ever been tested for speech/ language abnormalities? Yes No

Has the child ever received occupational or physical therapy? Yes No

Other: Has the child experienced any of the following:

Adoption Yes No Are they aware? Yes No Please describe:

Foster care/removal of child from home Yes No Please describe:

Other separation from parent/family Yes No Please describe:

Conflicts with parents Yes No Please describe:

Illness in family Yes No Please describe:

Death of a parent, loved one, close friend Yes No Please describe:

Family financial problems Yes No Please describe:

Loss of home Yes No Please describe:

Parent separation/divorce Yes No Please describe:

Unwanted pregnancy Yes No Please describe:

Victim of crime or violence Yes No Please describe:

Other:

Please elaborate on any of the above, how they have affected the child, and any symptoms as a result.
