Janet Lee Kemp, M.D., LLC
Adolescent & Child Form

Hi! Please fill out the best you can, as it will help me format the initial evaluation. Thank you!

Today's Date: _____

Child's Name: _____

Legal guardian(s): _____

Name of Pediatrician: _____

Name of Therapist (current)_____

Who Referred you: _____

School and Grade : _____

Please identify members of the child's household:

Name	Age	Relationship to Child	Living in the home?	Occupation
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	

Additional information on family:

Please list 3 goals for your child for the treatment:

1)

2)

3)

What are your child's strengths:

What are your child's hobbies, interests?

Please briefly comment if any of the below are concerns (a few examples listed below) :

Mood (depressed, anxious, panic attacks, obsessions/compulsions, mood swings):

Energy level (fatigue, hyperactivity)

Concentration (difficulty focusing, staying on task, distractibility)

Appetite (excessive, loss of, picky eating, weight changes)

Sleep (onset, maintenance, snoring, daytime sleeping)

Behavioral (rages, tantrums, impulse control)

Social (making friends, keeping friends, picking up social cues, relating to others, family dyanmics)

Coping Style (rigid, inflexible, accommodating, passive, aggressive)

Academics (change in grades, comprehension)

Any concerns during the child's early years, pregnancy, delivery, reaching milestones (talking, walking), sensory, temperament:

Please list child's school history:

Does your child have any accommodations in the school (MFE, IEP)? Yes / No
If yes, when was it implemented, did the child receive psychological testing if so when?

Please list any family history of psychiatric conditions (include mood disorders, academic difficulties, struggles socially, substance use):

Please list any medical history , please see below for a list of general checklist of conditions but not limited to:

Cardiovascular (murmurs, blood pressure abnormalities) , Endocrine: (thyroid, hormonal)

Hematologic: (anemia, blood related, abnormal bleeding) , Musculoskeletal: (muscle, bones)

Neurological (ex. seizures, injuries, tremors, migraines, concussions) , Nutritional (Vitamin deficiencies)

ALLERGIES:

Please list prior treatments (psychiatrists, counselors, treatment centers, substance use treatment) and dates:

Please list prior medications, dates, benefits, side effects:

Current list of medications (including non psychiatric medications) and response / side effects:

Additional Information: