Iadeluca NP Psychiatry PLLC

Iadeluca NP Psychiatry
7 Corporate Drive
Clifton Park, New York, US - 12065

Iadeluca NP Psychiatry Child/Adolescent New Intake

Your child's name: *

Your child's age: *

Your child's date of birth: *

Who has referred your child?

Who is the legal guardian for the child? If formal custody is established, please provide proof during your appointment. *

Address(es): *

Phone number(s): *

Who is your child's primary care doctor?

Do you consent for Kaitlynn Iadeluca to collaborate and share information with your primary care provider? *

Do you consent for Kaitlynn Iadeluca to collaborate and share information with your therapist? *

What are the problem(s) for which you are seeing help for your child?* *

Current Symptoms

- ☐ Depressed mood,
- ☐ Unable to enjoy activities,
- ☐ Sleep pattern disturbance,
- ☐ Loss of interest,
- ☐ Concentration/forgetfulness,
- ☐ Change in appetite,
- ☐ Excessive guilt,
- ☐ Fatigue,
- ☐ Racing thoughts,
- ☐ Impulsivity,
- ☐ Increase risky behavior,
- ☐ Decreased need for sleep,
- ☐ Excessive energy,
- ☐ Anger Outbursts,
- ☐ Physical aggression,
- ☐ Increased irritability,
- ☐ Crying spells,
- ☐ Excessive worry,
- ☐ Anxiety attacks,
- ☐ Avoidance,
- ☐ Prominent defiance,
- ☐ Prominent oppositional behaviors,
- ☐ Self-injury,
- ☐ Hallucinations,
- ☐ Suspiciousness

Prior Psychiatric Treatment

Has your child previously seen a psychiatrist or a therapist

☐ Yes ☐ No

Please provide the name/details of your child's therapist

Please provide name/details of previous psychiatrist

Previous diagnoses?

Please describe any previous medication trials

Medications

Medication Name	Intake Details

Any history of difficulty adhering to a medication regimen? (ie forgetting or stopping medications frequently)

Allergies

Allergies	Type	Severity	Reactions

Family History

Does anyone in the family suffer from physical health issues (ie hypothyroidism, cancer, etc). Please provide relationship to your child and diagnosis (if known)

Does anyone in your family suffer with mental health problems or substance abuse issues. Please provide relationship to your child and diagnosis & medications (if known)

Medical History

Does your child have any medical issues?

Date of last annual physical exam?

Any prior surgeries/hospitalizations?

Age of 1st period? _____

Last menstrual period? _____

Any history of head injury or seizure?

School

Which school does your child attend?

Which grade is your child in?

Is your child in special education classes

Has school contacted you with concerns about your child?

Developmental History

Is your child adopted?

If so, details of adoption? (ie age, current relationship with biological family)?

Pregnancy: ☐ Planned ☐ Unplanned

Any complications during pregnancy or following birth

Any exposure to substances (prescriptions medications, nicotine, alcohol, drugs) in utero?

Did your child meet developmental milestones (ie walking, talking, toileting) at the right age?

Did you child require early intervention, speech, occupation, or physical therapies?

Social History

Who does your child live with?

Are any of the parents in the military?

Are there any stressful events experienced by the family (for example death of a loved one, move, financial difficulties etc)

Has your child ever been exposed to any trauma/abuse? If so, please include ages and details.

Has your child ever used Alcohol, Tobacco, Marijuana or any other illicit drugs?

Has your child ever had any legal problems?

Does your child have access to firearms in the home(s)? *

Other:

Any other concerns or information you would like to include?