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**New Patient Registration and History Form**

Date Completed:

**Patient Name:** **Age:** **Date of Birth**: **Gender:** F / M

Please Print

Address: Occupation/Name of School & Grade: State: Zip:

Home Phone:( ) Work Phone: ( ) Cell Phone:( ) E-Mail:

For Pediatric Patients:

**Parent Name Parent Name:**

Address: Address:

State: Zip: State: Zip:

Cell Phone:( )

Occupation:

Employer:

Highest Education:

**Referred by: Pediatrician/PCP:**

Address: Address:

State: Zip: State: Zip:

Phone:( ) Phone:( )

**Person responsible for paying this account:**

Name: Relationship to patient:

Address: State: Zip:

Phone:( ) E-Mail:

All professional services are charged to the patient (or parent/guardian, if the patient is a minor), and are payable in full at time of service. Statements are provided but insurance filing is the payer’s responsibility. Dr. Ceranoglu does not take responsibility for any future insurance reimbursement. The patient (or parent/guardian) is responsible for all fees. Please note that Dr. Ceranoglu is *not* affiliated with insurers through his Private Practice. In the event that he is ‘in-network’ at Massachusetts General Hospital and you attempt to seek reimbursement independently at a future time you may be unsuccessful. Please sign below to express your understanding of the terms above.

**Signature:** **Date:**

**Print Name:** **Relationship to patient:**

*Thank you for filling out this form. Please consider including a signed* ***Authorization for Release and Receipt of Protected and Privileged Information Form****, a signed* ***Consent to Treatment Form*** *and a signed copy of* ***Office Policy Statement*** *within your package in order to make use of our time more efficiently.*

**Chief Complaint:** Please describe your (child’s) main symptoms or concerns.

**History of the Presenting Illness:** (Please provide a brief history of these problems)

When did these symptoms begin?

When were these first noted by family members?

Did something occur to precipitate them?

Course of symptoms:

Did the symptoms occur suddenly or gradually over time?

What are the times or settings the symptoms present? Have there been symptom free episodes?

**HPI:** (office use only)

**Problem Behavior Checklist:** Do you/your child have any of the following problems?

|  |  |
| --- | --- |
| **Symptom**  (please circle all that apply) | **Describe**  **(Past** or **present,** and **Age of Onset)** |
| Short attention span (distractible, doesn’t listen, can’t finish work, difficulty organizing work) |  |
| Impulsivity (acts before thinking, cannot wait turn) |  |
| Hyperactivity (motor over-activity) |  |
| Frequent accidents |  |
| Irritable, poor frustration tolerance |  |
| Easily riled up |  |
| Picks on others |  |
| Feels picked on |  |
| Teases others unmercifully |  |
| Bad temper |  |
| Gets out of control |  |
| Gets violent and aggressive |  |
| Cruel to animals |  |
| Fire setting |  |
| Get giddy and silly |  |
| Cry easily |  |
| Feeling that life is not worth living |  |
| Self-injurious/abusive behavior |  |
| Changes in concentration |  |
| Changes in energy during the day |  |
| Lack of interest or pleasure in activities |  |
| Isolate self from others |  |
| Sadness |  |

**Problem Behavior Checklist** *(Continued from previous page)*

|  |  |
| --- | --- |
| **Symptom**  (please circle all that apply) | **Describe**  **(Past** or **present,** and **Age of Onset)** |
| Changes in appetite or weight |  |
| Changes in amount of sleep (increase/decrease) |  |
| Problem falling or staying asleep |  |
| Early morning awakening |  |
| Wanting to hurt someone |  |
| Weight gain/loss |  |
| Worries a lot or excessively |  |
| Episodes of sudden panic/intense fear |  |
| Afraid to be alone |  |
| Fear of the dark |  |
| Other specific fears |  |
| Reluctance to go to school |  |
| Excessive concern about body defects |  |
| Hearing, seeing or feeling things that others do not |  |
| Get special messages from TV, radio, magazine, etc. |  |
| Talk a lot more or rapidly than usual |  |
| Act out of character, behave in ways that are regretted |  |
| Feel more energetic, needing much less sleep than usual |  |
| Obsessive thoughts (repeated, unwanted thoughts) |  |
| Compulsive behaviors (repetitive, distressing actions, such as counting or checking excessively) |  |
| Rituals (has to repeat same actions before sleep, school, etc.) |  |
| Hair pulling |  |
| Sensory urges or unusual sensation before tics |  |

**Treatment History:**

Please list **previous** medications that have been used:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of medication | Dates | Helpfulness | Side effects |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please list **current** medications:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of medication | Dosage & Frequency | Helpfulness | Side effects |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Name of Psychiatrist/Physician who prescribes these medications?

Address: Phone:

What other treatment have you/your child tried?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name of Professional consulted | Date | Phone Number |
| Individual Therapy/Counseling: |  |  |  |
| Family Therapy: |  |  |  |
| Behavioral Therapy: |  |  |  |

**Past Psychiatric History:** Please detail any hospitalizations or other treatments not directly related to the current problem or not included above.

**PPH:** *(Office use only)*

**Medical History:**

Current Medical Problems:

Current Medications:

*(Include vitamins, over-the-counter-medications, herbal remedies)*

**Allergies?** Yes / No – If Yes, to what?

Drug Reactions? Yes / No – If Yes, to what?

Do you smoke cigarettes? Yes / No How many?

Do you drink alcohol/use drugs? Yes / No – If yes, how much?

If female, are you pregnant? Yes / No If using contraception, what type?

**Past Medical History:** Please describe, including dates.

Previous illnesses:

Hospitalizations:

Surgery:

Please circle any which patient has had and include dates:

Head injury causing loss of consciousness

Seizures / convulsions / trance-like episodes

Other nervous system problems

Ear, nose or throat problems

Dental problems

Asthma

Other chest problems

Stomach or bowel problems / soiling

Urinary or bladder problems / wetting

Gynecological/menstrual problems

Heart Problems

Rheumatic fever / Strep infections

Encephalitis / Meningitis

Liver / Kidney problems

Skin problems

Joint / Limb problems

Trouble walking

Hearing / Vision problems

Growth / Endocrine problems

Serious accidents / Fractures

Childhood measles / Mumps / Chicken pox

Double vision

Tremor

Chronic dizziness

Unexplained poor coordination

Trouble walking

Memory problems

Other:

Girls: Age at first menstrual period Is menstruation regular? Are there any difficulties related to menstrual periods? Please explain

Are you /Is your child sexually active? YES NO NOT SURE

Do you / Does your child have a regular girl- or boy-friend? YES NO NOT SURE

Have you / your child traveled to a foreign country in the last 10 years? YES NO NOT SURE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Where |  |  | When |  |
|  |  |  |  |  |
|  |  |  |  |  |

Toxic or dangerous chemicals or materials:

Has your child ever been exposed to:

Insulation

Asbestos

Fumes

Metals

Lead

Mercury

Chemicals

Plastics

Solvents

Dyes

**Most recent Physical Exam:**

Date:

Result:

**Immunizations:** Are these up to date? Y / N

DPT

Polio

MMR (Measles/Mumps/Rubella)

HIB

Hepatitis B

Tetanus

Tuberculosis test (PPD)

**Growth:** Please bring any records of height, weight and head circumference to your appointment.

Is there anything else I should know about your child’s medical history?

**Family History:** List names, ages and relationship to all people living in the home:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Age** | **Relationship to patient:** |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

Give dates you/parents were:

Married: Separated: Divorced: Widowed:

List names, ages, relationship and whereabouts of immediate family members not at home:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Relationship to patient** | **Age** | **Whereabouts** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Psychosocial and Family Pedigree** *(office use only)*

**Family Psychiatric History:**

Has any family member had any of the following? Please circle and indicate which family member.

Depression

Mania/Bipolar Disorder

Suicidal thoughts/urges/actions/attempts

Anxiety

Panic

Obsessions/Compulsions

Rituals

Movement Disorder

Tics

Unusual noises / Vocalizations

Eating Disorder

Psychiatric Hospitalizations

Attention Deficit

Hyperactivity

Learning Disability

Coordination Problems

Intellectual Disability

Alcoholism

Drug Use

Legal problems

Psychosis

Autism/PDD/Asperger Disorder

Sleep Disorder

Other:

**Family Medical History:**

Is there anyone in the family with the following conditions? *Please list relationship to the patient.*

Migraine or other chronic headaches Seizures/Epilepsy

Stroke

High or Low Blood Pressure

Heart Murmur

Heart Arrhythmia

Heart Disease

Heart Attack

Sudden Unexplained Death

Tuberculosis

Emphysema

Lung Disease

Asthma

Hay Fever

Stomach Ulcers

Gastric Reflux Disease

Gallstones

Diabetes

High Cholesterol

Liver Disease

Hepatitis

Kidney or Renal Disease

Nephritis

Thyroid Disease

Arthritis

Obesity

Infectious Disease

HIV/AIDS

Glaucoma

Gout

Anemia

Allergies

Hemophilia or Bleeding Tendencies

Alzheimer’s Disease

Dementia

Cancer

Genetic Disorder

**Perinatal History:** [Adultpatients: Please complete to the best of your ability]

Was the pregnancy healthy? Yes / No – If yes, Problems:

Were drugs used during pregnancy? Yes / No – If Yes, what kind?

How often and which months?

Was alcohol used during pregnancy? Yes / No – If Yes, how much? Which months?

Did mother smoke during pregnancy? Yes / No

Was caffeine used during pregnancy? Yes / No – If Yes, how much/often?

Was pregnancy full-term? Yes / No – If No, Problems:

Was labor spontaneous/induced?

Was anesthesia used? Yes / No – If Yes, what type?

Was delivery normal? Yes / No – If No, Problems:

Was child born *(please circle)* head / feet first? Caesarean Section? Yes / No

Birth weight: Did baby have trouble starting to breathe? Yes / No

Was baby jaundiced? Yes / No Required treatment? Yes / No

Was baby *(please circle)* breast / bottle fed? How long? Gained weight adequately? Yes / No

Were there problems in the first week?

first month? first year?

Total number of pregnancies: Live births: Birth order of this baby:

**Developmental History:**

Place of birth: Where raised: Raised by:

Was pregnancy planned? Yes No Not sure

Was there a preference for a boy or girl? Boy Girl Not sure

Describe yourself/your child as an infant *(please circle, and describe)*:

Active / active but calm / passive / other

Cuddly / irritable / withdrawn / other

Cried easily and frequently / reasonable amount / seldom

Soothed easily / soothed with difficulty / average

Response to changes: severe / moderate / mild

Response to being held (describe):

Reaction to strangers: friendly / indifferent / fearful

Describe your (child’s) eating habits: Problems?

Describe your (child’s) sleeping patterns: Problems?

Did you/your child startle easily? Yes / No

Developmental **Milestones** [note age first achieved, brackets are averages only]

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Motor** |  | **Language** |  | **Adaptive** |
| Rolled front/back (4 mo) |  | Mile (4-6 wks) |  | Mouthing (3mo) |
| Sit with support (6 mo) |  | Coo (3 mo) |  | Transfers object (6 mo) |
| Sit alone (9-10mo) |  | Babble (6 mo) |  | Picks up raisin (11-12 mo) |
| Pull to stand (10 mo) |  | Jargon (10-14 mo) |  | Scribble (15 mo) |
| Crawl (10-12 mo) |  | First word (12 mo) |  | Drinks from cup (10 mo) |
| Walk alone (10-18 mo) |  | Follows 1-step commands (15 mo) |  | Uses spoon (12-15 mo) |
| Run (15-24 mo) |  | 2 word-combo (22mo) |  | Wash hands |
| Tricycle (3 yrs) |  | 3 word sentence (3 yr) |  | Undress |
| Bicycle (5 yrs) |  | Speech problems? Y / N |  | Bladder trained |
|  |  |  |  | Bowel trained |

Did your child ever: YES NO NOT SURE

Make strange sounds or use strange language

Have any kind of speech impediment

Require and/or receive speech therapy

Have discontinuous language development

Have language development stop or regress

Often repeat words or phrases he has just learned instead of responding to

what was just said or asked

Use incorrect pronouns to refer to himself (e.g. “he” or “she” instead of

“I” or “me”)

Use incorrect pronouns when referring to others

Seldom or never begin a conversation with someone else (once he could speak)

Only talk to himself, not others

YES NO NOT SURE

Has anyone ever suggested your child might have a developmental delay?

Has anyone ever suggested your child might be mentally handicapped

or retarded

Is your child affectionate and cuddly? Will he sit near you or others?

Will your child look at people, talk to them and interact with them the

way you would expect him to?

Has your child, or does your child, do any of the following; YES NO NOT SURE

Body rocking

Head banging

Hand flapping

Toe walking

Make repetitive nonsense sounds when old enough to speak normally

**Social History:**

Do you /Does your child have any good friends?

What attracted you (your child) to this / these friends?

What do you / they do together? How often do you /they get together?

What is your child best at doing?

What is he/she least good at?

If your child feels guilt or remorse for wrong doings, how does he/she show it?

Does your child feel guilty even when what he/she has done isn’t that terrible?

Does your child seem to like him/herself?

What does he/she like best about him/herself?

Does your child make negative self-statements? What are they?

Does your child feel like a “loser?

Does your child get picked on or teased?

Why? How does he/she handle it?

How does your child handle peer pressure?

Who is your child most likely to confide in?

Which parent is your child closest to?

How does your child get along with Mom?

How does your child get along with Dad?

How does your child get along with siblings?

Is there anything else I should know about your child’s social or developmental history?

**Education History:**

Name of School:Grade: Repeat Grades? Y / N; Which grade?

Address: State Zip

Special/resource classes? If yes, what classes?

Other special services? (Speech-Language, OT)

Academic grades received:

Evaluations performed:

Date: Type: Reason: Results:

Date: Type: Reason: Results:

Relationships with teacher? With peers?

Ability to work independently? Good Average Poor

Organize self? Good Average Poor

Attendance? Good Average Poor

Have you/Has your child received counseling at school? Yes No

School intervention: Other

College:

Post Graduate:

Describe your (child’s) activities/interests/hobbies/skills:

Describe your child’s attitude toward school

What are his/her best subjects?

What are his/her worst subjects?

How have your child’s grades changed over time?

Is there anything else you would like me to know about you (your child)?

**Family Social History:**

Have there been any recent stresses in the family? Please explain.

Has anyone recently left the family or died? Please explain.

Has anyone recently joined the family? Please explain.

Have there been any recent employment changes or job losses? Please explain.

Have there been any recent financial changes (good or bad)? Please explain.

Is there anything else I should know about your family**?**