Ben-Ami Psychiatry Children's Treatment Follow-up

PLEASE FILL OUT BOTH SIDES FOR EVERY FOLLOW UP VISIT

(You can save this to your computer and modify it for each visit, then print it out or email it to me)

Child's Name: Date of Visit: Birth Date: Age:

1) What changes have you seen in your child since the last visit?:

2) What changes have you made in your child's diet, supplements, and therapy since the last visit?:

3) What are your child's current supplements (include amounts)?:

4) What is he eating currently?:

Child's Name: Date of Visit:

5) What are your child's current medications? Do you need any refills?:

6) What is your child's current school placement and therapies?:

7) Have there been any medical problems since the last visit?:

8) How is your child's sleep?:

9) Describe your child's bowels:

10) Are there any unpleasant or problem behaviors?:

11) Describe your child's current language (noises, words, sentences, scripting, asking questions, conversations. How much is understandable?):

12) Describe your child's current social interactions (At home and school, with adults and peers):

13) Describe your child's current interests or behaviors:

14) What issues do you want us to focus on at this visit?:

CHILD/ADOLESCENT SYMPTOM CHECKLIST

Name of Child:_____ Date of Birth: _____ Age:_____ Date:_____

Name of person completing this form:_____ Relationship to child: _____

Please circle the symptoms that apply to this child in the past few weeks:

	Never	Rarely		Sometimes		Always
Hyperactive	0	1	2	3	4	5
Fidgety	0	1	2	3	4	5
Difficulty sitting still	0	1	2	3	4	5
Short attention span	0	1	2	3	4	5
Easily distracted	0	1	2	3	4	5
Forgets easily	0	1	2	3	4	5
Does not turn in assignments	0	1	2	3	4	5
Disorganized	0	1	2	3	4	5
Poor grades	0	1	2	3	4	5
Academically behind	0	1	2	3	4	5
Learning difficulties	0	1	2	3	4	5
Speech problems	0	1	2	3	4	5
Reading difficulty	0	1	2	3	4	5
Math difficulty	0	1	2	3	4	5
Defies authority	0	1	2	3	4	5
Loses Temper	0	1	2	3	4	5
Argumentative	0	1	2	3	4	5
Gets angry easily	0	1	2	3	4	5
Gets into fights	0	1	2	3	4	5
Throws or breaks objects	0	1	2	3	4	5
Problems with temper	0	1	2	3	4	5
Homicidal thoughts	0	1	2	3	4	5
Suicidal thoughts	0	1	2	3	4	5
Suicidal attempts, gestures	0	1	2	3	4	5
Hurts animals	0	1	2	3	4	5
Lies	0	1	2	3	4	5
Sets fires	0	1	2	3	4	5
Steals, shoplifts	0	1	2	3	4	5
Breaks curfew	0	1	2	3	4	5
Runs away form home	0	1	2	3	4	5
Skips school	0	1	2	3	4	5
Smokes	0	1	2	3	4	5
Uses alcohol	0	1	2	3	4	5
Uses drugs	0	1	2	3	4	5
Legal problems	0	1	2	3	4	5
Is or has been on probation	0	1	2	3	4	5
Is or was in juvenile detention	0	1	2	3	4	5
Problem making or keeping friends	0	1	2	3	4	5
Sleep disturbance	0	1	2	3	4	5
Trouble falling asleep	0	1	2	3	4	5
Interrupted sleep	0	1	2	3	4	5
Early morning wakening	0	1	2	3	4	5
Oversleeping	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Crying spells	0	1	2	3	4	5
Irritability, edginess	0	1	2	3	4	5
Excessive worry	0	1	2	3	4	5
Low energy, tired	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Overeating	0	1	2	3	4	5
Weight gain or loss	0	1	2	3	4	5
If so, how much in the last 3-6 months: Gained_____ Lost _____						
Lack of interest in usual things	0	1	2	3	4	5
Difficulty separating	0	1	2	3	4	5
Won't sleep in own bed	0	1	2	3	4	
Fears of ordinary things (For example, storms, crowds, doctor, germs, closed spaces, flying)	0	1	2	3	4	5
Excessive hand washing	0	1	2	3	4	5
Rituals that child must do (For example, need to check and recheck things in a certain order)	0	1	2	3	4	5
Counting behavior, thoughts	0	1	2	3	4	5
Need for organization, cleanliness	0	1	2	3	4	5
Anxiety, nervousness	0	1	2	3	4	5
Panic/anxiety attacks	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Stomachaches	0	1	2	3	4	5
Unexplained physical symptoms	0	1	2	3	4	5
Dizzy spells	0	1	2	3	4	5
Suspiciousness, paranoia	0	1	2	3	4	5
Hears voices (that others don't)	0	1	2	3	4	5
Sees things (that others don't)	0	1	2	3	4	5
Wets bed	0	1	2	3	4	5
Soils underclothing	0	1	2	3	4	5
Eating disorder	0	1	2	3	4	5
Picky eater	0	1	2	3	4	5
Binge-eating, purging	0	1	2	3	4	5
Anorexia	0	1	2	3	4	5
Trauma, other abuse	0	1	2	3	4	5