CATHY BUDMAN MD, PLLC
1615 NORTHERN BOULEVARD, SUITE #306, MANHASSET, NY 11030
TELEPHONE: (516) 365-0587

INTAKE QUESTIONNAIRE

Appointment Date (DD/MM/YY): _____/_____/_____

Appointment with: _____

Referral Source:

[ ]	TAA/LITA	[ ]	Internist
[ ]	School	[ ]	Other Healthcare Provider
[ ]	Self	[ ]	Therapist
[ ]	Pediatrician	[ ]	Other_____

I. REASON FOR REFERRAL

Please check your main areas of concern. Please circle the single major problem that you would like to address on the first visit.

[ ]	Abnormal movements	[ ]	Confirmation of diagnosis
[ ]	Behavior	[ ]	Second opinion
[ ]	Learning problems	[ ]	Medication management
[ ]	Educational concerns	[ ]	Vocational/occupational concerns
[ ]	Family concerns	[ ]	Other
[ ]	Marital Concerns		

Name of Primary Physician: _____

Primary Physician Telephone: _____*Fax:* _____

Primary Physician Address: _____

Date of Last Check-Up: _____

List All Current Medications: _____

List All Medication Allergies: _____

II. DEMOGRAPHIC INFORMATION

*Patient's Name: (Last)*_____*(First)*_____

Date of Birth (MM/DD/YY): _____/_____/_____

*Address*_____

City: _____ *State:* _____ *Zip:* _____

*Country*_____

Home Phone: _____ *Gender* [ ] Male [ ] Female

Race and Ethnicity:

[ ] African-American [ ] Asian [ ] White [ ] Hispanic [ ] American Indian

[ ] Native Hawaiian or Other Pacific Islander [ ] Other_____

Martial Status: [ ] Single [ ] Married [ ] Divorced [ ] Other

Primary Language Spoken at Home: [ ] English [ ] Spanish [ ] Other_____

Please Check all the individuals who live with the patient:

[ ]	Biological mother	[ ]	Biological father
[ ]	Step-mother	[ ]	Step-father
[ ]	Adoptive parents	[ ]	Foster parents
[ ]	Grandparents	[ ]	Siblings: # sisters_____# brothers_____
[ ]	Spouse	[ ]	Other partner
[ ]	Children	[ ]	Step-children
[ ]	Group home	[ ]	Other relatives (specify)_____
[ ]	Other non-relatives (specify) _____		

Parental Marital Status:

Father: [ ] Single [ ] Married/Intact [ ] Divorced [ ] Widowed [ ] Remarried

Mother: [ ] Single [ ] Married/Intact [ ] Divorced [ ] Widowed [ ] Remarried

Please indicate either the patient's or the patient's parental occupation:

1= Homemaker 2= Laborer 3= Clerical 4= Craftsman/Artist

5= Technical 6= Professional 7= Farmer 8= Self-employed

9= Unemployed 10= Other (specify)_____

Mother_____ Father_____ Patient_____ Spouse_____

Please indicate either patient's or parents' highest level of education:

1= Elementary school 2= Some college 3= High school graduate

4= Some college 5= College graduate 6= Graduate school

Mother_____ Father_____ Patient_____ Spouse/Partner_____

Emergency contact information:

Name of Person: (Last)_____ (First)_____

Relationship:_____

Home telephone number:_____ Cell:_____

Work telephone number:_____

III. BIRTH HISTORY

Please check all that apply regarding the maternal pregnancy of this patient:

[ ] Full-term [ ] Pre-term

If pre-term, how many weeks? _____

Were any medications received during pregnancy? (Specify): _____

Were any medications received during labor? (Specify): _____

[ ] Maternal excessive nausea

[ ] Psychological stress (specify): _____

[ ] Maternal alcohol use

[ ] Maternal illegal drug use (specify): _____

[ ] Maternal cigarette use

[ ] Maternal trauma

[ ] Maternal prescribed bedrest

[ ] Twin pregnancy

[ ] Maternal fetuses

[ ] Abnormal maternal bleeding (specify when): _____

[ ] Maternal infection

[ ] Maternal thyroid disorder

[ ] Maternal diabetes

[ ] Maternal seizure disorder

[ ] Gestational diabetes

[ ] Maternal autoimmune disorder

[ ] Maternal high blood pressure

[ ] Gestational

[ ] Pre-existing

[ ] Maternal psychiatric disorder

[ ] Gestational

[ ] Pre-existing

[ ] Other maternal medical illness (specify): _____

Please check all that apply regarding the labor and delivery of this patient:

[ ] Normal [ ] Induced [ ] Vaginal delivery [ ] C-section

[ ] Abnormal labor (specify):_____ _____

[ ] Birth complications (specify):_____

Birth weight _____lbs. _____ oz.

During the newborn period, were there any complications?

[ ] Required ICN [ ] Required surgery (specify):_____

[ ] Required UV therapy [ ] Required blood transfusion

[ ] Required antibiotics [ ] Required other medications (specify):_____

IV. DEVELOPMENTAL HISTORY

Please check all that apply regarding the developmental milestones of the patient:

[ ] Delayed motor milestones (specify):_____

[ ] Delayed social milestones (specify):_____

[ ] Delayed speech milestones (specify):_____

[ ] Required early intervention (specify program and duration):

_____

[ ] Required behavioral intervention (specify treatment and duration):

_____

[ ] Required medical intervention (specify treatment and duration):

_____

[ ] Required special dietary intervention (specify treatment and duration):

_____

[ ] Required educational intervention (specify type, duration, location):

_____

Handedness [ ] Left [ ] Right [ ] Both

Please check all that apply to the patient during childhood:

Sensory Sensitivities:

[ ] Sounds [ ] Smells [ ] Food textures [ ] Tactile [ ] Visual

[ ] Environmental/food allergies (specify):_____

Social Sensitivities:

[ ] Clingy	[ ] Poor eye contact	[ ] Attention problems
[ ] Difficult to console	[ ] Withdrawn	[ ] Demanding
[ ] Irritable	[ ] Fearful of new situations	[ ] Fearful of new people
[ ] Difficulties with transitions	[ ] Shyness	[ ] Other:_____

Behavioral Characteristics:

[ ] Anti-social	[ ] Easily frustrated	[ ] Easily angered	[ ] Easily frightened
[ ] Rigid rituals	[ ] Easily distracted	[ ] Moody	[ ] Self-injurious
[ ] Disobedient	[ ] Accident-prone	[ ] Habits	[ ] Attention-seeking
[ ] Immature	[ ] Poor sleeper	[ ] Picky eater	[ ] Bed-wetting
[ ] Frequent lying	[ ] Aggressive to others	[ ] Unusual repetitive behaviors_____	

Abnormal Movements and/or Sounds:

At what age did you first notice abnormal movements? _____

At what age did you first notice abnormal vocalizations? _____

How long did these abnormal movements and/or vocalizations last? _____

V. MEDICAL HISTORY

Please check and describe any of the following that apply to the patient currently and/or in the past:

[ ] **Lung** Disease such as asthma, COPD, cough

Describe_____

[ ] **Heart** Disease such as irregular heartbeat, MMI, high blood pressure

Describe_____

[ ] **Kidney Disease** such as kidney stones, infections, abnormalities

Describe_____

[ ] **Liver** Disease such as hepatitis, liver failure, abnormal labs

Describe_____

[ ] **Gastrointestinal Disease** such as heartburn, irritable bowel, gastritis, ulcer

Describe_____

[ ] **Endocrine** Disease such as thyroid disorder, diabetes, growth hormone deficiency

Describe_____

[ ] **Autoimmune Disease** such as Systemic Lupus Erythematosis (SLE), fibromyalgia

Describe_____

[ ] **Hematological Disease** such as anemia, clotting disorders, unexplained bleeding

Describe_____

[ ] **Repeated or Unusual Infectious Diseases** such as repeated streptococcal infections, chronic sinusitis, Lyme Disease, mononucleosis

Describe_____

[ ] **Eye** Disease or visual problems such as near-sightedness, glaucoma

Describe_____

[ ] **Ear** Disease or hearing problems such as chronic middle ear infections, deafness

Describe_____

[ ] **Skin** Disease such as eczema, acne, psoriasis, skin cancer, severe burns, scarring

Describe_____

[ ] **Nervous System** Disease such as seizures, headaches, tremor

Describe_____

[ ] **Urologic** Disease such as frequent urinary tract infections, enuresis, incontinence

Describe_____

[ ] **Sexual Problems** such as anorgasmia, erectile dysfunction, libido dysfunction, reproductive problems, menstrual irregularities

Describe_____

[ ] **Psychiatric Disorders** such as anxiety, depression, manic-depression

Describe_____

[ ] **Other** significant medical illness or congenital abnormalities

Describe_____

[ ] **Medication Allergies**

Describe_____

[ ] **Environmental Allergies**

Describe_____

[ ] **Physical or Sexual Abuse**

Describe_____

[ ] **Alcohol Abuse/Dependence**

Describe_____

[ ] **Substance Abuse/Dependence**

Describe_____

History of Sleep Problems:

[ ] Difficulty falling asleep	[ ] Difficulty staying asleep	[ ] Night terrors
[ ] Frequent nightmares	[ ] Sleep apnea	[ ] Snoring
[ ] Unable to sleep alone	[ ] Difficulty waking up	[ ] Bed-wetting
[ ] Restless legs		

Has the patient experienced any problem requiring hospitalization for a medical condition?

[ ] Yes [ ] No

Dates	Medical Problem	Hospital	Treating Physician

Has the patient experienced any problem requiring hospitalization for a psychiatric condition?

[ ] Yes [ ] No

Dates	Psychiatric Problem	Hospital	Treating Physician

Has the patient had any problem requiring detoxification from alcohol and/or illegal drugs?

[ ] Yes [ ] No

Dates	Problem	Facility	Treating Physician

Has the patient had any of the following evaluations/treatments? Check all that apply.

[ ] Allergy testing	[ ] PT	[ ] Brain CT	[ ] Speech therapy
[ ] Brain MRI	[ ] Genetic testing	[ ] EEG	[ ] Thyroid testing
[ ] Metabolic testing	[ ] Vision testing	[ ] EKG	[ ] Hearing testing
[ ] Sleep studies	[ ] Immunizations	[ ] OT	[ ] Psych. Testing
[ ] Educational Testing	[ ] Neuropsychological testing		

VI. FAMILY HISTORY

Please check all that apply to the patient's family history, if known, on both the maternal (M) and paternal (P) sides of the extended family.

History of Developmental Problems:		
Milestone Delays	[ ] M	[ ] P
Learning Disabilities	[ ] M	[ ] P
Mental Retardation	[ ] M	[ ] P
Speech and Language Problems	[ ] M	[ ] P
Socialization Problems	[ ] M	[ ] P
Other (specify)	[ ] M	[ ] P
History of Neuropsychiatric Problems:		
ADHD	[ ] M	[ ] P
Obsessive-Compulsive Disorder	[ ] M	[ ] P
Other Anxiety Disorders:		
Panic Attacks	[ ] M	[ ] P
Generalized Anxiety	[ ] M	[ ] P
Phobias	[ ] M	[ ] P
Separation Anxiety	[ ] M	[ ] P
Mood Disorders:		
Depression	[ ] M	[ ] P
Manic-Depressive Disorder	[ ] M	[ ] P
Manic	[ ] M	[ ] P
Post-partum	[ ] M	[ ] P
Suicide Attempts/Gestures	[ ] M	[ ] P
Self-injurious Behaviors	[ ] M	[ ] P
Trichotillomania	[ ] M	[ ] P
Pathological Gambling	[ ] M	[ ] P
Alcohol Abuse	[ ] M	[ ] P
Substance Abuse	[ ] M	[ ] P
Autism	[ ] M	[ ] P
Pervasive Developmental Disorder (PDD)	[ ] M	[ ] P
Tic Disorders	[ ] M	[ ] P
Alzheimer's Disease	[ ] M	[ ] P
Wilson's Disease	[ ] M	[ ] P
Parkinson's Disease	[ ] M	[ ] P

Dystonia	[ ] M	[ ] P
Restless Leg Syndrome	[ ] M	[ ] P
Seizure Disorder	[ ] M	[ ] P
Rheumatic Disease	[ ] M	[ ] P
Migraine	[ ] M	[ ] P

VII. MEDICATION HISTORY

Please check all of the medication categories that the patient has previously received:

[ ] Psychostimulants such as Ritalin(methylphenidate), Adderall (amphetamine - dextroamphetamine mixed salts)
[ ] Alpha-agonists such as clonidine
[ ] Selective serotonin reuptake inhibitors such as Prozac (fluoxetine), Zoloft (sertraline)
[ ] Conventional neuroleptics such as Haldol (haloperidol) or Orap (pimozide)
[ ] Atypical neuroleptics such as Risperdal (risperidone) or Abilify (aripiprazole)
[ ] Mood stabilizers such as Lithium, Lamictal (lamotrigine), Depakote (divalproex sodium)
[ ] Other antidepressants such as Wellbutrin (buproprion), Effexor (venlafaxine), Pamelor (nortriptyline)
[ ] Other medications not otherwise specified (please specify below)
[ ] Health supplements or alternative therapies (please specify below)

List all the psychotropic medications that the patient has previously tried and clinical responses:

Medication	Target Symptoms	Dose	Dates	Response	Side Effects

If necessary, please continue at the end of this questionnaire in the additional space provided.

VIII. EDUCATIONAL HISTORY

What is the child's current grade in school? _____

Has the child ever been asked or required to repeat a grade? [ ] Yes [ ] No

If so, please explain_____

Classification: [ ] Mainstreamed [ ] 504 Classification [ ] Special Education

What services does the child currently receive in school? *Please check all that apply:*

[ ] Speech Therapy [ ] Occupational Therapy [ ] Physical Therapy [ ] Social Skills
[ ] Resource Room [ ] Testing Modifications [ ] Classroom Aide [ ] Other (Specify)
[ ] Pre-Vocational Training [ ] Vocational Training

What services does the child currently receive at home? *Please check all that apply:*
[ ] Speech Therapy [ ] Occupational Therapy [ ] Physical Therapy
[ ] Family Therapy [ ] Individual Psychotherapy [ ] Tutoring (Specify):

_____

IX. OCCUPATIONAL THERAPY

If currently employed, how long at current position? _____

Has the patient ever been fired or asked to leave a job? [ ] Yes [ ] No
If yes, please explain: _____

How many different jobs as the patient had since graduation? _____
Does the patient receive any special work accommodations? [ ] Yes [ ] No
If married or in a committed relationship, please indicate how long? _____
Has the patient ever been arrested? [ ] Yes [ ] No

Thank you very much for completing this questionnaire. Your answers will be used to better meet you/your child's needs.
If you would like to make any further comments, please feel free to do so below:

_____
_____
_____
_____
_____