935 W. Exchange Pkwy, Ste. 110 Allen, TX 75013

PH# 972.985.7499 FAX# 972.985.7429 premierpsychiatric1@gmail.com

Questionnaire for Parents:

Child's Name: ____________________ Date of Birth: __/__/__ Age: _____ Sex : ____

Parent's Name: ____________________ Phone Number: ____________________

Address: ______________________________ City: ________ State: ___ Zip: ______

Parent's Name: ____________________ Phone Number: ____________________

Address: ______________________________ City: ________ State: ___ Zip: ______

Referred by: ______________________ Phone Number: ____________________

Please state your view of your child's challenges/symptoms/reason for the visit:

____

____

____

When did the problems begin: ____

What has been done so far to help alleviate the issue(s):

____

____

____

Psychiatric History:

Has your child ever been hospitalized for psychiatric care/needs? YES _____ NO _________

If so, Where and When: ____

Reason for Hospitalization: ____________________________________

Was treatment helpful/successful: _______________________________

Has your child had any other prior psychiatric providers, ie outpatient psychiatric medication management, behavioral counseling or therapy? YES _____ NO _______

If yes, please list provider: ____________________________________

____