Alabama Psychiatric Services, P.C.
Child/Adolescent Family Physician Questionnaire

Patient Name: ___________________________________ **Physician Name:** ________________________________

1. What was the patients' height and weight at the time of their last appointment?
   Date: ______ Ht. _____Wt. _____

2. Have you treated the patient for any of the following conditions? Please check those that apply.

Cardiovascular ☐ Please note results of EKG if ordered.

Seizure disorder ☐ Please note results of EEG if ordered.

Head Trauma ☐ Please note results of MRI / CT if ordered.

ADD / ADHD ☐ Were stimulant medications used? ☐ yes If Yes, please note name(s), dose/freq. and any Side effects of the medication(s):

Depression ☐ Anti-depressant medications used? ___ Yes If Yes, please note name(s), dose/freq. and any side effects:

Gastrointestinal disorder ☐ If checked, please give diagnosis and any medications used:

Asthmatic condition ☐ If checked, please give diagnosis and any medications used:

Comments you may wish to add:

Note: If you would like to receive a report of our findings please remind the parent to sign a release of information form when they bring their child to our office.

Physician Signature: ____________________________________ Date: ________________