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Please print clearly all sections of this questionnaire. All information is confidential.

Patients Name _____

Date of Birth _____ Age _____ Gender M F

Current Caregiver _____ Relationship _____ Phone _____

School _____ Phone _____

Teacher (or Counselor if in Middle School or High School) _____

Probation Officer (if applicable) _____ Phone _____

Social Worker (if applicable) _____ Phone _____

MOTHER

FATHER

Name _____

Name _____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

Home Tel _____

Home Tel _____

Work Tel _____

Work Tel _____

Cell _____

Cell _____

Email _____

Email _____

Occupation _____

Occupation _____

Other Children in the family (please list name, age and gender) _____

Who Referred You? _____

Primary Care Physician _____ Date of Last Physical Exam _____

List of Allergies or sensitivities to medications, foods or other things in the environment

List of any and all medical problems _____

List of any past medical problems _____

Current Medications (please list dose, response and any side effects) _____

Past medications (please list dose, response and side effects) _____

Briefly state the most important problem(s) that led you to seek my assistance _____

Any past history of emotional or developmental problems? (specify) _____

Any previous therapy? (specify names and dates) _____

Please specify any problems in any of these general areas?

School: _____

Mood: _____

Activity: _____

Level: _____

Sleep: _____

Appetite: _____

Anxiety: _____

Conduct: _____

Trauma or Abuse: _____

PLEASE RATE THE FOLLOWING ITEMS:

	NONE	MILD	MODERATE	SEVERE
Bedwetting	_____	_____	_____	_____
Bowel Problems	_____	_____	_____	_____
Depressed	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Inattentive	_____	_____	_____	_____
Hyperactive	_____	_____	_____	_____
Impulsive	_____	_____	_____	_____
Aggressive, fighting	_____	_____	_____	_____
Persistent obedience	_____	_____	_____	_____
Alcohol or Drug Use	_____	_____	_____	_____
Self Destructive	_____	_____	_____	_____
Suicidal	_____	_____	_____	_____
Homicidal	_____	_____	_____	_____
Fire setting	_____	_____	_____	_____
Unusual sexual behavior	_____	_____	_____	_____
Bizarre, unusual ideas	_____	_____	_____	_____
Panic Attacks	_____	_____	_____	_____
Muscle tics (twitches)	_____	_____	_____	_____
Excessive daytime sleepiness	_____	_____	_____	_____
