**Mark W. Wilson, MD**

**Executive Medical Director**

**Center for Wise Mind Living**

**Wise Mind Living Psychiatry**

**250 W54th Street, Suite 406**

**New York, New York 10019**

**(917) 566-5798 - office**

**(917) 621-6615 - emergency**

**(646) 514-5633 - fax**

[mark@markwwilsonmdpc.com](mailto:mark@markwwilsonmdpc.com)

[assistant@markwwilsonmdpc.com](mailto:assistant@markwwilsonmdpc.com)

### History Questionnaire

*\*Please note, this form is easier to complete typed as a Word document. Please elaborate whenever relevant, if possible.\**

##### Client Name:

##### Date of Birth:

##### Name of person completing form, if different from client:

##### The purpose of this questionnaire is to obtain a comprehensive summary of your child, your child's difficulties and circumstances prior to meeting in person. Case records are strictly confidential. If you do not desire to answer any question, simply leave it blank. To begin, it would be very helpful if you could write a narrative history of your child's difficulties:

##### What are your goals for this evaluation and/or treatment?:

##### If you are able, please indicate whether your child exhibited any of the following during the **first 12 months of life**; please elaborate when relevant:

* Difficulty getting to sleep:
* Difficulty with feeding:
* Colicky behaviors/symptoms:
* Difficulty being put on a schedule:
* Difficulty with alertness:
* Cheerful demeanor:
* Sociable behavior:
* Affectionate behavior:
* Easy to comfort:
* Difficulty keeping busy:
* Overactivity, being in constant motion:
* Stubborn, challenging nature:

##### If you are able, please indicate whether your child achieved the following **developmental milestones** by the listed age; please elaborate when relevant:

* Sat-up before 9 mo:
* Walked without assistance before 18 mo:
* Spoke first words before 18 mo:
* Joined words together before 2 ½ yo:
* Stopped wetting bed before age 4:
* Stopped soiling pants by age 4:

Please indicate whether your child experienced any of the following in **early childhood**; please elaborate when relevant:

* Recurrent, meaningless body movements (e.g., flapping, rolling, rocking, slapping self):
* Injured self on purpose/cut self with sharp instrument:
* Talked excessively or very fast speech:
* Yelled or screamed inappropriately; excessive temper tantrums (in frequency and/or intensity):
* Odd, eccentric behavior:
* Fixed facial expression; lack of emotional responsiveness; showed few social reactions:
* Repetitive speech, words, phrases:
* Resisted physical contact:
* Isolated self, preferred to be alone:
* Difficult to reach, contact or get through to; did not seem/appear to listen when spoken to directly:
* Did not try to communicate by words or gestures:
* Night terrors/nightmares:

##### Please indicate whether your child has experienced any of the following symptoms/experiences of **anxiety or worry**; please elaborate when relevant:

* Marked or specific fear of closed spaces, animals, heights, animals, crowded spaces, other:
* Afraid to try new things for fear of making mistakes:
* Blames self for problems, feels guilty:
* Excessive worry or anxiety; apprehensive anticipation:
* Excessive worry/fear about being liked (e.g., feel nervous when one is with other people and/or has to do something while being watched; fear of speaking in public or in front of others; fear of talking to people of authority or strangers; fear of being embarrassed, criticized, humiliated or perceived as worthless/inferior; feeling like one couldn’t do anything well or that one is not as good or as smart as other people, fear of social gatherings; when one is with others, experience blushing, palpitations, trembling/shaking, sweating):
* Excessive worry about harm befalling caregivers or excessive distress when alone and/or separated from family, when at school, when at sleepovers, etc:
* Extreme clinging behavior; follows parent like a shadow:
* Repeated complaints of physical symptoms when separated from caregivers, when at school, when at sleepover, etc:
* Other symptoms:

Please indicate whether your child has experienced any of the following symptoms/experiences of **panic**; please elaborate when relevant:

* Accelerated heart rate:
* Pounding heart:
* Heart palpitations:
* Sweating:
* Shortness of breath or difficulty breathing:
* Chest pain or discomfort:
* Sensation of choking:
* Trembling or shaking:
* Nausea, abdominal pain/distress/discomfort:
* Dizziness, unsteadiness, lightheadedness, or feeling faint:
* Chills or heat sensations:
* Tingling sensations:
* Derealization (feeling like life is not real or is like a movie):
* Depersonalization (feeling like one is not real or is floating above or beside oneself):
* Fear of losing control or “going crazy”:
* Fear of dying:
* Other symptoms:
* Persistent concern or worry about additional panic attacks or their consequences:
* Significant, maladaptive change in behavior related to panic attacks (or avoidance of potential triggers of panic attacks):

##### Please indicate whether your child has experienced any of the following symptoms/experiences related to **trauma**; please elaborate when relevant:

* Direct experience, witnessing, or learning of traumatic event(s):
* Repeated or extreme exposure to aversive details of the traumatic event(s):
* Recurrent, involuntary, intrusive, distressing memories of the traumatic event(s):
* Recurrent distressing dreams related to the traumatic event(s):
* Dissociative reactions (e.g. flashbacks); re-enactment of traumatic event(s) in play:
* Intense or prolonged psychological distress upon exposure to internal or external cues related to traumatic event(s):
* Marked physical reactions to internal or external trauma-related cues; hypervigilance:
* Persistent avoidance of stimuli associated with the traumatic event(s):
* Difficulty falling or staying asleep, related directly or indirectly to the traumatic event(s):
* Negative changes in cognition and mood (e.g. memory), related directly or indirectly to the traumatic event(s):
* Other symptoms:

##### Please indicate whether your child has experienced any of the following symptoms/experiences related to **obsessional thoughts and/or compulsive rituals/behaviors**; please elaborate when relevant:

* Obsessional thoughts about germs, contamination, dirtiness, and/or illness:
* Obsessional thoughts about religious issues/concerns (beyond regular religious practice):
* Obsessional thoughts about safety and/or harm to self or others:
* Obsessional thoughts about unwanted acts/images of violence or aggression:
* Obsessional/unwanted sexual thoughts/imagery:
* Obsessional thoughts about symmetry and/or order:
* Obsessional thoughts about numbers:
* Obsessional thoughts about exactness:
* Compulsive checking:
* Compulsive washing/cleaning:
* Compulsive counting:
* Compulsive ordering/arranging:
* Compulsive repeating of routines:
* Compulsive hoarding:
* Compulsive reassurance seeking:
* Other symptoms:
* How much time per day do obsessions and compulsions take up?:
* Do these obsessive or compulsive behaviors cause distress and/or impairment?:

##### Please indicate whether your child has experienced symptoms/experiences related to **restrictive eating, overexercising to lose weight, binge eating, purging through vomiting, excessive use of diuretics/laxatives, or other symptoms of eating disorders (anorexia nervosa, bulimia nervosa, or mixed eating disorder)**; please elaborate:

Please indicate whether your child has experienced any of the following symptoms/experiences related to **hypomanic or manic mood**; please elaborate when relevant:

* Unusually elevated, elated, silly, giddy, goofy or irritable/agitated/argumentative mood for most hours of the day for 4 or more consecutive days:
* Much more active or does many more things than usual for most hours of the day for 4 or more consecutive days:
* Much more social than usual and/or more interested in sex than usual for 4 or more consecutive days:
* Much more talkative and/or speak much faster than normal for 4 or more consecutive days:
* Too many ideas at once, ideas and/or thoughts that are unusually fast for 4 or more consecutive days:
* Exaggerated ideas about self or abilities; more self-confident than usual for 4 or more consecutive days:
* Tells tall tales and/or embellishes/exaggerates more than usual for 4 or more consecutive days:
* Displayed precocious sexual curiosity or behaviors (e.g., openly touched self or others’ private parts) when a child for 4 or more consecutive days:
* Does things or takes risks that are unusual for child or that other people might have thought were excessive, foolish or risky; spends money in a way that is unusual for child or that got child or family in trouble for 4 or more consecutive days:

Please indicate whether your child has experienced any of the following symptoms/experiences related to **depression**; please elaborate when relevant:

* Feels sad, depressed, blue and/or irritable mood for an extended period of time:
* Feels bored, like nothing is pleasurable/fun, or not interested in anything for an extended period of time:
* Periods of low energy or withdraws for an extended period of time:
* Feels like they’re being punished for an extended period of time:
* Feels guilty/blames self for an extended period of time:
* Gets less or no satisfaction from things/people for an extended period of time:
* For teens, less or no interest, pleasure, and/or functioning in sexual activity for an extended period of time:
* Cries more than usual or for no reason for an extended period of time:
* Periods of self-loathing, self-disgust, feelings of being a failure, feelings of disappointment in self for an extended period of time:
* Less appetite or loss of appetite and/or decreased weight for an extended period of time:
* Carbohydrate craving or increased appetite and/or weight gain for an extended period of time:
* Difficulty falling or staying asleep for an extended period of time:
* Sleeping more than normal/too much for an extended period of time:
* Wake up feeling like body is a lead pipe, difficult to move/get out of bed for an extended period of time:
* More intense interpersonal/rejection sensitivity for an extended period of time:
* Feel physically slowed down, like body is stuck in mud, for an extended period of time:
* Has more difficulties making decisions than usual for an extended period of time:
* Feels the future looks hopeless for an extended period of time:
* Have symptoms of depression or other mood symptoms above interfered with or caused difficulties in child’s life or in their quality of life?:
* Is mood affected by the season of the year?:
* If relevant, is mood affected by menstrual cycle?:

**Has your child ever told you that s/he has suicidal thoughts?:**

**Hs s/her ever attempted suicide?:**

**Does s/he engage in self-injurious behavior?**

Please indicate whether your child has experienced any of the following symptoms/experiences of **inattention/distractibility, impulsivity, and/or motor activity**; please elaborate when relevant:

* Difficulty paying attention to details; make careless mistakes, especially with boring/difficult work; start projects or tasks without reading:
* Difficulty maintaining attention on what needs to be done, especially in boring or repetitive work:
* Difficulty following through when given directions; fail to finish activities (not due to refusal or failure to understand); difficulties with wrapping up the final details of a project, once the challenging parts have been done:
* Difficulty organizing tasks and activities; trouble doing things in proper order:
* Avoids, dislikes, or does not want to start tasks that require ongoing mental effort:
* Difficulty losing things necessary for tasks or activities (toys, assignments, pencils, or books):
* Easily distracted by noises or other stimuli/difficulty concentrating even if people are speaking directly to child:
* Forgetful in daily activities; poor follow-through on promises:
* Fidgets with hands or feet or squirms in seat; feels restless:
* Leaves seat when remaining seated is expected, as in class:
* Difficulty stopping activities or behaviors when child should do so:
* Difficulty playing quietly; difficulty staying quiet in movies:
* Makes decisions impulsively, blurts out answers before questions have been completed:
* Difficulty waiting turn:
* Interrupts or intrudes on others’ conversations and/or activities, finishes others’ sentences; interrupts others when they’re busy:
* Difficulty wrapping up the final details of a project, once the challenging parts have been done:
* Difficulty remembering appointments or obligations:
* Difficulty unwinding and relaxing:
* Child feels or seems overly active and compelled to do things, like they were driven by a motor:
* Talks too much in social situations:
* When in a conversation, child often finishes the sentences of the people the child is talking to, before they can finish themselves:

Please indicate whether your child has experienced any of the following symptoms/experiences of **oppositional or defiant behavior or conduct problems**; please elaborate when relevant:

* Argues with adults; excessively confrontational:
* Actively defies or refuses to go along with requests or rules of adults in positions of authority or power:
* Deliberately annoys others:
* Blames others for their mistakes or misbehaviors:
* Is touchy or easily annoyed by others:
* Is angry or resentful:
* Is spiteful and wants to get even:
* Bullies, threatens, or intimidates others:
* Starts physical fights:
* Lies to get out of trouble or to avoid obligations (e.g., “cons” others):
* Skips school or work without notice:
* Is physically cruel to others:
* Has stolen things that have value:
* Deliberately destroys others’ property:
* Has used a weapon that can cause serious harm (bat, knife, brick, gun):
* Is physically cruel to animals:
* Has deliberately set fires to cause damage:
* Has broken into someone else’s home, business, or car:
* Has stayed out at night without permission as a child:
* Has run away from home overnight as a child:
* Drives with excessive speeds; high number of traffic tickets or traffic accidents:
* Has forced someone into sexual activity:

##### Please indicate whether your child has experienced any of the following **sensory/perceptual experiences**; please elaborate when relevant:

* Auditory, visual, or tactile experiences that others do not or cannot experience:
* Feelings that one is being followed or targeted:
* Feelings that someone is inserting or withdrawing thoughts from your mind:
* Feelings that messages on TV or media are referring to you:
* Feelings that your thoughts are being broadcast to others:
* Feelings that you have special powers that others do not or cannot have:
* Any other unusual feelings or experiences:

##### Does your child have **thoughts or urges to harm others**? If so, please elaborate:

##### **School history and performance**:

* Ever skipped a grade or been held back in school or had to repeat a year?:
* Ever been suspended or expelled from school?:
* Ever been in special education classes?:
* What are/were your child’s academic strengths and weaknesses?:

Please indicate whether your child has experienced any of the following **neuropsychological symptoms/problems**; please elaborate when relevant:

* Learning disorders:
* Sensory processing, sensory integration issues:
* Speech/language problems (expressive and/or receptive):
* Short term memory, processing speed issues:
* Coordination problems:
* Gross or fine motor control issues:
* Extreme sensitivity to textures of clothes, labels, and tightness of fit of socks or shoes:
* Complain of body temperature extremes or feeling hot despite neutral ambient temperature:
* Difficulties in reading, writing, mathematics:
* Other neuropsychological, neurological, or sensory/motor/coordination issues:

**Current/past psychiatric/psychological treatment**: with whom have you previously consulted about your difficulties?:

* **Psychiatrists**; please list the names and dates of treatment of any psychiatrists with whom you've worked:
* **Psychotherapists**; please list the names and dates of treatment of any psychotherapists with whom you've worked:
* **Neurologists**; please list the names and dates of treatment of any neurologists with whom you've worked:
* **Other clinicians**; please list the names and dates of treatment of other clinicians with whom you've worked:

Please list all **medications your child is taking or have taken for emotional, psychiatric, or behavioral difficulties, including over-the-counter and herbal/alternative homeopathic supplements**. Please list doses, time periods during which medication(s) or supplement(s) have been used, and any positive or negative effects:

##### Please list all previous **psychiatric hospitalizations**, including name(s) of hospital(s), dates of hospitalization(s), circumstances surrounding hospitalization(s), and notable clinical/treatment issues during hospital stay(s):

Please list all **non-psychiatric medications your child is taking for medical problems (other than psychiatric issues), including over-the-counter and herbal/alternative homeopathic supplements**; please include doses:

##### If taking prescription medication for non-psychiatric reasons currently, **who is the prescribing MD**? Please include type of MD, name and phone number:

**Any allergies to any medications?:**

Please indicate whether your child has experienced any of the following **physical symptoms/problems/medical disorders**:

* Headache, migraines:
* Nausea, vomiting, stomach aches, gastritis, esophagitis:
* Diarrhea, irritable bowel:
* Endocrine/hormone-related problems:
* Head injury, concussion, loss of consciousness:
* Shortness of breath, chest pain, chest tightness, or formal asthma:
* Chronic pain:
* High blood pressure/hypertension, heart attack/myocardial infarction, heart valve problems:
* Bone or joint problems:
* Seizures/epilepsy:
* Kidney-related issues, urinary tract problems:
* Chronic fatigue, mononucleosis/EBV, fibromyalgia, long COVID :
* Dizziness, vertigo, unsteadiness, balance problems, coordination problems:
* Numbness and tingling:
* Vocal or muscle tics (recurrent stereotyped movements or vocalizations):
* Faintness/fainting:
* Diabetes:
* Arthritis:
* Thyroid issues:
* Cancer:
* Autoimmune disorder(s):
* Broken bones:
* Severe cuts requiring stitches:
* Lead poisoning:
* Chronic ear infections (and whether required tubes):
* Hearing difficulties:
* Eye or vision problems:
* Bladder or bowel control problems:
* Rashes/skin issues:
* Exposure to tics/history of Lyme disease:
* Repeated strep/bacterial infections:
* Sexually transmitted diseases (e.g., herpes, HPV, HIV, syphilis, gonorrhea, etc):
* Abnormal muscle movements:
* Liver disease, hepatitis (A/B/C):
* Oral/dental problems:
* Bleeding/bruising issues:
* Any other physical/medical problems/symptoms/issues/complaints?:

##### Describe any **surgical operations, procedures, or medical hospitalizations**:

##### **Menstrual history**, if applicable:

* Age at first period?:
* Are periods regular?:
* How painful/uncomfortable are the premenstrual symptoms (PMS) in the 2-4 day prior to one's period?:
* Are psychiatric symptoms worse or different in the 7-10 days prior to one's period?:
* Are there other changes in psychiatric symptoms that correlate with the menstrual period?:

Please detail any current and **past alcohol and drug use**, amount and duration of use, any clinical/medical/legal problems associated with use, and any treatment associated with use, if applicable; please elaborate when relevant:

* Alcohol:
* Cigarettes/nicotine:
* Marijuana/THC/synthetic cannabinoids:
* Benzodiazepines (e.g., Xanax (alprazolam)):
* Opioids (e.g., oxycodone):
* Stimulants (e.g., amphetamine, cocaine):
* Inhalants:
* Bath salts:
* Psychedelic substances (e.g., LSD):
* Ecstasy/Molly/MDMA:
* Other recreational substances:

If able, please describe your **pregnancy, delivery, and early post-delivery infant medical course**; please elaborate when relevant:

* Age of mother at birth:
* Age of father at birth:
* Number of full term pregnancies:
* Number of miscarriages:
* Number of therapeutic terminations/abortions:
* Was pregnancy planned?:
* Duration of pregnancy:
* Bleeding during pregnancy?:
* High blood pressure during pregnancy?:
* Excessive nausea/vomiting during pregnancy?:
* Toxemia/preeclampsia during pregnancy?:
* Medications during pregnancy?:
* Swelling of ankles during pregnancy?:
* Kidney infection/disease during pregnancy?:
* Anemia during pregnancy?:
* Diabetes during pregnancy?:
* Recreational drug or alcohol use during pregnancy?:
* Rh incompatibility during pregnancy?:
* Other issues, problems, stresses/traumas, disorders during pregnancy?:
* Was delivery by caesarian section? Any complications?:
* Was delivery by forceps? Any complications?:
* Was there prolonged labor?:
* Was there meconium staining?:
* What were the Apgar scores?:
* Following delivery, was there any difficulty breathing? Was oxygen required? Any problems with pneumonia or asthma as an infant?:
* Following delivery, were there any neurologic issues/seizure(s)/meningitis as an infant?:
* Following delivery, were there any other infections as an infant?:
* Were there any birth defects?:
* Were there any other issues in pregnancy or delivery or in early post-delivery medical care?:
* Breast-fed as an infant? If so, how long?:

**Family history, psychiatric**: has any member of the extended multigenerational family ever had psychiatric, learning, behavioral/conduct, or alcohol/substance use problems; any suicide attempts, deaths by suicide, notable legal problems, or anything unusual? Please list family member, problem/disorder, and any treatment (including hospitalization(s)) for such problems:

##### **Family history, medical**: has any member of the extended multigenerational family had medical problems? **Has anyone died before the age of 40 from cardiovascular disease/disorders**? Please list family member, problem/disorder, and any treatment(s) for such problems:

As part of your child’s regular eating habits, does your child frequently ingest **grapefruits, grapefruit juice, or brussels sprouts**? These foods can affect the metabolism of medications. Any other unusual eating/dietary habits?:

**Firearms/guns**; please elaborate when relevant:

* Do you own or have access to firearm(s)/gun(s)/weapon(s)?:
* Is firearm(s)/gun(s) stored in a locked box?:
* Do you own or have access to ammunition?:
* Is ammunition stored separately from firearm(s)/gun(s) in a locked box?:
* If applicable, please list any other safety measures deployed:

##### **Personal** data:

* Interests, hobbies, activities, sports:
* Ever bullied verbally or physically?:
* Makes/keeps friends easily?:
* How would your child describe their gender?:
* How would your child describe their sexual orientation?:
* Sexually active? Using protection?:
* Age when started working:
* Jobs held (in chronological order) and how performed in them:
* If present, describe mother's personality and how your child and mother relate/related with each other:
* If present, describe father's or other parent/step-parent's personality and how your child and they relate/related with each other:
* Ever separated in youth from one or both parents for an extended period of time (aside from vacation or camp)? Give age at time of separation:
* Any step-parent(s)? Give child’s age when parent(s) remarried:
* If not brought up entirely by parents, who brought child up and when?:
* In what ways were your child disciplined by parents?:
* Give an impression of the home atmosphere in youth:
* Describe your child’s religious upbringing/training:
* Who are the most important people in your child’s life?:

What else would you like me to know about your child?: