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New Patient Registration and History Form

Date Completed

Patient Information					
Name			Age	Date of Birth	Gender at birth
Address			Occupation or Name of School & Grade		
State	Zip Code	Home Phone	Work Phone		Cell Phone
E-Mail					

(For Pediatric Patients)					
Parent Name			Parent Name		
Address			Address		
State	Zip	Phone	State	Zip	Phone
E-Mail			E-Mail		
Occupation			Occupation		

Pediatrician or Primary Care Physician			
Name	Phone		Fax
Address	State	Zip Code	Pager

Person responsible for payments			
Name	Relationship to patient	E-Mail	
Address	State	Zip Code	Phone

All professional services are charged to the patient (or parent/guardian, if the patient is a minor), and are payable in full at time of service. Statements are provided but insurance filing is the payer's responsibility. Dr. Ceranoglu does not take responsibility for any future insurance reimbursement. The patient (or parent/guardian) is responsible for all fees. Please note that Dr. Ceranoglu is not affiliated with insurers through his Private Practice. In the event that he is 'in-network' at Massachusetts General Hospital and you attempt to seek reimbursement independently at a future time you may be unsuccessful. Please sign below to express your understanding of the terms above.

Signature	Date
Print Name	Relationship to patient

Thank you for filling out this form. Please consider including a signed Authorization for Release and Receipt of Protected and Privileged Information Form, a signed Consent to Treatment Form and a signed copy of Office Policy Statement within your package in order to make use of our time more efficiently.

Chief Complaint: *Please describe your (child's) reasons seeking this evaluation.*

History of the Chief Complaint: *(Please provide the details of the symptoms and concerns you would like to address)*

When did these symptoms begin?

When were these first noted by family members?

Did something occur to precipitate them?

Course of symptoms (intensifications, fluctuations, etc.):

Did the symptoms occur suddenly or gradually over time?

What are the times or settings the symptoms present? Have there been symptom free episodes? What treatments or interventions, if any, were attempted? Please, provide any details you would like me to know.

Problem Behavior Checklist: Do you/your child have any of the following problems?

Symptom (please circle all that apply)	Yes	No	Describe (Past or present, and Age of Onset)
Short attention span (distractible, can't listen, can't organize or finish work)			
Impulsivity (acts before thinking, cannot wait turn)			
Hyperactivity (fidgety, restless, etc.)			
Frequent accidents, clumsiness			
Speech or language delays			
Difficulty making eye contact			
Difficulty making/keeping friendships			
Sensory difficulties (sounds, smells, touch, etc.)			
Repetitive movements (hand flapping, rocking, spinning, etc.)			
Repetitive speech patterns			
Worries a lot or excessively			
Episodes of sudden panic/intense fear			
Afraid to be alone			
Fear of the dark or other specific fears			
Reluctance to go to school			
Cry easily			
Feeling that life is not worth living			
Self-injurious/abusive behavior			
Changes in concentration			
Changes in energy during the day			
Lack of interest or pleasure in activities			
Isolate self from others			
Sadness			

Problem Behavior Checklist (Continued from previous page)

Symptom (Please circle all that apply)	Yes	No	Describe (Past or present, and Age of Onset)
Changes in appetite or weight			
Changes in sleep (increase/decrease)			
Problem falling or staying asleep			
Early morning awakening			
Irritable, poor frustration tolerance, or easily riled up			
Gets violent and aggressive			
Talk a lot more or rapidly than usual			
Act out of character, behave in ways that are regretted			
Feel more energetic, needing much less sleep than usual			
Get giddy and silly when not appropriate			
Hearing, seeing, or perceiving things that others do not			
Get special messages from TV, radio, magazine, etc.			
Obsessive thoughts (repeated, unwanted thoughts)			
Compulsions (repetitive, distressing actions, counting/checking excessively)			
Rituals (compelled to repeat same actions before sleep, school, etc.)			
Hair pulling, skin picking			
Excessive concern about body defects			
Sensory urges, unusual sensation before tics			
Wanting to hurt someone			
Feels picked on			
Teases others unmercifully			
Cruel to animals			
Fire setting			

Treatment History:

Please list current medications. Please attach additional page if necessary.

Name of medication	Dosage & Frequency	Helpfulness	Side effects

Please list previous medications that have been used. Please attach additional page if necessary.

Name of medication	Date of use	Helpfulness	Side effects

Prescriber Information

Name	Email		Phone
Address	State	Zip Code	Fax

What other treatment have you/your child tried?

Therapy Modality	Name of Provider	Date	Contact information
Individual Therapy/Counseling:			
Family Therapy:			
Behavioral Therapy:			

Past Psychiatric History: Please detail any hospitalizations or other treatments not included above.

Substance Use History

Cigarettes or E-cigarette use? Please provide details if any (daily amount, start date, etc. and whether you are considering quitting)

Alcohol or drug use? Please provide details if any (type, daily amount, start date, etc. and whether you are considering quitting)

Please provide any other details you would like to share. Please feel free to use additional pages if necessary.

Medical History:

Current Medical Problems, if any:

Current medications (include vitamins, over-the-counter medications, herbal remedies, attach a separate page if necessary)

Name of medication	Dosage & Frequency	Helpfulness	Side effects

Please list allergies, if any.
Previous illnesses, hospitalizations, surgeries

Please indicate below any which condition this patient has had, and include dates:

Head injury or Concussions	Serious accidents / fractures
Migraine or other chronic headaches	Seizures or Epilepsy
Alzheimer's Disease or Dementia (please describe)	Sudden or Unexplained Death
High or Low Blood Pressure	Stroke
Diabetes	High Cholesterol
Heart Problems (murmur, rhythm problems, birth defects, etc.)	Lung Disease (Asthma, Tuberculosis, Emphysema, etc.)
Stomach or Bowel Diseases (soiling, ulcers, Crohn's/colitis, etc.)	Kidney Disease (Inflammation, kidney stones, etc.)
Liver Disease (Hepatitis, etc.)	Urinary or bladder problems / wetting
Growth / Endocrine problems (thyroid disease, etc.)	Skin problems (psoriasis, acne, etc.)
Rheumatic fever / Strep infections / Childhood infections	HIV/AIDS
Joint problems (arthritis, gout, etc.)	Eye problems (glaucoma, visual problems)
Growth / Endocrine problems	Ear, nose or throat problems (hearing loss, etc.)
Blood or Bleeding Disorder	Genetic Disorder
Cancer	Obesity

Females

Age at first menstrual period?	Is menstruation regular?
Any difficulties related to menstrual periods?	

Most recent Physical Exam

Date of visit	Results/findings if any	Are patient's immunizations up to date?
Has there been any concerns about growth? Please bring any records of height, weight and head circumference to your appointment.		

Is there anything else I should know about your or your child's medical history? Please provide any details you would like to share and use additional pages if necessary.

Perinatal History: [Note for adult patients: Please complete to the best of your ability]

Was the pregnancy healthy? Please describe if there were any health problems.

Were drugs, nicotine or alcohol used during pregnancy? What kind and which months, if any.

Please circle appropriate response, and comment as needed.

Was labor spontaneous / Induced?	Was anesthesia used? Yes / No	Was delivery normal? Yes / No	Caesarean section? Yes / No
Was baby born head / feet first?	Did baby have trouble starting to breathe?	Was baby jaundiced? Yes / No	
Was baby (please circle) breast / bottle fed? How long?	Gained weight adequately? Yes / No		
Were there problems in the first week?	First month?	First year?	

Developmental History:

Was pregnancy planned?	Was there preference for a boy or girl?	
Place of birth	Where raised	Raised by

Describe yourself/your child as an infant (please circle, and describe):

Active / active but calm / passive / other

Cuddly / irritable / withdrawn / other

Cried easily and frequently / reasonable amount / seldom

Soothed easily / soothed with difficulty / average

Response to changes: severe / moderate / mild

Response to being held (describe):

Reaction to strangers: friendly / indifferent / fearful

Did you/your child startle easily? Yes / No

Describe your (child's) eating habits. Were there any problems?

Describe your (child's) sleeping patterns. Were there any problems?

Developmental Milestones [note age first achieved, brackets are averages only]

Motor	**Language**	**Adaptive**
Rolled front/back (4 mo)	Mile (4-6 wks)	Mouthing (3mo)
Sit with support (6 mo)	Coo (3 mo)	Transfers object (6 mo)
Sit alone (9-10mo)	Babble (6 mo)	Picks up raisin (11-12 mo)
Pull to stand (10 mo)	Jargon (10-14 mo)	Scribble (15 mo)
Crawl (10-12 mo)	First word (12 mo)	Drinks from cup (10 mo)
Walk alone (10-18 mo)	Follows 1-step commands (15 mo)	Uses spoon (12-15 mo)
Run (15-24 mo)	2 word-combo (22mo)	Wash hands
Tricycle (3 yrs)	3 word sentence (3 yr)	Undress
Bicycle (5 yrs)	Speech problems? Y / N	Bladder trained
		Bowel trained

Family History: The following questions are regarding the members of the patient's biological family.

Family Psychiatric History:

Has any family member had any of the following? Please provide any details you can share (family member, treatment status, etc.)

Autism Spectrum Disorder (formerly PDD, Asperger Syndrome)	Suicidal thoughts/urges/actions/attempts
Intellectual Disability	Panic or anxiety disorder
Attention Deficit/Hyperactivity Disorder (ADHD)	Obsessive-Compulsive Disorder
Learning Disability (e.g., dyslexia)	Posttraumatic Stress Disorder
Schizophrenia, Schizoaffective Disorder or Psychosis	Motor or Vocal Tics
Depression	Alcohol use problems
Bipolar Disorder	Drug use problems
Suicidal thoughts/urges/actions/attempts	Eating Disorder

Other Psychiatric Disorders (please describe)

Family Medical History:

Is there anyone in the family with the following conditions? Please list relationship to the patient.

Migraines or chronic headaches	Alzheimer's Disease or Dementia (please describe)
Seizures or Epilepsy	Stroke
High or Low Blood Pressure	Sudden or Unexplained Death
Heart Problems (murmur, rhythm problems, birth defects, etc.)	Lung Disease (Asthma, Emphysema, etc.)
Diabetes	High Cholesterol
Stomach or Bowel Diseases (Ulcers, Crohn's, Ulcerative Colitis, etc.)	Kidney Disease (Inflammation, kidney stones, etc.)
Liver Disease (Hepatitis, cirrhosis, etc.)	Urinary or bladder problems / wetting
Growth / Endocrine problems (thyroid disease, etc.)	Skin problems (psoriasis, etc.)
Joint problems (arthritis, gout, etc.)	Eye disease (glaucoma, macular degeneration, etc.)
Autoimmune disorders (Lupus, Rheumatoid Arthritis, etc.)	Ear, nose or throat problems (hearing loss, etc.)
Blood or Bleeding Disordera	Genetic Disorders
Cancer	Immune deficiencies

What else should I know about your (child's) family history? (Please, provide any details you would like to share and use additional pages if necessary)

Social and Language Development

Did your child ever… *(please check appropriate response)*	Yes	No	Comments
Make strange sounds or use strange language			
Have any kind of speech impediment			
Require and/or receive speech therapy			
Have language development stop or regress			
Often repeat words or phrases instead of responding to what was just said or asked			
Seldom or never begin a conversation with someone else (once he could speak)			
Only talk to self, not others			
Has anyone ever suggested your child might have a developmental delay?			
Has anyone ever suggested your child might be intellectually disabled?			
Is your child affectionate and cuddly? Sit near you or others?			
Will your child look at people, talk to them and interact with them the way you would expect?			
Has your child done any of the following?			
Body rocking, head banging, hand flapping			
Make repetitive nonsense sounds when old enough to speak normally			
Toe walking			

Social History:

What are your (child's) friendships like?

What attracted you (your child) to these friends?

What do you / they do together? How often do you /they get together?

How does your child handle peer pressure?

Describe your (child's) work/employment history:

Describe your (child's) activities/interests/hobbies/skills:

Is there anything else I should know about your child's social or developmental history?

Education History:

Current school attended	Grade	Repeat Grades? If yes, please indicate which grade
Special education services received, if any (please include speech-language, occupational therapy, too):		

Educational evaluations performed, if any:

Date	Evaluation type (Neuropsychological, Cognitive testing, etc.)	Reason, and Results (Please provide copies of report if available):

Child's attitude towards school (relationship with teacher(s), peers, academic performance, etc.):
Please provide any details you would like to share. Please feel free to use additional pages if necessary

Family Social History:

Have there been any recent stresses in the family? Please explain if any (Loss or addition of family member(s), relocation, job change, etc.).