

Medical History Form for the First Appointment

Dear parents, dear young people! To make the best use of the time in the first appointment, we kindly ask you to fill in this form in advance and in your own time. There are no right or wrong answers – your view is valuable to us. Simply leave out anything you do not know or would rather not answer; we will discuss it together. All information is subject to medical confidentiality.

Please bring to the first appointment: this completed form · e-card (Austrian health insurance card) · referral (if available) · Mother-Child Pass (Mutter-Kind-Pass) or child health record · existing reports, doctors' letters, psychological assessments, developmental reports · current list of medication · latest school report · if parents live apart: proof of custody.

Not an emergency service. Our practice works by appointment only and cannot provide acute care. In an acute crisis – including while you are waiting for the first appointment – please contact the **Child and Adolescent Psychiatric Outpatient Clinic, Kepler University Hospital, Neuromed Campus** (Wagner-Jauregg-Weg 15, 4020 Linz, phone +43 5 7680 87-35131). Further contacts: see section 4.

1 Details of the child / adolescent

Surname	First name	Date of birth
Social insurance number	Health insurance provider	Sex
Street, house number	Postcode, town	Nationality
First language / language(s) spoken at home	Paediatrician or general practitioner	Phone of paediatrician

2 Parents / legal guardians and contact

Mother: name	Phone	E-mail		
Father: name	Phone	E-mail		
Other caregiver (e.g. step-parent, foster parents, grandparents):	Phone			
Custody lies with	☐ both parents	☐ mother	☐ father	☐ child and youth welfare / other
Form completed by	☐ mother	☐ father	☐ adolescent	☐ other person
Preferred contact for appointments	☐ e-mail	☐ phone	☐ both	

3 Reason for referral

Who suggested the appointment?

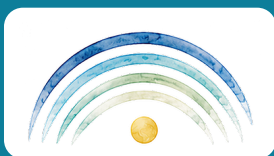
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|---|--|---|
| ☐ Referral by paediatrician / general practitioner | ☐ Recommendation by school / kindergarten | ☐ Recommendation by psychologist / psychotherapist |
| ☐ Hospital / outpatient clinic | ☐ Child and youth welfare services | ☐ Own initiative |

What is the main reason for the appointment? What worries you most?

Please use your own words – also from the child's or adolescent's point of view.

Since when have the difficulties existed?

Was there a trigger or a particular event?

Name of child / adolescent:

What do you expect or hope for from the appointment at our practice?

4

Current difficulties and symptoms

Please tick what currently applies (multiple answers possible):

- | | |
|---|--|
| ☐ Problems with concentration and attention | ☐ Restlessness, fidgeting |
| ☐ Impulsivity, "act first, think later" | ☐ Forgetfulness, disorganisation with tasks |
| ☐ Temper outbursts, irritability | ☐ Aggressive behaviour (verbal / physical) |
| ☐ Oppositional behaviour, breaking rules | ☐ Sadness, low mood |
| ☐ Lack of energy, loss of interest | ☐ Social withdrawal, few friendships |
| ☐ Anxiety (separation, school, social situations, specific fears) | ☐ Panic attacks |
| ☐ Obsessive thoughts / compulsive behaviour | ☐ Tics (motor / vocal) |
| ☐ Sleep problems (falling / staying asleep, nightmares) | ☐ Eating behaviour (restriction, binge eating, weight loss) |
| ☐ Physical complaints without medical cause (stomach aches, headaches) | ☐ Bedwetting / soiling |
| ☐ Self-harming behaviour | ☐ Suicidal thoughts or statements |
| ☐ School refusal, school absenteeism | ☐ Drop in school performance |
| ☐ Reading, spelling or maths difficulties | ☐ Speech or language difficulties |
| ☐ Difficulties in social interaction, special interests, rituals | ☐ Excessive media use (gaming, social media) |
| ☐ Use of nicotine, alcohol, cannabis, other substances | ☐ Experience of bullying |
| ☐ Mood swings, periods of elevated mood | ☐ Unusual perceptions, mistrust, withdrawal into own world |

Which three issues are currently the greatest burden for your child or your family?

Have there been dangerous situations (suicide attempt, serious self-harm, danger to others)?

☐

yes

☐

no

if yes, when:

Acute crisis? Please do not wait for the appointment. Our practice is not an emergency service. In case of acute danger to self or others, suicidal thoughts or a psychiatric emergency:

Child and Adolescent Psychiatric Outpatient Clinic, Kepler University Hospital, Neuromed Campus, Wagner-Jauregg-Weg 15, 4020 Linz, phone +43 5 7680 87-35131 · outside clinic hours via the emergency department of Kepler University Hospital

Emergency number 144 in case of immediate danger to life · **Krisenhilfe Oberösterreich** (crisis line) phone 0732 2177 (24/7) · **Rat auf Draht** phone 147 (for children and adolescents, free of charge, 24/7)

5

Pregnancy, birth and early development

Pregnancy

☐

uneventful

☐

complications

☐

nicotine / alcohol / medication

Birth in week of pregnancy

Birth weight

Mode of delivery (vaginal / caesarean / ...)

Complications at birth

Walking independently at (months)

First words at (months)

Sentences at (months)

Dry during the day at (years)

Development in infancy and early childhood

☐

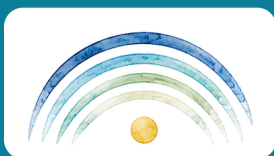
age-appropriate

☐

delayed

☐

unusual (contact, play, motor skills)

Name of child / adolescent:

Early intervention, speech therapy, occupational therapy or physiotherapy received?

☐ yes ☐ nowhat / when:

Attended nursery / kindergarten?

☐ yes ☐ nofrom age:

Particularities in early childhood (excessive crying, feeding or sleeping problems, separation difficulties, settling in)

6

School and education

Current school / place of training Type of school (primary, secondary, grammar school, Class / school year Class teacher or contact person Phone / e-mail of school Travel time / way to school

School history (in chronological order, including kindergarten):

Institution / school	Type of school	from – to	Particularities (deferred entry, repeated year, change of school and reason, special class)

School entry

☐ regular ☐ early ☐ deferred ☐ pre-school class

Current school performance

☐ good ☐ average ☐ weak ☐ very variable

Performance by subject (please tick):

German (reading / spelling)	☐ strong	☐ average	☐ weak	☐ extra support
Mathematics	☐ strong	☐ average	☐ weak	☐ extra support
English	☐ strong	☐ average	☐ weak	☐ extra support
General studies / sciences	☐ strong	☐ average	☐ weak	☐ extra support
Creative subjects and sports	☐ strong	☐ average	☐ weak	☐ extra support

Diagnosed specific learning disorder (dyslexia, dyscalculia)?

☐ yes ☐ nowhich / since when:

Special educational needs / compensation for disadvantages?

☐ yes ☐ noin which area:

School psychologist / counselling teacher / school social worker involved?

☐ yes ☐ nowhen:

Days absent in the last school year

☐ under 10 ☐ 10 to 30 ☐ over 30reason:

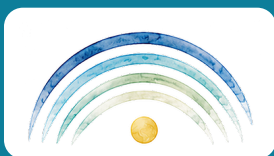
Homework

☐ independently ☐ with support ☐ regular conflictsdaily duration:

Experience of bullying (as victim or perpetrator)?

☐ yes ☐ nowhen / form:

How do teachers describe your child's behaviour in class, during breaks and towards classmates?

Name of child / adolescent: **Leisure and strengths: What does your child enjoy? What is he or she good at? What goes well in the family?***Strengths and resources are just as important for treatment planning as problems.***7 Physical health and medication****Known medical conditions (please tick):**

- | | | |
|--|--|---|
| ☐ Epilepsy / febrile seizures | ☐ Head injury, concussion | ☐ Heart disease, heart rhythm disorder |
| ☐ Thyroid disease | ☐ Asthma, allergies | ☐ Eczema (atopic dermatitis) |
| ☐ Diabetes | ☐ Migraine / frequent headaches | ☐ Gastrointestinal disease |
| ☐ Visual or hearing impairment (glasses, hearing aid) | ☐ Operations, hospital stays | ☐ Genetic / syndromic diagnosis |

Details of ticked items, other conditions Last hearing / vision test (date, result) Current weight (kg) Current height (cm) Sudden cardiac death or heart disease before age 40 in Known drug intolerances / allergies **Current medication (including supplements, melatonin, herbal remedies, contraceptives):**

Medication / active ingredient	Dose and times taken	since when	prescribed by	Effect / side effects

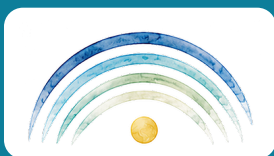
Previous psychiatric medication (e.g. methylphenidate, lisdexamfetamine, atomoxetine, guanfacine, antidepressants, antipsychotics, melatonin):

Medication / active ingredient	Maximum dose	from - to	Effect	Reason for stopping / side effects

Is the medication taken regularly?☐ yes ☐ often forgotten ☐ refused by child**Previous blood tests / electrocardiogram in connection with medication?**☐ yes ☐ no when / where: **8 Previous assessments, treatments and professionals involved**

Please list all previous assessments, treatments and professionals involved. If possible, bring reports with you or send them in advance.

Speciality / type (see below)	Name, institution, place	Period	Reason, result, diagnosis	Report enclosed



Name of child / adolescent:

Specialities: child and adolescent psychiatry · clinical psychology / testing · psychotherapy · occupational therapy · speech therapy · physiotherapy · paediatric neurology · inpatient / day clinic · child and youth welfare · counselling centre · early intervention

Has a child and adolescent psychiatric diagnosis already been made? ☐ yes ☐ no which / by whom: _____

Is there currently psychotherapy or another therapy? ☐ yes ☐ no with whom / since when: _____

Inpatient or day-clinic stay (child and adolescent psychiatry)? ☐ yes ☐ no where / when: _____

Is there an expert report (court, pension insurance, care allowance, school)? ☐ yes ☐ no which: _____

Contact with child and youth welfare services (family support, parenting support, out-of-home care)? ☐ yes ☐ no social worker, district: _____

Treatments discontinued in the past? ☐ yes ☐ no which / why: _____

In your view, what was helpful in previous treatments, and what was not?

9

Family and social environment

Parents ☐ live together ☐ separated ☐ divorced ☐ one parent deceased

Child lives with / living situation (including shared care, foster family, _____

If separated: since when, contact with the other parent _____

Occupation of mother _____

Occupation of father _____

Siblings:

First name	Age	full / half / step-sibling	lives in household	Particularities

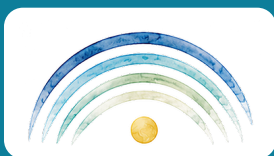
Stressful events in the family (current or past):

- | | | |
|--|--|--|
| ☐ Separation / divorce of parents | ☐ Death in the family | ☐ Serious illness of a family member |
| ☐ Move / change of school | ☐ Financial strain / unemployment | ☐ Violence in the family (experienced or witnessed) |
| ☐ Refugee / migration experience | ☐ Accident / natural disaster | ☐ Involvement of child and youth welfare |

Mental health or neurological conditions in the family (parents, siblings, grandparents, uncles / aunts):

- | | | |
|--|---|--|
| ☐ ADHD | ☐ Depression | ☐ Anxiety disorder |
| ☐ Obsessive-compulsive disorder | ☐ Bipolar disorder | ☐ Schizophrenia / psychosis |
| ☐ Autism spectrum disorder | ☐ Tic disorder / Tourette syndrome | ☐ Eating disorder |
| ☐ Addiction | ☐ Suicide / suicide attempt | ☐ Epilepsy / neurological disease |
| ☐ Reading and spelling disorder | ☐ Intellectual disability | ☐ none known |

Who (relationship) and which condition: _____

Name of child / adolescent: **10 Daily life, sleep and media**

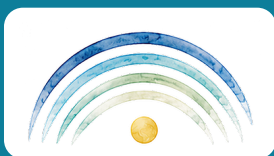
Usual bedtime (school day)	Wake-up time (school day)	Approximate sleep duration	Sleeps alone? Sleep aids?
Screen time on school days (hours)	Screen time at weekends (hours)	What (gaming, social media, television, ...)	
Hobbies, clubs, sports	Friendships (how many, how close, since when)		

Appetite and eating ☐ unremarkable ☐ eats little / picky ☐ eats a lot / binge eating ☐ weight concerns

What helps your child when he or she is feeling bad? What have you already tried as a family – and with what success?**11 For young people: your own view**

This part is for you. You can fill it in on your own. We will discuss what you write here with you – and only with your consent with your parents, unless there is a risk to you or others.

Why are you coming to us – from your point of view? What is on your mind most at the moment?**How have you been overall in the last two weeks?** ☐ very good ☐ fairly good ☐ fairly bad ☐ very bad**Are you coming because you want to?** ☐ yes ☐ not really ☐ I was sent**What would need to change for you to feel better? What do you hope for from us?****Is there anything you would like to discuss with me alone first?**

Name of child / adolescent: **12 Data protection, consent and signature****Privacy notice under Article 13 of the General Data Protection Regulation**

Controller: Dr. med. Daniel Stadler, Consultant Child and Adolescent Psychiatrist, Blütenstraße 15, 4040 Linz, Austria, ordination@kjp-drstadler.at.

Purpose and legal basis: The health data of your child and your contact details collected in this form are processed exclusively for child and adolescent psychiatric assessment and treatment, documentation and billing (Article 6(1)(b) and (c) and Article 9(2)(h) and (3) General Data Protection Regulation in conjunction with § 51 Austrian Physicians Act 1998 – duty of documentation). Voluntary additional services (consents below) are based on Article 6(1)(a) and Article 9(2)(a) General Data Protection Regulation. **Recipients:** social insurance providers for billing (Austrian General Social Insurance Act); the Austrian electronic health record (ELGA) under the Health Telematics Act 2012, unless an objection (opt-out) has been lodged with the ELGA objection office; IT service providers of the practice as processors (Article 28 General Data Protection Regulation). Other doctors, therapists, schools or authorities only receive data with your separate consent or where a statutory exception to medical confidentiality applies (§ 54 Austrian Physicians Act 1998, in particular notification of child and youth welfare services in case of reasonable suspicion of a risk to the child's welfare under § 37 Federal Child and Youth Welfare Act 2013). **Retention:** at least ten years after the last treatment (§ 51(3) Austrian Physicians Act 1998). **Your rights:** access to and inspection of the medical record (Article 15 General Data Protection Regulation, § 51(1) Austrian Physicians Act 1998), rectification, erasure (unless a statutory retention obligation applies), restriction of processing, withdrawal of consent with effect for the future, and complaint to the Austrian Data Protection Authority (dsb.gv.at). **Voluntary:** Completing this form is voluntary; unanswered questions have no disadvantage for treatment. **Adolescents:** For adolescents with capacity to consent – presumed from the age of 14 (§ 173 Austrian Civil Code) – medical confidentiality also applies towards the parents; information is shared with their consent. *This is a translation; in case of doubt, the German version applies.*

Consents (please tick individually – each consent can be withdrawn at any time):

- ☐ Sending reports to the referring doctor and to the paediatrician
- ☐ Release from medical confidentiality towards the professionals named in section 8 (exchange of reports)
- ☐ Contacting the school (class teacher, school psychologist) to coordinate support measures
- ☐ Communication by unencrypted e-mail (appointments, sending reports) to the address given above
- ☐ Appointment reminders by text message / e-mail

I confirm that the information has been given to the best of my knowledge, that I have read the privacy notice and that I am a legal guardian. In case of joint custody, I confirm that the other parent agrees to the appointment.

Place, date

Signature of parent / legal guardian (name in block capitals)

Signature of adolescent (from age 14)

Thank you! Please bring the completed form to the first appointment or send it in advance to ordination@kjp-drstadler.at.

Cancellations are only possible by e-mail to praxis@kjp-drstadler.at and at least 48 hours before the appointment.