MINDS *that* MATTER

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PATIENT AND FAMILY INFORMATION FORM

IDENTIFYING INFORMATION Date Completed: _____

Child's Name: _____ DOB: _____

Address: _____ Telephone: _____

Ethnicity/race: _____

Gender: _____ Male _____ Female Primary language if other than English: _____

Person answering questions: _____ Relationship: _____

Who has current custody/guardianship of child? ____ mother ____ father

____ both parents ____ relative:_____ other: _____

If the Legal Guardian is someone other than the parents complete the following:

Name: _____

Address: _____

Phone: _____

Relationship to child: _____

Comment on history/potential for changes in custody: _____
_____

Mother/Maternal Caregiver Information:

Relationship to child: _____ biological _____ adoptive _____ foster _____ step _____ other _____

Mother's name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Years of Education/Degree: _____

General Health: _____

Father/Paternal Caregiver Information:

Relationship to child: _____ biological _____ adoptive _____ foster _____ step _____ other _____

Father's name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Years of Education/Degree: _____

General Health: _____

Step Mother's Name (if applicable): _____

Step Father's Name (if applicable): _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Insured's Name: _____ Insured's DOB: _____/_____/_____

REASONS FOR EVALUATION

Who referred you to this clinic: _____

Please state your concerns; specify nature of problem, onset, duration, frequency, and severity:
_____
_____
_____
_____

Any unusual stressor your family is experiencing: _____

What do you hope to get from this evaluation/treatment? _____

Has your child received any early intervention services? _____ Yes _____ No If yes, please provide details about the services and provider(s): _____
_____
_____
_____

Can your child perform the following tasks without help: (check if yes)

_____ eat using a spoon and fork? _____
_____ cut meat/food with a knife? _____
_____ drink from a glass? _____
_____ undress? _____
_____ dress alone? _____
_____ tie shoelaces? _____
_____ toilet him/herself? _____
_____ bathe him/herself? _____

CHILD'S MEDICAL/PHYSICAL HISTORY

Who is the child's primary doctor? _____ Phone: _____

Address: _____

When was your child last seen by a physician? _____

For what reason? _____

Date and results of last physical examination: _____
_____

Child's current height: _____ weight: _____

Is the child's general physical health good? _____ Yes _____ No

Serious and/or chronic illness now (or in past)? _____

Sleep problems (too much/too little)? _____

Are immunizations up to date? _____ Yes _____ No

Does the child have any of the following impairments/conditions (documented)? _____ None reported
_____Unknown _____ Developmental disability _____Visual disability _____ Deaf _____ Hard of hearing
_____ Medically compromised _____ Medical/physical disability _____ Neurological disability
_____ FAS/FAE _____ Chronic medical/neurological condition which affects psychological functioning
_____ Other: _____

Has child had any history of seizures or head injury _____Yes _____ No (if yes, specify type, duration, frequency and date of last EEG)? _____
_____
_____

Has the child had any serious injuries/accidents or episodes with loss of consciousness?
_____ Yes _____ No
If yes, please provide details: _____
History of medical hospitalizations and/or surgeries: _____ None reported _____ Unknown

Provider Name(s):	Dates/duration:	Conditions treated:	Complications:	Discharge status:

Current ongoing use of non-psychiatric medications for physical health:
_____ None reported _____ Unknown

Name of medication(s):	Conditions:	Prescribing MD:	Dose/schedule:	Response/side effects:

Homeopathic, naturopathic, herbal and/or other alternative medicine treatments for physical health:
_____ None reported _____ Unknown

Current	Past	Name of treatment:	Condition(s):	Prescribing MD:	Response/side effects:

Medication Allergies: _____

Has your child had any of the following? (Please give details):

_____ recurrent headaches _____
_____ recurrent stomach aches _____
_____ recurrent diarrhea _____
_____ recurrent vomiting _____
_____ constipation _____
_____ vision problems _____

_____ hearing problems _____
_____ ear infections _____
_____ recurrent respiratory infections (bronchitis/bronchiolitis or pneumonia) _____
_____ allergies _____
_____ wheezing or asthma _____
_____ bladder problems _____
_____ problems with urination _____
_____ weight loss or gain _____
_____ skin problems _____
_____ problems with bones, muscles or joints _____
_____ tremor, shakes or jitters _____
_____ tics or other movement problems _____
_____ wets bed or him/herself _____
_____ soils bed or him/herself _____
_____ other _____

Does your child have any pain issues or concerns? _____ Yes _____ No If yes, please explain: _____
_____

Sexual Development (menstruation history, sexual activity, use of contraception, pregnancy history):
_____
_____
_____

DEVELOPMENTAL HISTORY

	Yes	No	N/A
Was this a surprise pregnancy?			
Any difficulty in becoming pregnant?			
Any illnesses during pregnancy?			
Any general anesthetics during pregnancy?			
Did you smoke cigarettes during pregnancy?			
Did you use any alcohol or street drugs during pregnancy?			
Was the delivery full term?			

Were there any problems during pregnancy? If yes, please specify: _____
_____

How many weeks were you at delivery? _____ Any problems with the delivery? ____
If yes, please specify: _____

Child's weight at birth _____ Any complications after delivery? _____

If yes, please specify: _____

Any difficulty in feeding (recurrent vomiting, "colic", poor suck, low weight gain? _____

If yes, please specify: _____

Was your child slow in	Yes	No	N/A
Sitting?			
Walking?			
Saying words?			
Using sentences?			
Toilet training?			
Did your child have problems socializing with others?			

CHILD SOCIAL-BEHAVIORAL AND PSYCHIATRIC HISTORY

How is your child's overall emotional health? _____
_____

List all past outpatient psychiatric/psychological/mental health services:
_____ None reported _____ Unknown

Provider Name(s):	Dates of tx:	Services provided:	Outcomes:	Termination reason(s):

List any history of psychiatric hospitalization and/or residential treatment:
_____ None reported _____ Unknown

Provider Name(s):	Dates of tx:	Services provided:	Outcomes:	Discharge status:

Psychiatric medication history for behavioral health:
_____ None reported _____ Unknown

Current	Past	Name of medication(s):	Conditions(s):	Prescribing MD:	Dose/schedule:	Response/side effects:

Please list all other persons or agencies who have evaluated your child in the past:

Type of service	Service provider/address	Results	Dates

Does your child have behavior problems at home? (please specify): _____
_____
_____

Does your child have behavior problems at school? (please specify): _____
_____
_____

Does your child have behavior problems in the community (e.g. grocery store, daycare, public places, etc? (please specify) _____
_____
_____

Does the child have any past/current substance use/abuse? _____ cigarettes _____ drugs _____ alcohol _____ denies use _____ remission 90+ days _____none If yes, please describe substances used, amount, and effect on child's performance at home and school: _____
_____
_____

History of violence/grief and loss:

Has child been exposed to domestic violence? _____ Yes _____ No

Has child been a witness to violence or traumatic death? _____ Yes _____ No

Has child experienced death of parent/psychological parent? _____ Yes _____ No

Child abuse/neglect history:

Has child had history of _____ physical abuse _____ sexual abuse _____ persistent inadequate parenting or neglect?

Has abuse/neglect been documented by Legal System? _____ Yes _____ No
_____
_____

Has the abuse history been previously addressed by a professional? _____ Yes _____ No If so, how?
_____
_____

Behavioral Problems:

Does your child currently have or has he/she ever had:	Yes	No
Problems with sleeping?		
Appetite change or sudden weight change?		
Irritability or temper outbursts?		
Depressive statements (for example: "I wish I was dead.")?		
Not coping in school like before?		
Withdrawn or prefers being alone?		
Frequent complaints of aches or pains?		
Recent drop in grades?		
Phobia or irrational fears?		
Difficulties separating from you?		
Bouts of severe anxiety or panics?		
Repetitive behaviors (for example: washing hands, checking locks)?		
Pulling out hair or eyelashes?		
Episodes of unusually high energy or talkativeness?		
Attention problems?		
Impulsive behaviors?		
Easily distracted from what he/she is doing?		
Hyperactive according to the teacher?		
Abnormal movements (for example: jerking or eye blinking)?		
Excessive noises (for example: throat clearing or sniffing)?		
Bossy?		
Refuses to do what he/she is told?		
Problems with the law?		
Expelled or suspended from school?		
Running away from home?		
Setting fires?		
Hurting animals or other people?		
Stealing?		
Abnormal lying?		
Smoking?		
Drinking?		
Illegal drug use?		
Inappropriate sexual behavior?		
Ever been sexually abused?		
Ever been physically abused?		
Slow to learn?		
Ever suspected of being mentally retarded?		
Ever suspected of being autistic?		
Plays with toys or other objects in an unusual way?		
Head bangs, flaps, twirls, or rocks?		
Injures him/herself (for example: bangs head, bites, or hits him/herself)?		
Resistant to change?		
Talks to him/herself?		
Have any imaginary friends?		
Ever appear to be hearing voices or seeing visions?		
Appear paranoid or afraid of others?		
Have any odd ideas or beliefs?		
Ever tried to kill themselves or others?		

FAMILY MEDICAL HISTORY

Does anyone in your family have any of the following conditions? Check all that apply, past or present:

Condition/Circumstance	**Child**	**Mother**	**Father**	**Sibling**	**Mother's Family**	**Father's Family**
Cardiovascular disease/sudden death from cardiac reason						
Diabetes						
Mental Retardation						
Learning disorder						
Attention Deficit						
Hyperactivity						
Epilepsy						
Neurological Disorders						
Alcohol Abuse						
Drug Abuse						
Physical/Emotional Abuse						
Sexual Abuse						
Depression						
Suicide Attempts						
Anxiety Disorders						
Specific Fears or Phobias						
Panic Attacks						
Schizophrenia						
Visual Disability/Problems						
Deaf/Hard of Hearing						
Tics/Tourette's Syndrome						
Chronic Illnesses						
Juvenile Delinquency						
Arrests/Incarceration						
Harassment by peers						
Homelessness						
Teen Pregnancy						
School suspension/expulsion						
Special Education						
Birth Defects						
Miscarriages						
Other: _____						

SCHOOL/VOCATIONAL HISTORY

Is the patient currently enrolled in school? _____ Yes _____ No

Current school placement:

School District: _____ Grade: _____

School Name: _____ Phone: _____

Teacher/Counselor/IEP Coordinator: _____

Is child enrolled in special education? _____ Yes _____ No Current IEP? _____ Yes _____ No (if yes, request copy)

Child is designated:
_____ Seriously behaviorally disordered _____ Learning disordered _____ Health impaired

Child's classroom is:
_____ Regular Education _____ Regular Education with pull out to Resource Room _____ Self-contained classroom _____ Generic special education classroom _____ Inclusive in regular education (_____ hours/day) _____ Other: _____

Describe current daily functioning in school setting (including strengths and needs): _____
_____
_____
_____

Review history of school placements and functioning: (including learning/behavior problems, multiple school placements, past educational testing, estimated level of achievement:) _____
_____
_____
_____

Has the child been suspended/expelled in past 12 months? _____ Yes _____ No How many times? _____

What school interventions have been used to address problems?: _____ None
_____ Special seating arrangement _____ Tutoring _____Token economy _____ Groups
_____ Classroom aide _____ Parent(s) called _____ other: _____

Vocational Assessment for Youth _____ Not applicable

Has youth had any paid employment? _____ Yes _____ No If yes, provide details of employment history:
_____

Social History:

If your child is adopted, how old was he/she when the adoption occurred? _____

If your child is adopted, do you have any information about his/her biological parents? _____
_____

Does your child have any brothers or sisters? _____

If yes, please complete the table below:

Name	Age	Sex	Where do they live?	Biological Status (example: full, half, step, sibling)

Does anyone else besides parents and siblings live in the home? _____

If yes, then please specify: _____

Are there any significant problems in the home?	**Yes**	**No**
Separation of parents		
Divorce		
Violence or abuse		
Drugs		
Alcohol		
Financial difficulties		
Eviction/Foreclosure		
Court cases/legal problems		
Unemployment		
Physical illness		