Patient Label

PROVIDENCE Medical Group

Child and Adolescent Psychiatry Clinic
1511 Division St., Suite 101, Oregon City, OR 97045
(Phone) 503.722.3705 (Fax) 971.282.0132

New Patient Intake Form

Patient name: ____**Date of Birth**:____________________

Current School:_________________________ Grade: ________School Counselor:_________________________________

Legal Guardian name:____

FAMILY DEMOGRAPHICS:

Please list all people in the household (please continue on back if needed):

Name	Relationship to patient	Age	Occupation/Workplace	Phone # of parent or primary caregiver

Second household, if applicable:

Name	Relationship to patient	Age	Occupation/Workplace	Phone # of parent or primary caregiver

Parents/guardians or siblings NOT living in the home:

Name	Relationship to patient	Age	Occupation/Workplace	Phone # of parent

Are there any documents related to guardianship and/or custody arrangements? ☐ Yes ☐ No

If yes, a copy of this documentation must be provided to the clinic at the outset of services. If there are any changes during the course of treatment, the guardian is responsible to update the clinic of any changes as soon as possible.

Current Primary Care Provider/Pediatrician:____

Clinic name and Phone #____

Current Therapist, Psychologist, or Counselor: ____

Clinic name and Phone #: ____

Others currently involved (Psychiatrist or PMHNP, DHS Caseworker, developmental disabilities): __________________________

Clinic name and Phone #: ____

CURRENT MEDICATIONS (please continue on back if needed):

Medication Name	Dose	How often taken?	When was it started?

Other mental health medications used in the past (please include dose, duration, reason for starting/stopping as able):

____

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MAIN CONCERNS/REASON FOR REFERRAL:

Please list the primary concerns you have about your child:____

____

How long have you had these concerns? ____

____

What are your goals for treatment for your child?____

____

PATIENT'S PSYCHIATRIC HISTORY:

Please list your child's past psychiatric care, psychological testing, therapy provided by schools, clinics, residential treatment, psychiatrists or PMHNP, therapists, or psychologists. **Bring evaluations to the first appointment as able.**

____

____

Please mark all boxes appropriately, and briefly explain "yes" answers. Details can be further discussed with your provider.		
Has your child been hospitalized for psychiatric reasons?	☐ Yes ☐ No	
Has your child ever attempted suicide?	☐ Yes ☐ No	
Has your child ever engaged in self-injurious behaviors?	☐ Yes ☐ No	
Any substances you think your child may be abusing?	☐ Yes ☐ No	
Has your child ever hurt others?	☐ Yes ☐ No	
Has your child ever destroyed property?	☐ Yes ☐ No	
Has your child ever been arrested/charged with a crime?	☐ Yes ☐ No	
Has DHS/Child Protective Services ever been involved?	☐ Yes ☐ No	

MEDICAL HISTORY:

Does your child have any current medical conditions (asthma, diabetes, seizure disorder, etc)? ☐ Yes ☐ No

Are there any specialists involved in your child's care (cardiologists, neurologists, gastroenterologists, etc) ☐ Yes ☐ No

When was your child's last physical exam (well-child)? __________________Was follow up recommended? ☐ Yes ☐ No

If you answered 'yes' to any of the above questions, please explain:______________________________________

Please circle any of the following that are part of your child's history and explain below:

surgeries, head injuries/concussions, seizures, fainting, heart problems (murmurs, arrhythmias, structural, etc.), hospitalizations, high blood pressure, high cholesterol, diabetes, sleep apnea, thyroid problems, anemia, strep throat, broken bones, motor/vocal tics, vision, dental, or hearing problems.

____

____

If your child is a female, has menstruation begun? Age of onset? Is mental state significantly affected by cycles?	☐ Yes ☐ No	
Has your child had any prior EKGs or blood draws?	☐ Yes ☐ No	
Does your child have any allergies to medication? Other allergies?	☐ Yes ☐ No	

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FAMILY HISTORY:

Please indicate on the chart below anyone in the child's biological family who has a history of any of the problems listed below.

	Child's Father	Father's Family	Child's Mother	Mother's Family	Child's Siblings	If any 'yes' answers, please explain (aunt, grandfather, etc.)
ADD/ADHD	☐	☐	☐	☐	☐	
Autism	☐	☐	☐	☐	☐	
Substance Abuse	☐	☐	☐	☐	☐	
Seizures/Convulsions	☐	☐	☐	☐	☐	
Cardiac defects/arrhythmias	☐	☐	☐	☐	☐	
Tourette's Syndrome	☐	☐	☐	☐	☐	
Eating Disorder	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	
Schizophrenia	☐	☐	☐	☐	☐	
Bipolar(manic/depressive) disorder	☐	☐	☐	☐	☐	
Mental Health Hospitalization	☐	☐	☐	☐	☐	
Suicide/Attempted Suicide	☐	☐	☐	☐	☐	
Trauma/PTSD	☐	☐	☐	☐	☐	

Please list significant medical illnesses in immediate family members (heart problems, thyroid problems, seizures, etc):

____

EDUCATIONAL HISTORY:

Please bring the IEP to your first appointment as able.

Does your child have an individualized education plan (IEP)? ☐ Yes ☐ No 504 plan? ☐ Yes ☐ No

What are the average grades or GPA your child receives?______________________

Has your child had any behavioral issues at school or been suspended/expelled? If 'yes', please explain. ☐ Yes ☐ No

____

Extracurricular/Sports/Hobbies: ______________________________________

Please describe your child's peer group/friends:______________________________

Please describe your child's use of screen time including TV, internet &/or cell phone:______________

____

Does your child currently have a job? ☐ Yes ☐ No If 'yes', what are the hours worked during the week?__________

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PREGNANCY, DELIVERY & INFANCY:

Patient was born at what week of pregnancy? _______Birth weight? __________ (Circle) induced, spontaneous, C-section

Please mark all boxes appropriately, and explain any 'yes' answers below:		
Was the patient adopted?	☐ Yes ☐ No	
Were there any complications with delivery?	☐ Yes ☐ No	
Was the mother experiencing any significant stress, conflict, or grief around the time of the pregnancy?	☐ Yes ☐ No	
During the pregnancy, did the mother take prescribed medication?	☐ Yes ☐ No	
During pregnancy, did the mother drink alcohol?	☐ Yes ☐ No	
During pregnancy, did the mother use any drugs or smoke cigarettes?	☐ Yes ☐ No	
Was the child breast fed? If so, for how long?	☐ Yes ☐ No	
Between the ages of 0-2 years, was the child extremely sensitive to slight changes in touch, sound level, lighting, etc.?	☐ Yes ☐ No	
Between the ages of 0-2 years, was the child unable to develop a regular sleeping pattern?	☐ Yes ☐ No	
Between the ages of 0-2 years, was the child impossible or very difficult to soothe or calm self when distressed/upset?	☐ Yes ☐ No	
Between the ages of 0-2 years, was the child unable to separate from parents without extreme distress?	☐ Yes ☐ No	
Between the ages of 0-2 years, was the child unable to show affection?	☐ Yes ☐ No	

Check the boxes as appropriate to describe developmental milestones:

Milestone	Age Achieved	Early	On Time	Late	Unknown
Walked alone		☐	☐	☐	☐
Spoke first word		☐	☐	☐	☐
Spoke in full sentences		☐	☐	☐	☐
Bladder training complete		☐	☐	☐	☐
Bowel training complete		☐	☐	☐	☐

SAFETY:

Please mark all boxes appropriately, and explain any 'yes' answers below.

Are medications in the home accessible to your child? ☐ Yes ☐ No
Are there any firearms in the home? ☐ Yes ☐ No
Do you have other safety concerns at this time? ☐ Yes ☐ No

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