PROVIDENCE
Medical Group

Patient Label Here

FAMILY DEMOGRAPHICS:

Patient name: _____ **Date of Birth**: _____

Cultural/ethnic and religious background: _____

Form completed by: _____ Date: _____

Legal Guardian name: _____

Please list all people in the household:

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 or siblings NOT living in the home:

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

Current Primary Care Provider/Pediatrician: _____

Clinic name: _____ Ph# _____

Current Therapist, Psychologist, or Counselor: _____

Clinic name: _____ Ph# _____

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

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. **Please 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	

FAMILY HISTORY:

Please place a check on the chart below for biological family members with history of the following problems.

	ADHD (Attention Deficit Hyperactivity)	Autism	Anxiety	Panic Disorder	Depression	Bipolar disorder	Eating Disorder	OCD (Obsessive Compulsive Disorder)	Paranoia or hallucinations	Schizophrenia	Substance Abuse (Drugs/Alcohol)	Trauma/PTSD	Psychiatric Hospitalization	Attempted Suicide/Suicide	Legal problems/Prison	Other
(Siblings, specify)																
(Maternal side)																
Mother																
Grandmother																
Grandfather																
Aunt																
Uncle																
Cousin																
(Paternal side)																
Father																
Grandmother																
Grandfather																
Aunt																
Uncle																
Cousin																

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

_____

_____

PREGNANCY, DELIVERY, & DEVELOPMENT:

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	
..use any drugs or smoke cigarettes?	☐ Yes ☐ No	
Was your child breast fed? If so, for how long?	☐ Yes ☐ No	

Were there any problems in infancy (colic, problems with sleep, soothing, etc) or developmental concerns? _____

_____

Please estimate your child's age when they:	
Walked alone	
Spoke first words/first sentences	/
Bladder/bowel training complete	/

Were there any significant changes or stressors in youth? _____

Family moves (# of moves, year): ☐ Yes ☐ No _____

Family divorce/separation (year): ☐ Yes ☐ No _____

Death of close family members: ☐ Yes ☐ No _____

Other losses (pets, romantic relationships): ☐ Yes ☐ No _____

EDUCATIONAL HISTORY:

Current School: _____ **Grade**: _____ School Counselor: _____

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

Please bring the IEP to your first appointment as able.

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

Has your child had any behavioral issues at school or been suspended/expelled? ☐ 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 (hours/week worked) ☐ 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

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	

CURRENT MEDICATIONS:

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):

_____

_____

_____

_____

SAFETY:

Are medications in the home accessible to your child? ☐ Yes ☐ No _____

Are there any firearms accessible to your child? ☐ Yes ☐ No _____

Do you have other safety concerns at this time? ☐ Yes ☐ No _____