Banner University Medicine

New Patient Intake Information

(Parent Report)

Welcome to the UA Whole Child Clinic! Our approach to treating your child is comprehensive and thorough. We consider various factors that contribute to your child's well-being including their behavior, growth and development, family, friends, school, physical health, diet, and physical activity. This intake form provides vital information about your child from your perspective as a parent. We hope you find that although the intake form is lengthy and requires an investment in time, it will allow us to understand your child and provide the best treatment.

To fill out this intake form, please allow at least 45 minutes so you can answer all of the questions accurately. All of the questions are very important for your psychiatrist to know about, so please take your time and answer as carefully as you can.

Because of our comprehensive approach, please allow 2 hours for the first appointment. After the first appointment, we may request to contact your child's school and therapist. Initial recommendations are usually given at the second appointment. At the first session, it is important that **caregivers** be present. For 2 parent families, both parents are HIGHLY encouraged to attend. In families with only a single parent, another key caregiver is invited to attend (if applicable).

Please bring the following with you to the first appointment, if available:

- ✓ Previous testing that has been done on your child (ex: neuropsychological testing, psychoeducational testing)
- ✓ Child's report card
- ✓ IEP (Individualized Education Program) or 504 plan if in place
- ✓ Testing done to create the IEP (Multi Factored Evaluation)
- ✓ All other relevant medical documents.
- ✓ All bottles/packages for all medications that the child is **currently** taking. This includes medications prescribed by a doctor, over the counter medications (ex: Tylenol), and all bottles of vitamins or nutritional supplements.
- ✓ Functional Behavior Assessments (FBA) and Behavior Intervention Plans (BIP)
- ✓ Legal paperwork establishing guardianship/custody arrangement (if applicable)

Thank you for choosing the UA Whole Child Clinic. We look forward to working with you and your child.

Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH

Patient Name: _____ **Date of Birth:** _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Referring Provider: _____

ALLERGIES

☐ **No Known Allergies** List any allergies and intolerances to **medications, food or the environment.**

Allergy	Reaction

MEDICATIONS

☐ **No Medications** List any medications you are taking, with dose and how often.

Medication Name	Dose	How often?

List any Vitamins, Supplements and Over the Counter Medicines

1.	2.
3.	4.
5.	6.

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0136
(01/2017)

Banner Health®

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH

MEDICAL / PSYCHIATRIC HISTORY

What **medical** problems have you had? Please mark **all** that apply:

	CONDITION		CONDITION		CONDITION		CONDITION
	ADD/ADHD		Bronchitis		Intermittent Explosive Disorder		Post-traumatic Stress Disorder (PTSD)
	Abdominal pain		Circadian rhythm disorder (sleep phase syndrome)		Major Depression-chronic		Prematurity
	Acne		Chickenpox		Major Depression-single episode		Psychotic Disorder
	Adjusted disorder with anxiety		Concussion/CHI		Menstrual Problems		Pyelonephritis
	Adjusted disorder with conduct disorder		Congenial Heart Disease		Migraines		Recurrent Depression Psychosis
	Adjustment disorder with depression		Constipation		Mood Disorder		Recurrent Otis Media
	Adjustment disorder with disturbance of emotions		Depression		Narcolepsy		Schizoaffective Disorder
	Allergic rhinitis		Diabetes		Obsessive Compulsive Disorder		Seizure Disorder
	Allergies		Drug Dependence		Oppositional Defiant Disorder		Seizure-Febrile
	Anemia		Dysthymic Disorder		Panic Disorder w/ agoraphobia		Sleep apnea
	Anxiety		Eczema		Panic Disorder w/o agoraphobia		Social Phobia
	Bipolar I		Fracture		Paranoid Schizophrenia		Substance Dependence
	Bipolar II		G.E.R.D.		Parasomnias		Suicidality
	Bleeding Disorder		Headache, migraine		REM _____ Non REM _____		Traumatic brain injury
	Borderline Personality Disorder		Hearing Problems		Pneumonia		Urinary tract infection
	Bronchiolitis		Heart murmur		Poly-substance Dependence		Other: _____

Other medical problems:

_____

SURGICAL HISTORY

What **surgeries** have you had? Please mark **all** that apply and include the year they were performed.

	Adenoidectomy		Hypospadias repair		Tonsillectomy
	Appendectomy		Inguinal hernia repair		Umbilical hernia repair
	Circumcision		Lymph node biopsy		
	Dental surgery		PET placement		

Other surgeries: _____

_____

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NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				
Brother				
Sister				

SOCIAL HISTORY

TOBACCO / ALCOHOL / CAFFEINE / DRUGS
(For patients 12 and older)

Tobacco/smoking status: Never _____

Current _____ Type _____ Amount _____ Duration _____

Former _____ Type _____ Amount _____ Duration _____

Tobacco use in the household? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No Type _____ Amount _____ Frequency _____

Alcohol use in the household? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No Type _____ Amount _____ Frequency _____

Substance abuse use in the household? ☐ Yes ☐ No

TOBACCO / ALCOHOL / CAFFEINE / DRUGS
(For patients under 12)

Tobacco use in the household? ☐ Yes ☐ No

Alcohol use in the household? ☐ Yes ☐ No

Substance abuse use in the household? ☐ Yes ☐ No

HOME ENVIRONMENT

Child lives with: _____

EXERCISE

Do you exercise? ☐ Yes ☐ No If yes, list type of exercise and number of times/week: _____

EMPLOYMENT/SCHOOL

Grade in school: _____ Name of school: _____

Occupation _____ Employer _____

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NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH

REVIEW OF SYSTEMS

CONSTITUTIONAL			CARDIOVASCULAR			NEUROLOGICAL		
Headaches	Yes	No	Heart trouble	Yes	No	Frequent or recurring headaches	Yes	No
Recent weight gain	Yes	No	Palpitations	Yes	No	Head injury	Yes	No
Recent weight loss	Yes	No	Sudden heart beat changes	Yes	No	Stroke	Yes	No
EYES			**RESPIRATORY**			Tremors	Yes	No
Eye disease/injury	Yes	No	Asthma	Yes	No	**PSYCHIATRIC**		
Glaucoma	Yes	No	COPD	Yes	No	Depression	Yes	No
ENT			Use oxygen	Yes	No	Memory loss or confusion	Yes	No
Hearing loss	Yes	No	Wheezing	Yes	No	Nervousness	Yes	No
GENITOURINARY			**GASTROINTESTINAL**			Sleep problems	Yes	No
Frequent urination	Yes	No	Gastroesophageal reflux	Yes	No	**ENDOCRINE**		
Incontinence or dribbling	Yes	No	Loss of appetite	Yes	No	Glandular/hormone problem	Yes	No
Sexual difficulty	Yes	No	Nausea/Vomiting	Yes	No	Thyroid disease	Yes	No
MUSCULOSKELETAL						**HEMATOLOGIC**		
Back pain	Yes	No				Easily bruised/bleed	Yes	No
Difficulty walking	Yes	No						
Weakness of muscles/joints	Yes	No						

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Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

Current Mental Health Providers

Counselor/Therapist Name _____ Phone _____

Psychiatrist Name _____ Phone _____

Specialty _____

Current School _____ School Phone _____

Contact Name _____

Current grade level _____ Average grades _____

Homework problems _____

_____

Current Concerns

Please describe your child's problem(s) (that is, the concerns that brought you here today):

When did these problems begin?

Please give examples of the problem:

Why do you think your child is having this particular problem?

Challenging Behavior

1. Record each problem behavior the individual displays and describe it specifically. Include any damage resulting from the problem behavior either to the individual or others. Please rank in order of concern to yourself or other caretakers.

	Behavior	Description
A.	_____	_____
B.	_____	_____
C.	_____	_____
D.	_____	_____
E.	_____	_____
F.	_____	_____
G.	_____	_____

Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

2. Estimate the severity of the problem behavior of greatest concern (circle one)
   Moderate Severe Life-threatening
3. Has the individual ever been sent to the hospital to treat an injury resulting from the behavior? No Yes
   Describe: _____
4. Has the individual ever sent someone else to the hospital to treat an injury resulting from the behavior? No Yes
   Describe: _____
5. Has the individual ever been hospitalized to develop a treatment for these behavior problems? No Yes
   Describe: _____
6. In what settings do these behaviors occur?
   a. Home
   b. School
   c. Community: specify _____
   d. Other: _____
7. Estimate the current frequency of the problem behavior(s) (circle one).
   a. Less than one episode per week (list frequency)
   b. 1 to 3 episodes per seek
   c. Occurs about once daily
   d. Occurs several times per day
   e. Occurs every hour while awake
8. How long has the individual been engaging in the problem behavior(s) (circle one)?
   a. Within past 6 months
   b. More than 6 months but less than 1 year
   c. More than 1 year but less than 3 years
   d. More than 3 years but less than 5 years
   e. More than 5 years but less than 10 years
   f. More than 10 years
9. When is the problem behavior(s) likely to occur (circle all that apply)
   a. When individual is left alone or unattended
   b. When lots of people are around
   c. When demands are placed on the individual
   d. Mealtimes, dressing or bathing (circle)
   e. Time of day: _____
   f. Other: _____
10. Are there any occasions when the problem behavior(s) rarely or never occurs?

    _____

    _____

11. a. How do people (staff, parents, etc.) typically respond when the individual engages in the problem behavior(s)?

    _____

    (If a formal program is currently being conducted, refer to it here and send a copy)

11. b. How long has the program been in place? _____

    _____

12. Estimate the general trend of the problem behavior(s) during the past year (circle one)
    a. Increasing (behavior getting worse) b. Decreasing (behavior getting better) c. Stable (about the same)
13. Does the individual display aggressive behavior toward staff or peers? If yes, explain: _____

    _____

    _____

    _____

14. Was the onset of the problem behavior(s) associated with any specific event or series of events?

Have the following procedures ever been used to treat the problem behavior(s)? (circle all that have been used)

a. Restraint

Describe: _____

Start Date: _____ Still used? No / Yes Stop Date: _____

Estimated degree of success:

Which problem behavior(s) was the treatment indicated for?

b. Protective Equipment

Describe: _____

Start Date: _____ Still used? No / Yes Stop Date: _____

Estimated degree of success:

Which problem behavior(s) was the treatment indicated for?

c. Behavior Modification - positive reinforcement

Describe: _____

Start Date: _____ Still used? No / Yes Stop Date: _____

Estimated degree of success:

Which problem behavior(s) was the treatment indicated for?

d. Behavior Modification - punishment
Describe: _____
_____
Start Date: _____ Still used? No / Yes Stop Date: _____
Estimated degree of success:
_____
_____
Which problem behavior(s) was the treatment indicated for?
_____
_____

e. Other Describe: _____
_____
Start Date: _____ Still used? No / Yes Stop Date: _____
Estimated degree of success:
_____
_____
Which problem behavior(s) was the treatment indicated for?
_____

What are your goals for consulting with our clinic? That is, what would you like to happen?
1. _____
2. _____
3. _____
4. _____

What feelings does your child MOST OFTEN show when faced with stress or other problems? (i.e. anger, fear, sadness, etc.)

What seems to help your child deal with stress or problems?

What seems to make things worse?

Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

Life Stress

Major Stresses: Please mark if any of the following events have happened to your child in the past TWO YEARS?
Check all that apply:

- ☐ Moving to a new home
- ☐ Change to a new school
- ☐ Parents fighting
- ☐ Parents separated
- ☐ Parents divorced
- ☐ New stepmother or stepfather
- ☐ Mother or father lost a job
- ☐ Mother or father got a new job
- ☐ Change in parent's financial status
- ☐ Increased absence of a parent
- ☐ Parent in trouble with the law
- ☐ Parent went to jail
- ☐ Child had major personal injury/illness
- ☐ Serious illness or injury in the family
- ☐ Death of a family member
- ☐ Serious illness of a friend
- ☐ Boyfriend/girlfriend/friend having operation
- ☐ Male: Girlfriend become pregnant
- ☐ Female: Became pregnant
- ☐ Death of a friend
- ☐ Loss of a pet
- ☐ Got a new pet
- ☐ Got own car
- ☐ New brother or sister
- ☐ Trouble with a brother or sister
- ☐ More arguments with parents
- ☐ Less arguments with parents
- ☐ Getting a new boyfriend/girlfriend
- ☐ Breaking up with boyfriend/girlfriend
- ☐ Making up with boyfriend/girlfriend
- ☐ Losing a close friend
- ☐ Got a new job
- ☐ Lost a job
- ☐ Special recognition for good grades
- ☐ Making the honor role
- ☐ Joining a new club
- ☐ Making an athletic team, cheerleading, etc.
- ☐ Failing to make athletic team, cheerleading, etc.
- ☐ Trouble with teacher
- ☐ Trouble with classmates
- ☐ Making failing grades in school classes
- ☐ Failed a grade/put back a grade
- ☐ Skipped a grade/put ahead a grade
- ☐ Got suspended from school
- ☐ Got into trouble with the police
- ☐ Got put into detention, jail

Sleep

Where does your child sleep? *Please check all that apply.*

- ☐ Own bed
- ☐ Shares a bed. If so, with whom? _____
- ☐ Other (couch, floor, etc.) _____
- ☐ Own room
- ☐ Shares a room. If so, with whom? _____

What time does child usually go to bed on SCHOOL days? _____

What time does child usually go to bed on WEEKENDS? _____

How long (in minutes) does it usually take for child to fall asleep each night?	15 or less ☐	16 – 30 ☐	31 – 60 ☐	61 or more ☐

Problems falling asleep? ☐ No ☐ Yes If yes, please describe: _____

Problems staying asleep? ☐ No ☐ Yes If yes, please describe: _____

Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

On average, how many hours does your child sleep at night?

☐ Less than 6 hours ☐ 7 – 8 hours ☐ 9 hours ☐ 10 hours ☐ More than 10 hours

What time does child usually wake up on SCHOOL days? _____

What time does child usually wake up on WEEKENDS? _____

Problems waking up? ☐ No ☐ Yes If yes, please describe: _____

How often does your child take a nap?

☐ Never ☐ 1 – 2 days per week ☐ 3 – 6 days per week ☐ Every day

There is a television in my children's room. ☐ No ☐ Yes

Any current or history of: *Check all that apply*

☐ Loud Snoring
☐ Restless Sleep
☐ Sleepy during the day
☐ Mouth breathing
☐ Observed apnea (stops breathing) while sleeping
☐ Sleep Terrors
☐ Dry mouth
☐ Grinds teeth
☐ Sleep Walking
☐ Awaken gasping for breath or choking
☐ Irresistible urge to move legs or arms
☐ Bedwetting at night
☐ Recurrent nightmares
☐ Pain in legs at night

Diet and Nutrition

Is your child currently on a special diet? (e.g., vegetarian, vegan, high protein, gluten free) ☐ No ☐ Yes

If yes, please list dietary restrictions: _____

How many meals per week does your family eat together where your child is present?

☐ None ☐ 1 – 5 ☐ 6 – 10 ☐ 11 – 15 ☐ 16 or more

How many mornings per week does your child eat breakfast?

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

The amount of certain foods and beverages your child eats on an AVERAGE day:

Soda (glasses, cups, or cans of Coke, Pepsi, etc)	☐ None	☐ 1	☐ 2 or more	☐ Don't know
Caffeinated tea (cups of iced tea or hot tea)	☐ None	☐ 1	☐ 2 or more	☐ Don't know
Caffeinated coffee (8 ounce cups)	☐ None	☐ 1	☐ 2 or more	☐ Don't know
Energy drinks (cans, glasses, or cups)	☐ None	☐ 1	☐ 2 or more	☐ Don't know
Fast Food	☐ None	☐ 1	☐ 2 or more	☐ Don't know
Restaurant meals (including take out)	☐ None	☐ 1	☐ 2 or more	☐ Don't know
Prepackaged meals (including frozen meals)	☐ None	☐ 1	☐ 2 or more	☐ Don't know
Servings of fruit	☐ None	☐ 1	☐ 2 or more	☐ Don't know
Servings of vegetables	☐ None	☐ 1	☐ 2 or more	☐ Don't know

Physical Activity and Exercise

How many days a WEEK does your child spend at least 60 minutes in physical exercise that made child breathe hard and increase heart rate (running, swimming, riding a bicycle, playing sports):

☐ None ☐ 1-2 days ☐ 3-4 day ☐ 5-6 days ☐ 7 days

Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

Does your child have and attend Physical education (PE) class at school:

☐ No ☐ Yes ☐ Don't know

Screen Time

For an average day, how many hours does your child spend:

Watching TV _____

Playing video games _____

Using computer _____

Cell phone _____

Other electronic device _____

Playing video games: include online games, X Box, Play Station, iPad/tablet, iPhone/smartphone

Using a computer: school work, internet, emailing, Skype. DO NOT include video games

Cell phone, other electronic device: for texting, talking with friends, etc.

Child's Past Psychiatric or Mental Health Care

Past Psychiatric Medications

What prescription psychiatric medications have been tried with your child in the PAST? Include all medications that have been prescribed by a doctor or other health care provider (if you have them, please bring all medication bottles to your first visit).

Name of Past Psychiatric Medication	Strength (Ex: 50 mg, 5 units)	Dose (Ex: 1 capsule daily, 1 teaspoon twice a day)	Reason Started	Side Effects

Has your child EVER seen a therapist or counselor before? (e.g., psychologist, social worker, school counselor)

☐ No ☐ Yes If yes, when and why? _____

_____

_____

Has your child EVER seen a psychiatrist before? ☐ No ☐ Yes If yes, when and why? _____

_____

_____

Does the child have a history of:

☐ Seizures ☐ Concussions ☐ Head traumas

☐ Passing out ☐ Palpitations (rapid heartbeat) ☐ Heart murmur

☐ Rheumatic fever ☐ Chest pain or shortness of breath with exercise

☐ High blood pressure ☐ Reflux

Does the child have a history of eczema ☐ No ☐ Yes If yes, when diagnosed: _____

Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

FOR GIRLS:

Has your daughter begun menstruation (having her periods)? ☐ No ☐ Yes If yes, at what age? _____

Are her menstrual cycles ☐ Regular (every 28 days) ☐ Not regular (3 weeks, 5 weeks)

Does she have significant mood changes that go along with her monthly cycles? ☐ No ☐ Yes

If yes, please describe: _____

Does your daughter take birth control? ☐ No ☐ Yes

Review of Systems:

Please indicate by your child has had any of the following medical problems within the past month. *Check all that apply.*

General
- ☐ Fever
- ☐ Fatigue
- ☐ Recent weight loss or gain
- ☐ Restriction of numerous foods
- ☐ Heat or cold intolerance
- ☐ Difficulty sleeping

Head, Eyes, Ears, Nose, Mouth, Throat
- ☐ Headache
- ☐ Dizziness
- ☐ Loss of hair
- ☐ Swollen glands
- ☐ Red or irritated eyes
- ☐ Ringing in ears
- ☐ Dry mouth
- ☐ Bad breath
- ☐ Mouth sores
- ☐ Sore throat
- ☐ Voice changes
- ☐ Swollen glands
- ☐ Running nose
- ☐ Post nasal drip

Respiratory
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest pain on taking a deep breath
- ☐ Other chest pain or tightness
- ☐ Cough

Genitourinary
- ☐ Pain with urination
- ☐ Increase in frequency or urgency in urinating
- ☐ Blood in urine

Cardiovascular
- ☐ Irregular heart beat
- ☐ Murmur
- ☐ Palpitations

Bones, Muscles, Joints
- ☐ Morning stiffness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Neck pain
- ☐ Low back pain
- ☐ Numbness or tingling

Skin
- ☐ Rash over cheeks
- ☐ Hives or welts
- ☐ Easy bruising
- ☐ Sun sensitivity
- ☐ White, blue, or red skin color change in fingers when exposed to cold
- ☐ Strong foot odor

Gastrointestinal
- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Heartburn, indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain or cramps in abdomen
- ☐ Abnormal stool patterns
- ☐ Bloated abdomen and gas/burping
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Vomiting blood

Family History

Questions in this section are separated between biological parents and guardians/foster parents. If you are a guardian or foster parent, please first answer what you know about the child's biological mother and father. Then, move to the section about yourself.

Biological Parents

Biological Mother

Biological mother's current age: _____

If deceased, age at death and cause of death: _____

Biological mother's race/ethnicity:

☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black / African American ☐ Hispanic / Latino ☐ Middle Eastern Indian
☐ Native Hawaiian / Other Pacific Islander ☐ Other _____ ☐ Unknown

Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

Biological mother's highest level of completed education?

- ☐ Elementary School only (grades 1-8)
- ☐ Some high school, but did not finish (grades 9-11)
- ☐ Completed high school or GED (high school graduate)
- ☐ Some college, but have not completed a degree
- ☐ Two-year college degree / A.A / A.S.
- ☐ Four-year college degree / B.A. / B.S.
- ☐ Some graduate work but have not completed a degree
- ☐ Completed a Master's degree or professional degree (e.g., ARNP)
- ☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Biological mother's current employment status?

☐ Employed full time ☐ Employed part time ☐ Unemployed / Looking for work ☐ Homemaker ☐ Retired

If employed full or part time, what is biological mother's occupation or type of work? _____

_____

Has the biological mother ever sought psychiatric treatment? ☐ No ☐ Yes

If yes, please explain the purpose: _____

Has the biological mother ever had treatment or counseling for alcohol or drug use? ☐ No ☐ Yes

If yes, please explain: _____

Does/has anyone on the biological mother's side of the family...

Take psychiatric medications? ☐ No ☐ Yes If yes, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ☐ No ☐ Yes If yes, who and why? _____

_____

Ever been hospitalized for alcoholism or drug abuse? ☐ No ☐ Yes If yes, who and why? _____

_____

Ever attempted suicide? ☐ No ☐ Yes If yes, who? _____

Ever committed/completed suicide? ☐ No ☐ Yes If yes, who? _____

Biological Father

Biological father's current age: _____

If deceased, age at death and cause of death: _____

Biological father's race/ethnicity:

☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black / African American ☐ Hispanic / Latino ☐ Middle Eastern Indian
☐ Native Hawaiian / Other Pacific Islander ☐ Other _____ ☐ Unknown

Biological father's highest level of completed education?

- ☐ Elementary School only (grades 1-8)
- ☐ Some high school, but did not finish (grades 9-11)
- ☐ Completed high school or GED (high school graduate)
- ☐ Some college, but have not completed a degree
- ☐ Two-year college degree / A.A / A.S.
- ☐ Four-year college degree / B.A. / B.S.
- ☐ Some graduate work but have not completed a degree
- ☐ Completed a Master's degree or professional degree (e.g., ARNP)
- ☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Banner Health

NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

Biological father's current employment status?

☐ Employed full time ☐ Employed part time ☐ Unemployed / Looking for work ☐ Homemaker ☐ Retired

If employed full or part time, what is biological father's occupation or type of work? _____

_____

Has the biological father ever sought psychiatric treatment? ☐ No ☐ Yes

If yes, please explain the purpose: _____

Has the biological father ever had treatment or counseling for alcohol or drug use? ☐ No ☐ Yes

If yes, please explain: _____

Does/has anyone on the biological father's side of the family:

Take psychiatric medications? ☐ No ☐ Yes If yes, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ☐ No ☐ Yes If yes, who and why? _____

_____

Ever been hospitalized for alcoholism or drug abuse? ☐ No ☐ Yes If yes, who and why? _____

_____

Ever attempted suicide? ☐ No ☐ Yes If yes, who? _____

Ever committed/completed suicide? ☐ No ☐ Yes If yes, who? _____

If your child is <u>NOT</u> adopted, please <u>SKIP</u> this section, and resume at "Family Medical History"

Non-Biological/Adoptive Parents

How long has this child been with you? _____

Are you related to the child (grandparent, aunt/uncle)? ☐ No ☐ Yes

If yes, how related? _____

Non-Biological Mother In the following questions, "mother" refers to the foster or adoptive mother

Mother's current age: _____

If deceased, age at death and cause of death: _____

Mother's race/ethnicity:

☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black / African American ☐ Hispanic / Latino ☐ Middle Eastern Indian
☐ Native Hawaiian / Other Pacific Islander ☐ Other _____ ☐ Unknown

Mother's highest level of completed education?

☐ Elementary School only (grades 1-8)
☐ Some high school, but did not finish (grades 9-11)
☐ Completed high school or GED (high school graduate)
☐ Some college, but have not completed a degree
☐ Two-year college degree / A.A / A.S.
☐ Four-year college degree / B.A. / B.S.
☐ Some graduate work but have not completed a degree
☐ Completed a Master's degree or professional degree (e.g., ARNP)
☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

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NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

Mother's current employment status?
☐ Employed full time ☐ Employed part time ☐ Unemployed / Looking for work ☐ Homemaker ☐ Retired
If employed full or part time, what is mother's occupation or type of work? _____

Please describe the medical problems the mother may have: _____

Please describe any behavioral/emotional problems the mother may have: _____
Has the mother ever sought psychiatric treatment? ☐ No ☐ Yes
If yes, please explain the purpose: _____
Has the mother ever had treatment or counseling for alcohol or drug use? ☐ No ☐ Yes
If yes, please explain: _____
Does/has anyone on the mother's side of the family…
Take psychiatric medications? ☐ No ☐ Yes If yes, who, what medications, and why? _____

Ever been hospitalized for a psychiatric problem? ☐ No ☐ Yes
If yes, who and why? _____
Ever been hospitalized for alcoholism or drug abuse? ☐ No ☐ Yes
If yes, who and why? _____
Ever attempted suicide? ☐ No ☐ Yes
If yes, who? _____
Ever committed/completed suicide? ☐ No ☐ Yes
If yes, who? _____

Non-Biological Father. In the following questions, "father" refers to the foster or adoptive father.
Father's current age: _____
If deceased, age at death and cause of death: _____
Father's race/ethnicity:
☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black / African American ☐ Hispanic / Latino ☐ Middle Eastern Indian
☐ Native Hawaiian / Other Pacific Islander ☐ Other _____ ☐ Unknown
Father's highest level of completed education?
☐ Elementary School only (grades 1-8)
☐ Some high school, but did not finish (grades 9-11)
☐ Completed high school or GED (high school graduate)
☐ Some college, but have not completed a degree
☐ Two-year college degree / A.A / A.S.
☐ Four-year college degree / B.A. / B.S.
☐ Some graduate work but have not completed a degree
☐ Completed a Master's degree or professional degree (e.g., ARNP)
☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Father's current employment status?
☐ Employed full time ☐ Employed part time ☐ Unemployed / Looking for work ☐ Homemaker ☐ Retired
If employed full or part time, what is father's occupation or type of work? _____
Please describe the medical problems the father may have: _____

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Please describe any behavioral/emotional problems the father may have: _____

Has the father ever sought psychiatric treatment? ☐ No ☐ Yes

If yes, please explain the purpose: _____

Has the father ever had treatment or counseling for alcohol or drug use? ☐ No ☐ Yes

If yes, please explain: _____

Does/has anyone on the father's side of the family:

Take psychiatric medications? ☐ No ☐ Yes If yes, who, what medications, and why? _____

Ever been hospitalized for a psychiatric problem? ☐ No ☐ Yes

If yes, who and why? _____

Ever been hospitalized for alcoholism or drug abuse? ☐ No ☐ Yes

If yes, who and why? _____

Ever attempted suicide? ☐ No ☐ Yes

If yes, who? _____

Ever committed/completed suicide? ☐ No ☐ Yes

If yes, who? _____

Family Medical History

Does anyone in your child's BIOLOGICAL FAMILY have a history of:

Sudden or unexplained death in someone young?	☐ No ☐ Yes
Sudden cardiac death or "heart attack" in members younger than 35 years of age?	☐ No ☐ Yes
Sudden death during exercise?	☐ No ☐ Yes
Cardiac arrhythmias?	☐ No ☐ Yes
Hypertrophic cardiomyopathy or other cardiomyopathy?	☐ No ☐ Yes
Long QT syndrome, short-QT syndrome or Brugada syndrome?	☐ No ☐ Yes
Wolff-Parkinson-White syndrome?	☐ No ☐ Yes
Marfan syndrome?	☐ No ☐ Yes
Celiac disease?	☐ No ☐ Yes

Caregiver Stress Level

To Be Filled Out By The Main Caregiver. Answer these questions about YOUR level of stress.

	Not at all	A little bit	Moderate amount	A good deal	Very much
Stress means a situation in which a person feels tense, restless, nervous or anxious, or is unable to sleep at night because his/her mind is troubled all the time. How much do you feel this kind of stress these days (at the present time)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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	No stress						Extreme stress
In the past year, how would you rate the amount of stress you have in your life, at home and at work?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

These questions ask about your feelings and thoughts during the PAST TWO WEEKS (14 days). For each, please indicate how often you felt or thought a certain way.

	Never	Almost never	Some times	Fairly often	Very often
How often have you felt that you were unable to control the important things in your life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt confident about your ability to handle your personal problems?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt that things were going your way?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt difficulties were piling up so high that you could not overcome them?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

	I can shake off stress						Stress eats away at me
In general, how would you rate your ability to handle stress?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Child's Developmental History

Prenatal History and Mother's Health during Pregnancy

Was the pregnancy with this child: ☐ Planned ☐ Unplanned ☐ Unknown

During pregnancy, did mother... *Please check all that apply*

☐ Smoke cigarettes ☐ Drink alcohol ☐ Use medical marijuana ☐ Use illegal drugs ☐ Unknown

Was mother depressed during pregnancy? ☐ No ☐ Yes ☐ Unknown

If yes, how long did it last? _____

Was mother depressed after pregnancy? ☐ No ☐ Yes ☐ Unknown

If yes, how long did it last? _____

Was father depressed after pregnancy? ☐ No ☐ Yes ☐ Unknown

If yes, how long did it last? _____

Birth and Postnatal Period

Where was this child born? _____

City State Country

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Child's primary caregiver in the first year: ☐ Mother ☐ Father ☐ Other: _____

Child's primary caregiver after the first year: ☐ Mother ☐ Father ☐ Other: _____

Developmental History

If you can recall, please record the age at which your child reached the following developmental milestones. If you cannot recall the age, please check the box that best describes when the milestones were reached.

	Age	Best recollection, if exact age is not recalled		
Sat without support	_____	☐ Early	☐ Normal	☐ Late
Crawled	_____	☐ Early	☐ Normal	☐ Late
Stood without support	_____	☐ Early	☐ Normal	☐ Late
Walked without assistance	_____	☐ Early	☐ Normal	☐ Late
Bowel trained	_____	☐ Early	☐ Normal	☐ Late
Bladder trained, day	_____	☐ Early	☐ Normal	☐ Late
Bladder trained, night	_____	☐ Early	☐ Normal	☐ Late
Tied shoelaces	_____	☐ Early	☐ Normal	☐ Late
Rode bicycle	_____	☐ Early	☐ Normal	☐ Late

Did your child ever receive Early Intervention? ☐ No ☐ Yes

If yes, please describe: _____

Language Development

Please indicate the child's age when the following language milestones were reached. (Beside each question is the age most children reach the milestone. They may not be the same for your child).

- Several words besides mama and dada (1 year) _____
- Naming several objects: ball, cup, etc. (15 months) _____
- Three words together: subject, verb, object (2 years) _____

When compared to peers, was there any problem with vocabulary, articulation, and comprehension?

☐ No ☐ Yes ☐ If yes, describe: _____

Has your child ever received speech therapy? ☐ No ☐ Yes If yes, at what age? _____

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Social Development

Please indicate the child's age when the following social milestones were reached. (Beside each question is the age most children reach the milestone. They may not be the same for your child).

- Smiled (2 mo) _____
- Shy with strangers (6 - 10 mo) _____
- Separates from parent easily (2-3 yrs) _____
- Cooperative play with others (4 yrs) _____

Were there problems with attachment with mother or father? ☐ No ☐ Yes

If yes, describe: _____

Were there problems when the child was first separating from home, for example when starting daycare/preschool/ kindergarten/first grade? ☐ No ☐ Yes

If yes, describe: _____

Problems in relationships with other family members? (Include siblings) ☐ No ☐ Yes

If yes, describe: _____

Problems in past peer interactions. That is, has the child had difficulty getting along with friends?

☐ No ☐ Yes ☐ If yes, describe: _____

Friendships

Does your child get along with other children currently? ☐ No ☐ Yes

Does your child get invited for sleepovers or birthday parties? ☐ No ☐ Yes

Does your child attend sleepovers or birthday parties? ☐ No ☐ Yes

Does your child have a best friend? ☐ No ☐ Yes

Animals

Does your child have any fears of animals? ☐ No ☐ Yes

Does your child have a pet now or had a pet in the past? ☐ No ☐ Yes Pet's name _____

Emotional Development

Each child is BORN with a natural form of interacting with people, places, and things. This is called their "temperament." Of the following, how would you describe your child's temperament?

- ☐ **Easy or flexible** children are generally calm, happy, regular in sleeping and eating habits, adaptable, and not easily upset. Because of their easy style, parents need to set aside special times to talk about the child's frustrations and hurts because he or she won't demand or ask for it.
- ☐ **Difficult, active, or feisty** children are often fussy, irregular in feeding and sleeping habits, fearful of new people and situations, easily upset by noise and commotion, high strung, and intense in their reactions.
- ☐ **Slow to warm up or cautious** children are relatively inactive and fussy, tend to withdraw or to react negatively to new situations, but their reactions gradually become more positive with continuous exposure.

Does your child have fears/phobias (the dark, snakes, clowns, etc.)

☐ No ☐ Yes ☐ If yes, describe: _____

Does your child have special objects (blanket, dolls, etc.)

☐ No ☐ Yes ☐ If yes, describe: _____

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NEW PATIENT MEDICAL HISTORY
BEHAVIORAL HEALTH PEDIATRIC

Housing and Household

Child's Housing. Which of the following best describes your child's current housing situation?

- ☐ Own single/multiple family home
- ☐ Rented apartment
- ☐ Rented house
- ☐ Subsidized housing (e.g., HUD)
- ☐ Boarding school
- ☐ Group home
- ☐ Shelter
- ☐ Residential treatment
- ☐ Homeless

What is the primary language spoken in the home? _____

Do you have any concerns about the security or safety of the home or neighborhood?

☐ No ☐ Yes If yes, please describe: _____

For this current year, what do you expect your family income from all sources before taxes to be?

- ☐ Under $25,000
- ☐ $25,000 - $39,999
- ☐ $40,000 - $49,999
- ☐ $50,000 - $74,999
- ☐ $75,000 - $99,999
- ☐ $100,000 - $124,999
- ☐ $125,000 - $149,999
- ☐ Over $150,000 Prefer not to disclose
- ☐ Prefer not to disclose

Legal

Has Child Protective Services ever been involved in your family's life? ☐ No ☐ Yes

If yes, please describe: _____

_____

Does a parent or child have a history with the legal system? ☐ No ☐ Yes

If yes, please describe: _____

_____

Family Religious/Spiritual Beliefs

Does your family attend religious services? ☐ No ☐ Yes If yes, please describe: _____

_____

Is your child involved in a youth group through your family's religion? ☐ No ☐ Yes

If yes, please describe: _____

What religious/spiritual dimensions should we consider in planning your child's care, if any? _____

_____

Discipline

What disciplinary techniques do you use with your child? _____

_____

Have these techniques been effective? ☐ No ☐ Yes

What methods of discipline seem to work best with the child? _____

_____

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School History

Does the child currently have a learning disability or a history of a learning disability? ☐ No ☐ Yes

If yes, please describe: _____

_____

_____

Comments from teachers: _____

_____

_____

Other school/educational concerns: _____

_____

Does the child have an **Individualized Education Program** (IEP)? ☐ No ☐ Yes

If yes, what are the accommodations? _____

_____

Are you satisfied with the accommodations? ☐ No ☐ Yes

Does the child have a **504 plan**? ☐ No ☐ Yes

If yes, what are the accommodations? _____

_____

Are you satisfied with the accommodations? ☐ No ☐ Yes

ADDITIONAL INFORMATION

Is there any additional information you would like us to know or which you believe will be helpful to better understand your child?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____