

**PRAIRIE VIEW
PATIENT INFORMATION FORM
For Child / Adolescent**

Please fill out the following patient information.

Name of person filling out form:	Relationship to patient:	Date:
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PATIENT DATA

Last Name:		First Name:		Middle Name:	
<input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> also/known/as:					
Birth date:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:		
Address:			P.O. Box:		County:
Street Address:			City:		State:
City:			State:		ZIP Code:
How long at this address?			Patient's Phone Number: Home: ()		
Has patient been seen previously at this office? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Race: (choose all that apply)					
<input type="checkbox"/> Am. Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African Am. <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other					
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic					
Emergency Contact Person(s):					
1) Name:			Relationship:		
Street Address:		City:		State:	Zip Code:
Home Phone: ()		Cell Phone: ()		Work Phone: ()	
2) Name:			Relationship:		
Street Address:		City:		State:	Zip Code:
Home Phone: ()		Cell Phone: ()		Work Phone: ()	
Referral Source: <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> SRS Area Office <input type="checkbox"/> Social/Community Agency <input type="checkbox"/> Court <input type="checkbox"/> Other: _____					
Referred by:		Relationship To Patient:		Phone: ()	
Street Address:		City:		State:	Zip Code:
Patient's Primary Care Physician: Name:			Phone: ()		
Street Address:		City:		State:	Zip Code:

FINANCIAL INFORMATION

Responsible party for billing purposes:					
Name:					
Street Address (if different than patient):					
City:		State:		Zip Code:	
Home Phone: ()		Cell Phone: ()		Work Phone: ()	
Employee Assistance Program: Is patient covered by an EAP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, employee name – Last:			First:		Middle Initial:
If yes, company name:				Phone: ()	
Primary Insurance Company: Name:					Phone: ()
Subscriber name – Last:		First:		Middle Initial:	
SS #:		Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer:		ID #:		Group #:	
Secondary Insurance Company: Name:					Phone: ()
Subscriber name – Last:			First:		Middle Initial:
SS #:		Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer:		ID #:		Group #:	
Income: Gross family annual income: \$				Number of persons in household:	
Patient receives financial support from:					

Patient Name: _____
Last
First
MI

Case Number: _____ Page 1 of 7

PRAIRIE VIEW BEHAVIORAL HEALTH SERVICES – Patient Information Form – For Child / Adolescent

CONFIDENTIALITY

All patient information and records will be kept confidential in accordance with all pertinent state and federal laws, as well as within the guidelines of professional codes of ethics. Two circumstances in which confidentiality is limited are outlined as follows: 1) In an instance where child or elder abuse is disclosed or suspected, the clinician is required by state law to report this information to the local human service agency responsible for protecting these vulnerable populations. 2) In the event that information is disclosed that indicates to the clinician that a client or another party is at imminent risk of harm, there is a duty to warn the threatened party and to take the appropriate legal action as defined by state and federal statutes to protect the threatened party.

List all persons who are legally authorized to receive information about and make decisions regarding the patient's care:

Name:	Relationship:
Name:	Relationship:

Spiritual Affiliation: Contact person: Phone: ()

Would you like this person to be notified and involved in your child's treatment at Prairie View? Yes No

Inpatient Services Only:

Please list the persons who may have contact with the patient while they are at Prairie View.

Full Name:	Relationship:
Full Name:	Relationship:

Please list physicians or other treatment providers you would like notified of the patient's admission to the hospital:

Name:	Agency:	Phone: ()
Name:	Agency:	Phone: ()

FAMILY RELATIONSHIPS

Parents:	Age:	Living in: City, State:	Health Status:
Father's Name:			
Mother's Name:			

Household Members:	Name	Relationship to Patient		Age
		F-father M-mother B-brother S-sister	B-biological A-adoptive S-step H-half F-foster	

Siblings Living Outside the Home:	Name	Relationship to Patient (see above)		Age	Currently living at:
		B,S	B,A,S,H,F		

Supportive Relationships (list any other supportive persons in the child's life)

Name	Relationship	Phone
		()
		()

Patient Name: _____
 Last First MI

Case Number: _____

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CUSTODY STATUS

Are there custody/visitation arrangements between any parties? Yes No
 If yes, please describe and note any court orders.

Do any of the following apply to the patient?	If yes...	Phone
Legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Address:	()
SRS custody? <input type="checkbox"/> Yes <input type="checkbox"/> No	SRS worker: Address:	() () (fax)
Out-of-home placement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement agency worker: Name of agency: Address:	() () (fax)
Juvenile Justice involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Responsible worker: Address:	() () (fax)
Juvenile Justice custody? <input type="checkbox"/> Yes <input type="checkbox"/> No	Responsible worker: Address:	() () (fax)

Have parental rights been severed: Yes No If yes, when?

If answered YES on any of the above questions,
 please provide copies of court orders or any other pertinent legal documentation.

Foster Care Contractor (select one option)
Not applicable KCSL (foster care) The Farm UMY KVC St. Francis DCCCA

CURRENT RESIDENTIAL SETTING

Current Residential Setting (select one option)

<input type="checkbox"/> Jail / detention	<input type="checkbox"/> Residential treatment / Level VI	<input type="checkbox"/> Temporarily living w/ relative or family friend
<input type="checkbox"/> State hospital	<input type="checkbox"/> Group home (Levels III, IV, V)	<input type="checkbox"/> Permanent home (biological / adoptive)
<input type="checkbox"/> Inpatient psychiatric unit	<input type="checkbox"/> Emergency shelter	<input type="checkbox"/> Independent living
<input type="checkbox"/> Crisis resolution / stabilization unit	<input type="checkbox"/> Therapeutic foster care	<input type="checkbox"/> Homeless
<input type="checkbox"/> Drug / alcohol treatment center	<input type="checkbox"/> Foster home	

LEGAL ISSUES WITHIN LAST 30 DAYS

Total number of arrests: _____ Number of adjudicated felonies for crimes against persons: _____
 Number of adjudicated felonies for crimes: _____ Number of adjudicated misdemeanors: _____
 Number of adjudicated felonies for property crimes: _____ Number of law enforcement contacts: _____

CURRENT EDUCATIONAL STATUS

Current Educational Status (select one option)

<input type="checkbox"/> Not applicable	<input type="checkbox"/> Home schooling not provided by school district	<input type="checkbox"/> Other
<input type="checkbox"/> Institutional instruction	<input type="checkbox"/> Not in school (suspended)	<input type="checkbox"/> Alternative education with intensive psychosocial
<input type="checkbox"/> Residential school	<input type="checkbox"/> Not in school (graduated)	<input type="checkbox"/> Preschool
<input type="checkbox"/> Home-based instruction w/school district	<input type="checkbox"/> Not in school (working on GED)	<input type="checkbox"/> Therapeutic services for preschool children
<input type="checkbox"/> Special education	<input type="checkbox"/> Not in school (expelled)	<input type="checkbox"/> Enrolled in post-secondary ed.
<input type="checkbox"/> Reg. classroom with special ed. services	<input type="checkbox"/> Not in school (drop-out)	
<input type="checkbox"/> Regular classroom	<input type="checkbox"/> Not in school (summer break)	

PRESENTING PROBLEM

What problem brings you to seek treatment for the child at this time? _____

 Has this (problem) ever happened before? Yes No

PRAIRIE VIEW BEHAVIORAL HEALTH SERVICES – Patient Information Form – For Child / Adolescent

Current Services: Is the child currently being seen in outpatient therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Therapist: Name:		Agency:	
Street Address:		City:	State:
Phone: ()		Zip Code:	
How long has the child been seeing this person?		Why is child being seen?	
How often? <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly		Date of last appointment:	
<input type="checkbox"/> Case Manager: Name:		Phone: ()	
<input type="checkbox"/> Attendant Care Worker: Name:		Phone: ()	
<input type="checkbox"/> Family Support Worker: Name:		Phone: ()	
<input type="checkbox"/> Group Therapy: Leader's Name:		Phone: ()	

PATIENT HISTORY – MEDICAL / PHYSICAL PROBLEMS / PSYCHIATRIC

1) Describe any current health concerns / medical illness / pain: _____

2) Is the child up to date on immunizations? Yes No If no, describe: _____
Please bring immunization records.

**Please bring ALL medications the child is on.
 If child lives in an agency setting, please bring the current Medication Administration Record.**

3) Has the child been consistently taking all medications as prescribed? Yes No
 If no, describe: _____

4) Pharmacy Name: _____ Phone: ()

5) **ALLERGIES** (name all that apply and describe reaction)
Medication Allergies: _____

Food Allergies: _____

Environmental Allergies: _____

6) When was the child's last complete physical? _____ Did it include lab / blood work? Yes No
 Comments: _____

7) **PATIENT'S MEDICAL HISTORY** (check all that apply)

<input type="checkbox"/> Ear infections	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Vision loss (glasses, contacts)	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mumps	<input type="checkbox"/> Head injury	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Seasonal allergies	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Liver disease
	<input type="checkbox"/> German measles		

Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type of surgery	Date

Cancer Yes No If yes, type: _____ Date: _____

Describe any other **major illness / injury**: _____

8) **PATIENT'S PSYCHIATRIC HISTORY** (check all that apply)

<input type="checkbox"/> ADHD-Attention Deficit Hyperactivity Disorder	<input type="checkbox"/> Alcohol / drug abuse	<input type="checkbox"/> Mood swings / Bipolar
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Suicide attempts	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Depression		

SOCIAL HISTORY

- 1) If the child has not always lived with her / his biologic parents, with whom did they live and when? _____
- 2) To whom in the family is the child the closest? _____
- 3) With whom in the family does the child have the most conflict? _____
- 3) What do you consider to be the child's **strengths**? _____

 What do you consider to be the child's **weaknesses**? _____

- 4) List significant changes / events in the household in the past year (i.e. change in school, birth of sibling, move, illness)

- 5) Are there any family members experiencing significant health / emotional problems? _____

DEVELOPMENTAL HISTORY

- 1) Did the patient's mother experience any problems during pregnancy with patient? Yes No
 If yes, describe: _____

 Did patient's mother use drugs or alcohol during pregnancy with patient? Yes No
 Was the pregnancy: (choose one) Full term Premature Late
 Was the delivery: (choose one) Normal delivery Cesarean section
- 2) **Milestones**
 Patient started walking at age: _____
 Patient started talking at age: _____
 Patient was toilet trained at age: _____
 (check all that apply) wets / day wets / night soils / day soils / night How often? _____

CURRENT FUNCTIONING

- 1) **Physical Activity:** Child has tended to be: (check all that apply)
 Overactive Under active Normally active Energetic Easily tired Sluggish
- 2) **Appetite:** Describe the child's appetite (choose one)
 Excessive Good Poor Picky
- 3) **Sleep**
 Describe the child's sleep: (check all that apply)
 Difficulty falling asleep Sound Restless Wakes in the middle of the night Difficulty waking
 Has bad dreams: (choose one) Never Rarely Occasionally Often
 Sleepwalks: (choose one) Never Rarely Occasionally Often
- 4) **Temperament** (check all that apply)
 Active Quiet Calm Difficult Affectionate
 Rejecting Shy Withdrawn Sensitive Easily hurt
 Rebellious Attention seeking Hyperactive Aggressive
- 5) **Peer Relations** (check all that apply)
 Popular Follower Disliked Provocative
 Leader Loner Rejects others Teased
 In with wrong crowd Gets in fights Prefers to be with adults
- 6) **Disruptive Behaviors** (check all that apply)
 History of numerous injuries Initiates fights Aggressive and has used a weapon
 Fire setting: age _____ Bullies others Verbal threats to harm others
 Property destruction Theft in home Physical aggression towards others
 Truancy Theft outside home
 Runaway (If checked: when, how long, and where do they go when they run?) _____
- 7) **Interests:** What does the child enjoy doing? _____
 Leisure / Recreation / Community Activities: _____

Patient Name: _____
 Last First MI

Case Number: _____

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8) Friends

Does the child have a best friend? Yes No
Child makes friends: (choose one) easily slowly not at all
Child's friendships: (choose one) are brief last a long time

SCHOOL FUNCTIONING

- 1) Name of school: _____ City: _____
Highest grade completed: _____
Teacher: _____ Principal: _____ Counselor: _____
- 2) Does the child like school? Yes No If no, describe: _____
- 3) Have there ever been significant problems with child's school performance? Yes No
If yes, explain: _____
- 4) What is child's relationship to teachers? Good Troubled Comments: _____
- 5) Has the child ever attended special education classes? Yes No
If yes, explain: _____
- 6) Does the child currently have an IEP (Individualized Education Plan)? Yes No

ADDITIONAL COMMENTS/CONCERNS

Any additional information or clarification: _____

Patient Name: _____
Last First MI

Case Number: _____