Prairie View
Behavioral & Mental Healthcare

Name:_____

Prairie View Case Number:_____

Child / Adolescent

PATIENT INFORMATION FORM

This Patient Information Form is reviewed as part of the assessment process.

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

PATIENT DATA

Last Name:	First Name:	Middle Name:
Preferred Name:	Date of Birth:	Age:
Race:	Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Other (specify):_____	
Address: Street Address:		County:
City:	State:	ZIP Code:
Primary Phone: ( ) ☐ Home; ☐ Cell; ☐ Work	Secondary Phone: ( ) ☐ Home; ☐ Cell; ☐ Work	
Has patient been seen previously at Prairie View? ☐ Yes ☐ No		
Referral Source: ☐ Self ☐ Family ☐ Doctor ☐ Court ☐ DCF ☐ Other:_____		

CUSTODY / LEGAL 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? ☐ Yes ☐ No	Name:	( )
DCF custody? ☐ Yes ☐ No	DCF Worker:	( )
Out-of-home placement? ☐ Yes ☐ No	**Foster Care Contractor** (select one): ☐ KCSL ☐ The Farm/TFI ☐ Ember Hope/UMY ☐ KVC ☐ St. Francis ☐ DCCCA	( )

Have parental rights been severed: ☐ Yes ☐ No If yes, whose?_____ When?_____

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

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 patient or another party is at imminent risk of harm, there is a duty to take appropriate action to protect the threatened party.

Also refer to NOTICE OF PRIVACY PRACTICES.

List all persons who are authorized to receive information regarding the patient's care:

Name:	Relationship:
Name:	Relationship:

PRESENTING PROBLEM

Why are you seeking treatment at this time?_____

_____

Has this happened before? ☐ Yes ☐ No If yes, when?_____

What treatments have been helpful?

_____

How long has this been occurring?_____

List any major changes in your life within the last year:

_____

_____

List any current or previous mental health diagnoses:

_____

_____

Current Services – List any current mental health providers (therapy & medication) outside of Prairie View:

Name/Agency	Reason	How Often	How Long	Date of Last Appt.

Previous Services – List any previous mental health services, including reason and dates:

_____

_____

_____

_____

_____

CURRENT FUNCTIONING

(check ALL that apply)

Current Concerns:

☐ Anger/Violence	☐ Excessive physical complaints	☐ Learning/School	☐ Sleep
☐ Anxiety/Worry	☐ Fear/Panic	☐ Mood/Depression	☐ Substance use
☐ Appetite/Eating	☐ Hallucinations/Delusions	☐ Self-harm	☐ Suicidal thoughts
☐ Attention problems	☐ Homicidal thoughts	☐ Sexual behaviors	☐ Trauma/Abuse
☐ Autism	☐ Impulse control	☐ Sexuality	

Sleep: How many hours per night does the child sleep? _____ hours

☐ Difficulty falling asleep ☐ Disturbed ☐ Restful ☐ Wakes in the middle of the night
☐ Difficulty waking up ☐ Nightmares ☐ Sleep walking

Appetite: ☐ Increased ☐ Decreased ☐ Excessive ☐ Good ☐ Poor ☐ Picky

Physical Activity: ☐ Overactive ☐ Underactive ☐ Normal ☐ Energetic ☐ Tires easily ☐ Sluggish

Temperament:

☐ Active	☐ Attention seeking	☐ Easily hurt	☐ Rebellious	☐ Shy
☐ Affectionate	☐ Calm	☐ Hyperactive	☐ Rejecting	☐ Withdrawn
☐ Aggressive	☐ Difficult	☐ Quiet	☐ Sensitive	

PSYCHOSOCIAL HISTORY

Mother's Name:_____

Health Status: ☐ Healthy ☐ Declining ☐ Seriously Ill ☐ Deceased
Relationship with child: ☐ Good/Positive ☐ Strained/Negative ☐ No Relationship
Lives in the Home with Child: ☐ Yes ☐ No

Father's Name:_____

Health Status: ☐ Healthy ☐ Declining ☐ Seriously Ill ☐ Deceased
Relationship with child: ☐ Good/Positive ☐ Strained/Negative ☐ No Relationship
Lives in the Home with Child: ☐ Yes ☐ No

List any **other people who live in the household** (include age & relationship):

_____
_____
_____

List any **siblings who live outside of the home** (include age, relationship, where they live):

_____
_____
_____

If the child has not always lived with her/his biological parents, **with whom did they live and when**?

_____
_____

Are there any **family members experiencing significant health / emotional problems**?

_____
_____

With whom in the family is the child the closest?_____

With whom in the family does the child have the most conflict?_____

List sources of social support (examples: friends, relatives):

_____
_____

Current or Past Trauma/Abuse: ☐ Yes ☐ No If yes, check those that apply.

☐ Emotional ☐ Human Trafficking ☐ Perpetrator of Abuse ☐ Racial ☐ Verbal
☐ Exploitation ☐ Neglect ☐ Physical ☐ Sexual ☐ Witness to Abuse
☐ Other:_____

If yes to current or past trauma abuse, was it reported? ☐ Yes ☐ No
To whom?_____ Date(s):_____

SCHOOL FUNCTIONING

❑ Not applicable; check if NOT in school

School Name:_____ City:_____
Highest grade completed:_____
Teacher:_____ Counselor:_____

Educational Status (check all that apply)**:**
☐ Regular classroom ☐ Home-based Instruction ☐ Special education classes
☐ Alternative education ☐ Preschool ☐ IEP / 504 plan
☐ Other (specify):_____

Check all that apply**:**
☐ School refusal ☐ Has been expelled ☐ Has been suspended
☐ Attention problems ☐ School testing completed ☐ Aggression at school
Comments:_____

Does the child like school? ☐ Yes ☐ No If no, describe:_____
_____

Have there ever been significant problems with child's school performance? ☐ Yes ☐ No
If yes, explain:_____
_____

What is child's relationship to teachers? ☐ Good ☐ Troubled Comments:_____
_____

DEVELOPMENTAL FUNCTIONING

Pregnancy/Delivery

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

Milestones

Age began walking:_____

Age began talking:_____

Age toilet trained:_____
Check all that apply: ☐ wets / day ☐ wets / night ☐ soils / day ☐ soils / night How often?_____

SOCIAL FUNCTIONING

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

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

Peer Relations (check all that apply):

☐ Bullied ☐ Gets in fights ☐ Loner ☐ Provocative
☐ Disliked ☐ In with wrong crowd ☐ Popular ☐ Rejects others
☐ Follower ☐ Leader ☐ Prefers to be with adults ☐ Teased

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

Disruptive Behaviors (check all that apply):

☐ Aggressive & has used a weapon ☐ Initiates fights ☐ Theft in home
☐ Bullies others ☐ Physical aggression towards others ☐ Theft outside home
☐ Drug / alcohol use ☐ Property destruction ☐ Tobacco / nicotine use
☐ Fire setting: age:_____ ☐ Runs away ☐ Truancy
☐ History of numerous injuries ☐ Sexually acting out behaviors ☐ Verbal threats to harm others

Interests:

What does the child enjoy doing?_____

What leisure/recreation/community activities is the child involved in?_____

Religious / Spiritual Preference:_____

How important is faith to the child?
☐ Not Important ☐ Somewhat Important ☐ Important ☐ Very Important

Legal:

Are there any legal issues for the child (examples: arrests, warrants, felonies)? ☐ Yes ☐ No
If yes, describe:_____
Contact (e.g.; probation/corrections officer):_____ Phone:_____

MEDICAL HISTORY

ALLERGIES (list all medication and food allergies and describe reaction):

Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____

Does the child have a **Primary Care Physician**? ☐ Yes ☐ No
If yes, name of provider:_____

Does the child have any **ongoing pain** problems? ☐ Yes ☐ No
If yes, location of pain:_____
Rate 0-10 (0=none and 10=highest) Current Pain Level:_____ Typical Pain Level:_____

Describe any current **health concerns / medical illness / pain**:_____

When was last **complete physical**?_____
Did it include lab / blood work? ☐ Yes ☐ No
Comments:_____

Is the child up to date on **immunizations**? ☐ Yes ☐ No

If NO, describe:_____

PATIENT / FAMILY HISTORY

Mark each that apply: "**P**" for patient, "**M**" for mother's side, "**F**" for father's side, "**S**" for sibling:

_____ ADHD	_____ Hallucinations / Delusions	_____ Self-injury
_____ Alcohol / Substance abuse	_____ Heart disease	_____ Schizophrenia
_____ Anxiety / Panic	_____ High blood pressure	_____ Stroke
_____ Cancer	_____ Mood swings / Bipolar	_____ Suicide attempts
_____ Depression	_____ Psychiatric hospitalizations	
_____ Diabetes	_____ PTSD	

PATIENT HISTORY (Check all that apply to patient only)

☐ Asthma	☐ Hearing loss	☐ Mumps	☐ Tonsillitis
☐ Chicken pox	☐ Kidney disease	☐ Rheumatic fever	☐ Tuberculosis
☐ COVID-19	☐ Liver disease	☐ Seasonal allergies	☐ Vision loss (glasses, contacts)
☐ Ear infections	☐ Loss of consciousness	☐ Seizure disorder	☐ Whooping cough
☐ Head injury	☐ Measles	☐ Thyroid problems	☐ Other:_____

List any past **hospitalizations / surgeries**, and approximate dates (including psychiatric hospitalizations):

_____ Dates:_____

_____ Dates:_____

_____ Dates:_____

Has the child been to the **Emergency Room** in the last year? ☐ Yes ☐ No

If yes, cause of visit:_____

MEDICATIONS

List ALL medications your child is taking currently: prescription, over-the-counter, & supplements:

If child lives in an agency setting, please bring the current Medication Administration Record (MAR).

Name	Dosage	Physician	Start Date	Reason

ADDITIONAL COMMENTS & CONCERNS

Please describe any events regarding the child's family you would consider to be significant events in the child's life, including:

- parents' marital histories
- family deaths
- moves
- other events

If the child is in State custody, use this area to document child's placement history.

Any additional information or clarification:_____