Prairie View
Behavioral & Mental Healthcare

Name:_____

Prairie View Case Number:_____

Child / Adolescent

PATIENT INFORMATION FORM

Please fill out the following patient information.

PATIENT DATA

Patient's Name:	Age:	Birth date:	
Address: Street Address/P.O. Box:	City:	State:	Zip Code:
Phone: ( )	Social Security Number:		Race:
Referral By:		Phone: ( )	
Relationship To Patient:			
Emergency Contact Person:		Phone: ( )	
Patient's Primary Care Physician:		Phone: ( )	

Household Members: Name	Relationship to Patient	Age

FINANCIAL INFORMATION

Responsible party for billing purposes:			COPY INSURANCE CARDS
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? ❑Yes ❑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: ❑Male ❑Female
Employer:	Ins. ID #:		Group #:
Secondary Insurance Company: Name:			Phone: ( )
Subscriber name – Last:	First:		Middle Initial:
SS #:	Date of Birth:		Gender: ❑Male ❑Female
Employer:	Ins. ID #:		Group #:
Income: Gross family annual income: $			Number of dependents claimed:
Patient receives financial support from:			

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:

Name:_____

Prairie View Case Number:_____

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: ( )

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? ❑Yes ❑No	Name: Address:	( )
SRS custody? ❑Yes ❑No	SRS worker: Address:	( ) ( ) (fax)
Out-of-home placement? ❑Yes ❑No	Placement agency worker: Name of agency: Address:	( ) ( ) (fax)
Juvenile Justice involvement? ❑Yes ❑No	Responsible worker: Address:	( ) ( ) (fax)
Juvenile Justice custody? ❑Yes ❑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)

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

LEGAL ISSUES WITHIN LAST 30 DAYS

Total number of arrests:_____

Number of adjudicated felonies for crimes:_____

Number of adjudicated felonies for property crimes:_____

Number of adjudicated felonies for crimes against persons:_____

Number of adjudicated misdemeanors:_____

Number of law enforcement contacts:_____

CURRENT EDUCATIONAL STATUS

Current Educational Status (select one option)

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

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PRESENTING PROBLEM

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

_____

Has this (problem) ever happened before? ❑Yes ❑No

Current Services: Is the child currently being seen in outpatient therapy? ❑Yes ❑No			
❑**Therapist:** Name:	Agency:		
Street Address:	City:	State:	Zip Code:
Phone: ( )	How long has the child been seeing this person?		
Why is child being seen?			
How often? ❑weekly ❑bi-weekly ❑monthly Date of last appointment:			
❑**Case Manager:** Name:		Phone: ( )	
❑**Attendant Care Worker:** Name:		Phone: ( )	
❑**Family Support Worker:** Name:		Phone: ( )	
❑**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)

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

Surgery ❑Yes ❑No	If yes, type of surgery	Date

Cancer ❑Yes ❑No If yes, type: Date:

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

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

❑ADHD-Attention Deficit Hyperactivity Disorder ❑Alcohol / drug abuse ❑Mood swings / Bipolar
❑Anxiety ❑Suicide attempts ❑Schizophrenia
❑Depression

Psychiatric Hospitalizations ❑Yes ❑No If yes, list admissions:

Date	Location	Why / Problem

FAMILY MEDICAL / PSYCHIATRIC HISTORY

1) **MEDICAL HISTORY** (mark each that apply – "M" for mother's side, "F" for father's side)

Diabetes_____ Stroke_____ Heart disease_____ High blood pressure_____
Cancer_____ (type)_____

2) **PSYCHIATRIC HISTORY** (mark each that apply – "M" for mother's side, "F" for father's side)

Alcohol / drug abuse_____
Depression_____
Anxiety_____
Suicide attempts_____
Antisocial behavior (difficulties with police / violence)_____
Physical abuse - survivor_____
Sexual abuse - survivor_____
Verbal abuse - survivor_____
Physical abuse - perpetrator_____
Sexual abuse - perpetrator _____
Verbal abuse - perpetrator_____
Dementia_____
Mood swings / Bipolar_____
Schizophrenia_____
Psychiatric hospitalizations_____

3) Please describe any **events regarding the child's family**, including parents' marital histories, family deaths, moves, and other events you would **consider to be significant** events in the child's life.
If the child is in **State custody**, use this area to **document placement history**.

_____

_____

_____

_____

_____

PATIENT ABUSE HISTORY

Specify: S-survivor P-perpetrator of abuse?	Type of Abuse– Physical Sexual Emotional-Verbal Neglect	Patient's age at time of abuse	If survivor, abused by whom? If perpetrator of the abuse, who did patient abuse?	Approxi-mately when did abuse occur?	Was it reported?	If yes, who reported?
					❑Yes ❑No	
					❑Yes ❑No	
					❑Yes ❑No	
					❑Yes ❑No	
					❑Yes ❑No	

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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:_____

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:_____