SUNFLOWER
PEDIATRIC | BEHAVIORAL | HEALTH

NEW PATIENT INFORMATION FORM

General Information

Date: _____

Person completing this form: _____ Relationship to patient: _____

Child's Legal Name: _____
Last First Middle

Nickname: _____ Child's DOB: _____ Age: _____ Gender: M / F

Child's Primary Address: _____
Street / Apt City State Zip

Primary Phone Numbers: _____
Home Cell Work Other

Can we contact you at these numbers?: Home Y / N Cell Y / N Work Y / N

Can we leave a message at these numbers?: Home Y / N Cell Y / N Work Y / N

E-Mail: _____ Can we contact you through e-mail? Y / N

Emergency contact:

Name: _____ Relationship to patient: _____

Address (if different from above): _____

Home phone: _____ Work phone/other: _____

Referral Information

Who referred the child to this clinic?: _____

Primary Reason(s) for Referral:

_____
_____
_____
_____

What do you hope to gain from services in this clinic?:

_____
_____
_____
_____

Family Information

Who has legal custody of this child?

_____ Both parents
_____ Mother
_____ Father
_____ Relative: _____
_____ Other: _____

**Please bring custody or court papers to the first appointment if you are not the birth parent(s)*

Patient resides with:

_____ Both parents
_____ Mother - (circle one): biological adoptive foster stepmother other: _____
_____ Father – (circle one): biological adoptive foster stepfather other: _____

Living arrangements for child: _____

Maternal caregiver information:

Name: _____ DOB: _____
Address (if different from above): _____
Home phone: _____ Work phone/other: _____
Occupation: _____ Employer: _____
Marital status: _____

Paternal caregiver information:

Name: _____ DOB: _____
Address (if different from above): _____
Home phone: _____ Work phone/other: _____
Occupation: _____ Employer: _____
Marital status: _____

Guardian information (if Guardian is different from above):

Name: _____ DOB: _____
Address (if different from above): _____
Home phone: _____ Work phone/other: _____
Occupation: _____ Employer: _____
Marital status: _____

Child's primary care physician: _____
Which practice? _____ Phone number: _____

Other Members of the Household: (*for example, siblings, step-siblings, niece/nephew, foster children*):

Name	Age	Sex	Relation to child	Health/learning issues?

Social Information

Strengths and Interests:

What are your child's interest areas and extracurricular activities?:

_____

_____

_____

Employment history (if any): _____

In your opinion, what are your child's greatest strengths and accomplishments?:

_____

_____

_____

_____

Educational History:

Current educational setting: (circle one)

Preschool Kindergarten Elementary Middle/Jr.High High School Home School

Current grade: _____ Teacher's name: _____
Name of school: _____ School district: _____
School address: _____ School phone: _____

Does your child have an IEP or 504 Plan? If so, what are the areas of focus & modification?:
No _____ Yes _____

_____

Has your child ever received any type of educational programming (Special Education, Learning Disabilities, Behavioral / Emotional Disorders, Speech/Language services, Resource Room)?:
No _____ Yes (explain): _____

_____

Child's Grades (either currently or last school year): _____

What is your overall impression of your child's learning in the following areas?:

	Below Average	Average	Above Average	Comments
Reading				
Math				
Writing				

Has child ever been suspended, expelled, or retained in a grade?:
No _____ Yes (explain): _____

Other disciplinary/behavioral issues in the school setting?:
No _____ Yes (explain): _____

Is your child's teacher concerned about your child?:
No _____ Yes (explain): _____

How would you rate your relationship with your child's teacher?:
Good _____ Fair _____ Poor _____

Social Information:

Does your child:	Yes	No; Explain any concerns
Get along with other children		
Get along with adults		
Have friends		
Keep friends		
Play with children his/her own age		
Have problems with bullying		
Have problems with peer pressure		

Describe any social concerns you have for your child: _____

_____

_____

Mental Health History:

Has your child ever been evaluated or treated by a mental health professional?
No _____ Yes _____

If "Yes", has any of the past mental health treatment been delivered in a hospital setting?
No _____ Yes (explain): _____

_____

_____

If "Yes", who else has provided mental health treatment for your child (please provide provider names, services rendered, diagnoses given, and dates if possible)?:

_____

_____

_____

Please list family members (both immediate and extended) who experience mental health concerns and any diagnoses that you are aware of: _____

_____

_____

Mental Health Symptom Checklist:

Which of the following **recently have been** or currently **are** problems with your child?:							
	Never	Sometimes	Frequently		Never	Sometimes	Frequently
Won't mind				Attention / Focus			
Too active				Soiling / Bedwetting			
Bad temper				Cries a lot			

Which of the following **recently have been** or currently **are** problems with your child?:							
	Never	Sometimes	Frequently		Never	Sometimes	Frequently
High strung/nervous				Sibling relations			
Clings to parents				Destructive			
Easily upset				Impulsive			
Clumsy				Odd behaviors			
Too shy				Seems sad			
Eating/feeding				Bedtime / Sleep			

Where are these problems occurring (circle any)? Home School Public setting (stores, etc)

Has your child ever used:

Alcohol? No _____ Yes _____
Tobacco? No _____ Yes _____
Other illicit substances? No _____ Yes _____

Sleep Information:

Time to bed: _____ Time to sleep: _____ Time awake: _____ Naps?:_____

Has sleep been problematic for your child?: No _____ Yes (explain): _____
_____

Exposure to stressors:

Has your child ever been exposed to domestic violence?: No _____ Yes _____

Has your child experienced any other traumas or significant stressors (e.g., abuse, moves, deaths, divorces, financial hardship in the family, etc.)?
No _____ Yes (explain): _____
_____

Medical History

Does your child have any active physical health problems?:
No _____ Yes (explain): _____
_____
_____

Do any of your child's conditions interfere with his/her functioning (*vision, hearing, motor, speech*)? No _____ Yes (explain): _____
_____

Has your child ever been hospitalized?: No _____ Yes: _____

Is your child receiving any occupational, physical, or speech therapy services? If so, where and how often?: No _____ Yes (explain): _____

Is your child taking any medications? Y / N

If yes, please list medication, dose, and time of day given:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list any past medication trials, and the reason for discontinuing the medication:

_____
_____
_____

Please list any over the counter supplements, vitamins, or other alternative medical treatments your child takes?:

_____

Allergies to medication?: No _____ Yes: _____

Is there a history of any seizures?: No _____ Yes: _____

Has your child had any surgeries?: No _____ Yes: _____

Is there a history of head trauma or other loss of consciousness?
No _____ Yes: _____

Have any family members ever had a heart problem they think came from birth or died at a young age from a heart related condition?: No _____ Yes: _____

<u>Pregnancy and Delivery:</u>

Did you and/or your doctor note any problems with pregnancy?:
No _____ Yes (explain): _____

Delivery was: Vaginal / Cesarean (circle one) Baby was: Full term / Premature (_____ weeks) (circle one)
Complications during labor and delivery?: No _____ Yes (explain): _____

_____

Problems after birth?: No _____ Yes (explain): _____

Developmental History:

What is your general impression of your child's infant development?:
Good _____ Fair _____ Poor _____

Please indicate when your child achieved the following milestones:
(either enter approximate age when skill was acquired or if you felt their attainment was in the early, normal or delayed range):

	Estimated Age	Early	Normal	Delayed
Sat Alone (average 6 to 8 mos.)				
Crawled (average 9 mos.)				
Spoke Words (average 10 mos.)				
Fed Self (average 10 to 12 mos.)				
Walked (average 12 to 18 mos.)				
Put 2-3 words together (average 18 to 24 mos.)				
Toilet Trained (average 2 to 3 yrs.)				

Any concerns with the following during infancy-toddlerhood?:

	No	Yes; Explanation of concerns
Oral motor problems (late drooling, poor sucking, poor chewing)		
Colicky		
Not easily soothed or calmed		
Excessive restlessness		
Did not enjoy cuddling		
Poor eye contact		

General medical review of systems:

Does your child suffer from any of the following symptoms?
(please check if present and explain)

___ Stomach aches? Nausea? Poor appetite? _____
___ Loose stools? Constipation? _____
___ Recurrent headaches? _____
___ Dizziness/feeling like passing out? _____
___ Daytime fatigue? _____
___ Wears glasses? Vision changes? _____
___ Hearing problems? Ear infections? _____
___ Congestion/sore throat/drainage? _____
___ Urine/stool accidents/bedwetting? _____
___ Problems with menstruation (if appropriate)? _____
___ Chest pain/poor exercise tolerance? _____
___ Easy bruising/bleeding? _____
___ Muscle/joint pain? _____
___ Skin rashes/itching? _____
___ Pain? _____

Other Information

Is there anything else about your child you think is important for us to know?:

_____
_____
_____
_____
_____