

PATIENT AND FAMILY INFORMATION FORM FOR AGES 6-18

IDENTIFYING INFORMATION

Child's Name: _____

Date Completed: _____

Person answering questions: _____

DOB: _____

Relationship: _____

REASONS FOR EVALUATION

Who referred you to Seattle Children's Hospital? _____

What are your primary concerns about your child/adolescent? _____

At what approximate age did your child/adolescent start having this problem? _____

When it first started, was the problem the same or different than it is now? _____

Where does this problem primarily occur (check all that apply)? ☐ home ☐ school ☐ daycare ☐ public settings

Details: _____

What services are you hoping to receive at our clinic (please check all that apply)?

☐ Evaluation Only ☐ Medication ☐ Therapy Comments: _____

What specific questions would you like answered by this evaluation?

1. _____

2. _____

PATIENT PSYCHIATRIC/ MEDICATION TREATMENT HISTORY

Patient Psychiatric Treatment History: ☐ no prior treatment

Please list all mental health services (inpatient or outpatient) that your child is receiving now or has received in the past:

Provider name and type (MD, PhD, Counselor)	Approximate Dates	Results of treatment	Status in treatment
			<input type="checkbox"/> Past <input type="checkbox"/> Current
			<input type="checkbox"/> Past <input type="checkbox"/> Current
			<input type="checkbox"/> Past <input type="checkbox"/> Current

Psychiatric Medication History: ☐ None reported

Name of medication	Status of medication	Prescribing provider	Results (including side effects)
	<input type="checkbox"/> Past <input type="checkbox"/> Current		
	<input type="checkbox"/> Past <input type="checkbox"/> Current		

CHILD'S MEDICAL/PHYSICAL HISTORY

Who is the child's primary doctor? _____

Phone #: _____

Who is the child's primary dentist? _____

Phone #: _____

When was your child last seen by a physician? _____

For what reason? _____

Any serious, acute, and/or chronic illness now (or in past)? ☐ Yes ☐ No

Details: _____

Has your child had any history of medical hospitalizations or surgeries? ☐ Yes ☐ No

Details: _____

Is your child having any sleep problems (e.g. too much/too little)? ☐ Yes ☐ No

Details: _____

Does your child snore or have sleep disordered breathing? ☐ Yes ☐ No

Details: _____

Has child had any history of seizures, head injury, concussion, serious injuries, or loss of consciousness ☐ Yes ☐ No

Details: _____

Does your child have any pain issues or concerns? ☐ Yes ☐ No

Details: _____

Is your child currently taking any non-psychiatric medication (including homeopathic, naturopathic, or alternative medicines) for physical health conditions? ☐ Yes ☐ No If yes, please provide information below.

Name of medication	Prescribing provider	Results (including side effects)

BIRTH AND EARLY INFANCY HISTORY

☐ No information available about biological parents' history

This information should be provided as it relates to the biological parents of the child, if known.

Was the pregnancy planned? ☐ Yes ☐ No ☐ Unknown

Was the mother exposed to any of the following while pregnant: ☐ None ☐ Unknown

TYPE	LIST SPECIFIC SUBSTANCES	MONTH(S) OF PREGNANCY
DRUGS		
ALCOHOL		
TOBACCO		
MEDICATIONS		
X-RAYS		

Did the mother experience any significant illnesses during pregnancy? ☐ Yes ☐ No ☐ Unknown

Details: _____

Length of pregnancy: _____ (wks) Child's birth weight: _____ Age of mother: _____

Were there any labor or delivery problems? ☐ Yes ☐ No ☐ Unknown

Details: _____

Were there any problems while the baby was still in the hospital? ☐ Yes ☐ No ☐ Unknown

☐ Jaundice ☐ Need for incubator/oxygen ☐ infection ☐ feeding problems ☐ convulsions

☐ Other: _____

Were there any difficulties during the baby's infancy? ☐ Yes ☐ No ☐ Unknown

☐ attachment problems ☐ excessive crying ☐ health problems ☐ recurrent vomiting ☐ colic

☐ feeding problems ☐ low weight gain ☐ Other: _____

DEVELOPMENTAL HISTORY

Please identify your child's developmental progress in the following areas:

Areas of Development	Compare your child's development to other children his/her age (please put an X in the box below):			Please comment on areas of strength and weaknesses in your child's development (e.g. delay/deterioration/loss of skills)
	Same as others	Slower	Faster	
Gross Motor Skills (running, throwing ball, bicycling)				
Fine Motor Skills (coloring, drawing, writing, scissors use)				
Speech & Language Skills (pronunciation, vocabulary)				
Social Skills (sharing, cooperating, taking turns)				
Self-Control Skills (impulse control, delaying gratification)				
Self-Concept (child's opinion of self, abilities, worth)				
Cognitive Skills (memory, comprehension, knowledge)				

Has your child had any formal developmental testing or received any early intervention services? ☐ Yes ☐ No

Details: _____

CHILD AND FAMILY SOCIAL-BEHAVIORAL HISTORY

My child currently lives with: ☐ home with ☐ biological or ☐ adoptive family or ☐ relative ☐ foster care

☐ group care setting ☐ residential treatment facility ☐ other; if so, where _____

With whom does this child live currently (list all adult and child members of household):

Name	Gender	Age	Relationship
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		

Does your child have thoughts of harming him/herself or other people? ☐ Yes ☐ No

Details: _____

...

Does your child have access to any firearms or weapons at home, relatives or friends houses? ☐ Yes ☐ No

Are the firearms/weapons locked up or otherwise secured? ☐ Yes ☐ No

Has your child been experienced any of the following: ☐ exposure to domestic violence ☐ exposure to other violence or traumatic death ☐ death of parent/psychological parent ☐ none of these experiences

Details: _____

...

Has child had history of ☐ physical abuse ☐ sexual abuse ☐ persistent inadequate parenting or neglect?

If yes, has abuse/neglect been documented by CPS/Legal System? ☐ Yes ☐ No

Details: _____

Does your child participate in any community activities (e.g. sports, boys & girls, church)? ☐ Yes ☐ No

If yes, please list the activities/groups: _____

Please describe forms of discipline which have been used in the home and their effectiveness: _____

Please list those qualities about your child that you consider to be strong positive points. _____

Does your child have any attachment difficulties with a history of disrupted parenting before age 5? ☐ Yes ☐ No

Details: _____

FAMILY MEDICAL HISTORY

Information about family medical history can be very helpful in understanding current emotional and behavioral issues for children and adolescents seen in our clinic. Please indicate if anyone in your family has the following conditions. Check all that apply, past or present:

Condition/Circumstance	Child	Mother	Father	Sibling	Mother's Family	Father's Family
Intellectual Disability						
Learning Disorder						
Attention Deficit						
Hyperactivity						
Seizures/Epilepsy						
Other Neurological Disorders						
Alcohol Abuse						
Drug Abuse						
Physical/Emotional Abuse						
Sexual Abuse						
Depression						
Bipolar Disorder						
Suicide Attempts						
Anxiety Disorders						
Specific Fears or Phobias						
Obsessive-Compulsive Disorder						
Panic Attacks						
Schizophrenia or Psychosis						
Visual Disability/Problems						
Deaf/Hard of Hearing						
Tics/Tourette's Syndrome						
Chronic or Serious Medical Illnesses (e.g. Cancer , Asthma, Diabetes, Heart Disease)						
Juvenile Delinquency						
Arrests/Incarceration						
Harassment by peers						
Homelessness						
Teen pregnancy						
School suspension/expulsion						
Special Education						
Birth Defects						
Miscarriages						

SCHOOL/VOCATIONAL HISTORY

Is the patient currently enrolled in school? ☐ Yes ☐ No

Please indicate your child's attendance in the current and past quarter of school:

☐ On average, my child is missing less than one day per week of school

☐ On average, my child is missing more than one day per week of school

Current school placement:

School District: _____

Grade: _____

School Name: _____

Phone #: _____

Teacher/Counselor/IEP Coordinator: _____

Is child enrolled in special education? ☐ Yes ☐ No Current IEP? ☐ Yes ☐ No (if yes, request copy)

Child is designated: ☐ Seriously behaviorally disordered ☐ Learning disordered ☐ Health impaired

Child's classroom is: ☐ Regular Education ☐ Regular Education with pull-out to Resource Room

☐ Self-contained classroom ☐ Inclusion in regular education (___ hours/day) ☐ Other: _____

Describe current daily functioning in school setting (including strengths and needs): _____

Is there anything else you would like us to know about your child that we did not ask? _____
