The Evergreen Clinic

Minor Patient Health Information

The purpose of this questionnaire is to help make your first visit here as useful as possible, both by providing information needed for your care as well as by helping you to participate in your treatment. Please answer the following questions and items as completely and honestly as you can.

Patient's Name: _____ DOB: _____ Age: _____

Home Address: _____

Home Phone: _____ Cell: _____ Other: _____

Mother's Name: _____ Marital Status: _____

Employer/Occupation: _____ Phone: _____

Father's Name: _____ Marital Status: _____

Employer/Occupation: _____ Phone: _____

Stepparents / Guardian(s): _____

_____

	Name	Age	Relation	In Home
Biological Siblings:	_____	____	_____	_____
	_____	____	_____	_____
Half Siblings	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____
Step Siblings:	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____
Other:	_____	____	_____	_____
	_____	____	_____	_____

Primary Care Physician: _____

Address: _____ Phone: _____

Referred By: _____

What questions/concerns do you have regarding your child that brings you here?

_____
_____
_____
_____

What would your child state is their reason for being here?

_____
_____
_____
_____

Please list any other medications your child is currently taking or has taken in the past.

Medication and Dosage	**Date Started**	**Reason for Taking This Medication**	**Prescriber**

Has your child ever participated in counseling before? ____ Yes ____ No

If yes, please provide information on:

When? _____ Where? _____

With whom? _____

Please list any major illness, injury, or mental health issues your child currently has or has had in the past.

_____
_____
_____

Please list any major illness, injury, or mental health issues any member of your family currently has or has had in the past.

_____
_____
_____

Does your child or any other family member have any current or past drug or alcohol related issues?

_____
_____
_____

Describe any stresses within the family that may be affecting your child.

_____
_____
_____

Describe any medical conditions that are affecting your child's everyday life.

_____
_____
_____

Describe any concerns you have regarding your child's education.

_____
_____
_____

Describe any testing that your child has ever received in school or elsewhere.

_____
_____
_____

Academic Skill Development (check if applicable)

Poor physical coordination	____
Poor handwriting or letter formation	____
Poor memory (short or long term)	____
Right-left confusion or directional problems	____
Dominance established late (what age? ____) or not at all	____
Late letter recognition skills	____
Poor word recognition skills	____
Trouble with reading comprehension	____
Poor phonic base	____
Inability to form ideas on paper	____
Difficulty with mathematics	____
Poor spelling in day-to-day assignments	____
Difficulty in completing homework	____
Difficulty with attention span	____
Poor peer relationships	____
Conflict with a teacher	____
Certified for special education	____
Drop in achievement tests	____
Repeated grade (which grade? _____)	____
Sudden drop in grades	____
Attendance difficulties	____
School refusal	____

Schools Attended	Year

Does your child have a 504 Plan or IEP (individualized education plan)?

_____

_____

_____

Please indicate if the following concerns are present or have been present	Check if "Yes"	Age/Age
Difficult to discipline		
Becomes upset easily		
Temper tantrums		
Nail biting		
Thumb sucking		
Difficulty sleeping		
Nightmares		
Bed wetting or toilet training difficulties		
Destructiveness		
Preferring to be alone		
Unusually active, fidgety		
Unusually inactive, apathetic		
Unusual difficulty with siblings		
Unusual difficulty in getting along with other children		
Inattentive		
Procrastination		
Easily distracted		
Blames others for their own mistakes		
Expresses no guilt over their own mistakes		
Lying		
Stealing		
Truancy		
Refusal to cooperate with school		
Physical violence against persons or property		
Alcohol/drug abuse		
Unrealistic worry and/or pessimistic attitude		
Anxiety		
Headaches, stomachaches, nausea		
Sadness, crying		
Self-conscious, easily embarrassed		
Avoidance of peer interactions or other non-familiar social contacts		
Argumentative		
Stubbornness		

Excessive concern with weight or chronic eating		
Chronic motor or vocal tics and/or other oddities of speech		
Enuresis (wetting)		
Encopresis (soiling)		
Resistance to changes in environment and difficulties with transition		
Self-injurious behavior		
Panic attacks		
Decreased productivity at school, work, or home		
Chronic exhaustion		
Decreased interest in pleasurable activities		
Thoughts of death or suicide		
Hallucinations or delusions		
Social inappropriateness		
Odd/bizarre ideas and/or speech		
Changes in personal hygiene		
Cruelty to animals		
Overly dependent/helpless		
Plays with fire		