Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

Name: _____ **DOB:** _____

Gender: MALE FEMALE **Social Security #:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Numbers:

Home: ( ) _____ Can we call you at Home? Yes No

Cell: ( ) _____

Work: ( ) _____ Can we call you at Work? Yes No

Email: _____

Marital Status (circle one): Single Married Divorced Separated

Race (circle one):

American Indian or Alaska Native	Black/African American	Chinese
Filipino	Guamanian or Chamorro	Korean
Hispanic White	Japanese	Other Asian
Native Hawaiian	Other Pacific Islander	Samoan
White/Caucasian	Other Race	

Ethnicity (circle one):

Cuban	Mexican/Mexican American	Not Hispanic or Latino
Other Hispanic or Latino	Puerto Rican	

Preferred Language (circle one):

English Spanish Chinese Italian Polish Russian French Turkish Other

Known Allergies: _____

Employer: _____ **Occupation:** _____

Are you a Student? Yes No **If yes, Name of School:** _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

Primary Care Physician: _____ **Phone #:** _____

Address: _____

Therapist Name: _____ **Phone #:** _____

Discipline: _____

Preferred Pharmacy Name: _____ **Phone #:** _____

Pharmacy Address: _____

EMERGENCY CONTACT:

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

PRIMARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

SECONDARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

For Partial Hospitalization Clients Only

Will you be driving to the program? _____

Make/Model/Plate #: _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

PH5623

ALLERGIES:_____ SPECIAL DIET:_____

1. CURRENT PROVIDER OF MEDICAL CARE (Include name and address of regular health care providers).

Physician/Program Name Address Phone Number

_____

_____

2. BIRTH AND DEVELOPMENT HISTORY (Check all that apply. Note complications in any areas in the comments section).

A. Pregnancy

Prenatal Care	❑ Yes	❑ No
Drugs/Alcohol/Cigarettes	❑ Yes	❑ No
Illness/Medications	❑ Yes	❑ No

B. Condition at Birth

Normal	❑ Yes	❑ No
Birth Weight	❑ Low	❑ Normal

C. Delivery

Full Term	❑ Yes	❑ No
Premature	❑ Yes	❑ No
C-Section	❑ Yes	❑ No

D. Infancy - Any Problems

Feeding	❑ Yes	❑ No
Sleeping	❑ Yes	❑ No
Responding to Environment	❑ Yes	❑ No

E. Milestones - Age at which child:

Walked without support_____ Spoke first word_____

Spoke first 3 word sentence_____

Toilet Trained - Urine_____ Bowel_____

Comments:_____

_____

3. FAMILY HISTORY (For each blood relative, provide the information requested. Note additional siblings under "Other").

A. Biological Family (Include current age, age at death (if deceased), cause of death).

Patient_____

Mother_____

Father_____

Sibling_____

Sibling_____

Sibling_____

Other_____

B. Illnesses (Indicate if biological family has had any of the following and include relationship to patient).

Tuberculosis_____
Diabetes_____
High Blood Pressure_____
Heart Problems_____
Cancer_____
Epilepsy_____
Blood Disease_____
Mental Illness_____
Alcohol Use/Abuse_____
Drug Use/Abuse_____
HIV/AIDS_____
Other_____

4. PATIENT HISTORY (Provide the information requested, as appropriate).

A. Immunization History

Are all required Immunizations up to date? ❑ Yes ❑ No

If no, what required Immunizations need to be completed?

_____

_____

B. Allergies

Specify_____

C. Medical History

Date of Last Physical _____ By whom _____

Significant Findings_____

_____

Ear Infections ❑ Yes ❑ No

Comments_____

_____

Head Injury ❑ Yes ❑ No

Comments (Include if ever unconscious after an injury or ever vomited after an injury)

_____

_____

Seizure Disorder ❑ Yes ❑ No

Comments_____

_____

D. Eating Disorder (Include history of purging, bingeing, food restriction, excessive exercise, laxative or diuretic abuse, pre-occupation with body weight, distorted body image and history of eating disorder treatment).

_____

_____

_____

_____

E. Dental History

Date of Last Exam_____ Cavities ❑ Yes ❑ No

Under Treatment (Specify)_____

Family Dentist (Name, Address, Phone Number)

_____

F. Other

Accident Prone ❑ Yes ❑ No

Comments _____

Last Vision Screening (Date and Findings)_____

Last Hearing Screening (Date and Findings)_____

Onset of Menses _____ Last Menstrual Period _____ Sexually Active ❑ Yes ❑ No

Comments (Include type of protection used) _____

_____

_____

_____

5. EVALUATION (To be completed by a Nurse Practitioner, Physician, Physician's Assistant or Registered Nurse).

T_____ P_____ R_____ B/P_____ Ht._____ Wt._____

Do you have current pain? ❑ Yes ❑ No

Do you have chronic or re-occurring pain? ❑ Yes ❑ No

*****If YES for either question, completed a Pain Assessment Form*****

Date of last physical within 1 year? ❑ Yes ❑ No

If No, Parent/Patient agrees to obtain history and physical by primary care physician? ❑ Yes

Does Patient require nutritional referral? ❑ Yes ❑ No

Patient is able to self administer medication while at Partial Hospital as per prescription? ❑ Yes ❑ No

_____

_____

_____

_____

Staff Signature _____ **Title** _____ **Date**_____

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Patient Label

MS4365

Patient Name: _____ Date of Birth: _____

Please list below any medications that you are currently taking for medical and psychiatric illnesses, and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

Medication	Dose	Route	Directions	Prescriber

Form Completed By: _____ Date: _____


PH5609

FAMILY

Name:	Age:	Occupation:	Check if Estranged:	Check if Resides w/ Client
(bio) Mother				
(bio) Father				
(step) Mother				
(step) Father				
Sibling				
Sibling				
Sibling				
(step) Sibling				
(Significant relationship with extended family member)				
Grandmothers				
Grandfathers				
Aunts				
Uncles				
Cousins				

FINANCIAL

If not applicable list N/A

Financial Problems

Difficulty meeting basic needs: i.e. food, shelter

Parent Job Change

Loss Employment

Assistance Received

EATING DISORDER

Changes in eating patterns?

Significant weight loss or gain?

Preoccupation with weight/body?

Excessive exercise?

Has child been diagnosed/treated for Anorexia, Bulimia, or Binge - Eating Disorder?

SEXUALITY

Patient "Dating" History_____

Sexually Active_____

Promiscuity_____

Pregnancy, Miscarriage, Abortions_____

Does client have children?_____

Conflict Re: Homosexuality_____

Has sexuality been discussed within the home?_____

Prostitution_____

CHILDHOOD HISTORY

	Yes / No	Age	Explain
Delayed Speech Development			
Poor Coordination			
Can't Sit Still			
Talk Too Much / Too Loudly			
Can't Tolerate Delay			
Impulsive			
Can't Accept Corrections			
Temper Tantrums			
Self Mutilation			
Wets the Bed			
Feeling Left Out			
Rocking			
Lying			
Stealing			
Vandalism			
Fights			
Accident Prone			
Easily Frustrated			
Constantly Touching Others			
Responds to Structure			
Doesn't Follow Directions			
Daydreams			
Short Attention Span			
Unresponsive to Discipline			

PARENT DISCIPLINE

Please explain parent discipline style/consequences to behavior_____

ADOLESCENT STRENGTHS

MENTAL HEALTH

Describe child prior to onset of illness_____

What changes in mood/behavior have you noticed since onset of illness?_____

What observed/reported symptoms on mental illness have you noticed?_____

When was onset of illness?_____

History of mental illness in the family_____

LEGAL

Order of Protection_____

PINS_____

Client Arrests/Criminal Record_____

Parent/Sibling Arrests/Criminal Record_____

Probation_____

EDUCATION

Attendance_____

Truancy_____

Classified ED or LD_____

Tutoring_____

Attends BOCES Program_____

Speech/Language Therapy_____

Extracurricular Activities (spots, music, etc.)_____

Summer School_____

Difficulty with Reading, Writing, Math_____

Adjustment Difficulty to Kindergarten/1st Grade_____

Poor Task Completion_____

Overall Academic Performance_____

INTERPERSONAL RELATIONSHIPS

Observation of Peer Relationships_____

Duration/Quality of Peer Group_____

Changes in Peer Group_____

Interest Level in Socialization_____

Isolation/Withdrawn from Peers_____

Role Models_____

Relationships with Adults Other than Family (i.e. Teachers, Clergy, Coaches, etc.)

_____

Aggressive Behavior_____

Physical Confrontations_____

Gang Memberships_____

Communication Skills_____

HISTORY OF ABUSE/TRAUMA

Physical Abuse_____

Sexual Abuse_____

Incest_____

Emotional/Verbal Abuse_____

Client Witnessing Physical, Sexual, Emotional, Abuse of Sibling or Parent

_____

CPS Involvement_____

Other_____

DRUG/ALCOHOL

	Drug Type	Currently Uses Yes / No	Past Use (How Long Ago)	Treatment Received
Client History				
Family History of Drug/Alcohol Abuse				
Name				

SIGNIFICANT FAMILY EVENTS

Name(s)	Client Age	Explain Events and Client Change in Functioning Following Event
Death of Relative		
Death of Friend		
Parent Separation		
Parent Divorce		
Parent Remarriage		
Parent/Marital Discord		
Separation from Siblings		
Moving Residence		
Change in School District		
Friend Moving Away		
Adoption		
Foster Care		

CULTURAL

Ethnic Background _____

Languages Spoken by Child/Parents _____

Religion _____