

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

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#: _____

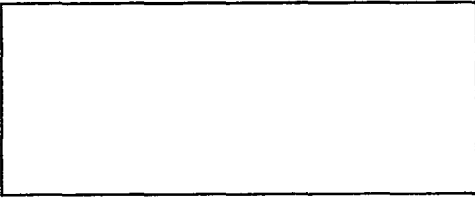
For Partial Hospitalization Clients Only

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**



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

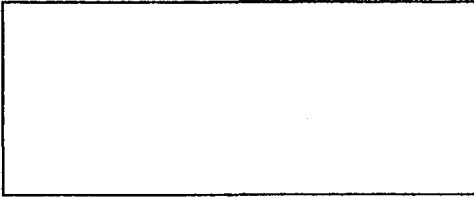

MS4365

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: _____



<u>FAMILY</u>				
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 _____				

<u>FINANCIAL</u>
If not applicable list N/A
Financial Problems _____
Difficulty meeting basic needs: i.e. food, shelter _____
Parent Job Change _____
Loss Employment _____
Assistance Received _____

<u>EATING DISORDER</u>
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 _____

<u>DRUG/ALCOHOL</u>				
Drug Type	Currently Uses Yes / No	Past Use (How Long Ago)	Treatment Received	
Client History _____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
Family History of Drug/Alcohol Abuse Name				
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

<u>SIGNIFICANT FAMILY EVENTS</u>		
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 _____	_____	_____

<u>CULTURAL</u>
Ethnic Background _____
Languages Spoken by Child/Parents _____
Religion _____