PARTIAL HOSPITAL CLIENT REGISTRATION

Date: _____ Client Phone #:_____ Client Cell #:_____

Client Name:_____
(Last) (First) (M.I.)

Address:_____
(Street) (City/Town) (State) (Zip Code)

Age: _____ Date of Birth:_____ Birth Place:_____ Sex:_____

E Mail Address: _____

Martial Status:_____ Client Social Security #: _____

Pharmacy Name & Address :_____

_____

Pharmacy Phone #: _____

** **RACE**: American Indian or Alaskan Native, Asian, Asian Indian,

Black or African American, Chinese, Filipino, Guamanian or Chamorro, Hispanic/White,

Japanese, Korean, Native Hawaiian, Other Pacific Islander, Other Race, Samoan, Unknown,

Undisclosed, Vietnamese, White or Caucasian,

** **ETHNICITY (Circle One)**: Cuban, Mexican, Mexican American, Not Hispanic or Latino

Puerto Rican, Undisclosed, Unknown

****PREFERRED LANGUAGE (Circle One)**: English Spanish Chinese Italian Polish

Russian French Turkish Other

KNOWN ALLERGIES_____

Client Occupation: _____ Employer Name: _____

Employer Address: _____ Employer Phone: _____

Notify in Case of Emergency- Name & Address: _____

_____

Relationship to Client: _____ Emergency Contact Home Phone: _____

Emergency Contact Cell Phone # 1: _____ Work Phone # 1: _____

Emergency Contact Cell Phone # 2: _____ Work Phone # 2: _____

PARTIAL HOSPITAL CLIENT REGISTRATION

Number of Insurance Plans: _____

Policy Holder- Name: _____ Date of Birth: _____

Address: _____

Insured Employer – Name & Address: _____

_____

Relationship to Client: _____ Policy Holder Home Phone: _____

Insured SS#: _____ Policy Holder Work Phone: _____

Primary Insurance: _____ Phone #: _____

Group Number: _____ Identification Number: _____

Secondary Insurance: _____ Phone #: _____

Policy Holder- Name: _____ Relationship to Client: _____

Insured SS#: _____ Insured Date of Birth: _____

Group Number: _____ Identification Number: _____

Will you be driving to program? _____ Make/ Model / Plate #: _____

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**_____

PH5617

Patient Name:_____ Date of Birth:_____

Please list below the current medications that you are taking for your psychiatric illness (please include any herbal remedies or dietary supplements).

Name	Dose	Route	Frequency	Reason

Are you prescribed any medications for your medical illness? ❑ Yes ❑ No

Do you take any medication including over the counter medications or herbal remedies or any dietary supplements for any other reason? ❑ Yes ❑ No

If you answered "Yes" please enter those medications on the additional medical medication form.

Form completed by:_____ Date:_____

I have reviewed the patient's Home Medication List and compared it to the medications being prescribed.

_____ _____ _____

Physician / NP Signature ID# Date

PATIENT/FAMILY SELF REPORTED HOME MEDICATION LIST
PSYCHIATRIC MEDICATIONS LIST

Patient Name:_____ Date of Birth:_____

Please list any of the medications that you are currently taking for your medical illnesses, or any other reason, and the name of the practitioner who prescribes them. Please include any over the counter medications or herbal remedies or dietary supplements. Please update this list when medications are discontinued, doses are changed, or new medications (including over the counter products) are added.

Name	Dose	Route	Frequency	Reason	Prescriber Name

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 _____