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REFERRAL INFORMATION

Individual completing this form (name and relationship to patient):				**Date:**	
Patient's Name:				**Nickname:**	
Date of Birth:		**Age:**		**Gender:**	
Who referred patient to this clinic?					
Primary Reason(s) for Referral?					

MENTAL HEALTH HISTORY

Has the patient ever received mental health treatment (If yes, provide information below)? Yes No

Dates	Provider	Reasons for treatment	Diagnoses (if any)	Progress (none, poor, fair, good, excellent)

Do you have a history of any inpatient psychiatric hospitalizations? Yes No

Reason for Hospitalization: **Dates/Length of Stay:**

Current Psychiatric Medications:	Dosage	How long (months)?	Prescribing Clinician:

SUBSTANCE USE HISTORY

Does the patient have a history of recreational drug use? Yes No		**Did patient receive treatment for substance abuse?**	Yes No
History of alcohol abuse? Yes No			
Current substance use (including nicotine)? Yes No		**If Yes, please indicate substance, amount, frequency, and date of last use:**	

MEDICAL INFORMATION

Primary Care Physician (PCP):		**Can we share information with your PCP?**	Yes No
Any hospitalizations, surgeries, emergency room visits?	Yes No	**If yes, please briefly describe:**	
Past medical conditions?	Yes No	**If yes, please briefly describe:**	
Current medical diagnoses (including problems with vision or hearing)?	Yes No	**If yes, please briefly describe:**	
History of brain injury or neurological evaluation?	Yes No	**If yes, please briefly describe:**	
Sexual/menstrual developmental concerns?	Yes No	**If yes, please briefly describe:**	
Current *non-psychiatric* medications?			
Allergies (including medications):			

FAMILY HISTORY

Any family history of mental health concerns or mental health treatment?	Yes No	**If yes, please briefly describe (diagnosis/relationship to child):**	
Any family history of substance use/abuse (including nicotine)?	Yes No	**If yes, please briefly describe:**	
Any family history of suicide attempts or completions?	Yes No	**If yes, please briefly describe:**	
Any significant family medical history?	Yes No	**If yes, please briefly describe (diagnosis/relationship to child):**	

PRENATAL/DEVELOPMENTAL INFORMATION

Any exposure to drug/alcohol/tobacco or prescription medication during pregnancy?			Yes	No Unsure
Did you and/or your doctor note any pregnancy complications?			Yes	No Unsure
Did you and/or your doctor note any problems with delivery?			Yes	No Unsure
Birth weight:		**Length of pregnancy?**	Full-term	Premature
Did the patient have any complications after birth? (e.g. premature birth, jaundice, breathing difficulties?			Yes	No Unsure

Indicate when the patient achieved the following activities (indicate if you felt it was ***N****ormal* or ***D****elayed*):

Crawled (avg 9 mos)	N D	**Walked (avg 12-18 mos)**	N D
Spoke words (avg 10 mos)	N D	**Toilet Trained (avg 2-3 yrs)**	N D

SOCIAL INFORMATION

Biological parents are:	Married	Engaged	Separated	Divorced	Never married		
Parent/Caregiver name:				**Parent/Caregiver name:**			
Biological	Step	Adoptive	Foster/Guardian	Biological	Step	Adoptive	Foster/Guardian
Home Phone:		**Work Phone:**		**Home Phone:**		**Work Phone:**	
Place of employment:				**Place of employment:**			
Occupation:				**Occupation:**			

Other individuals living in the patient's home? (siblings, grandparents, etc)	**Name**	**Age**	**Gender**	**Relationship to patient?**

Other support systems? (grandparents, non-custodial parent/stepparent)	**Name**	**How often?**	**Relationship to patient?**

EDUCATIONAL INFORMATION

Current grade level (if summer, grade child will be entering):		**School name:**	
Has the patient ever been suspended, expelled, or retained in a grade?	Yes	No	
Has the patient ever received early intervention or special education services?	Yes No	**If yes, please list verification (if known):**	
		Most recent IQ or educational assessment:	
Extracurricular Activities:			

LIFESTYLE INFORMATION

Does the patient have a legal history or offender issues?	Yes No Unsure	**If yes, please describe:**	
Does the patient have a history of neglect?	Yes No Unsure	**If yes, please describe:**	
Does the patient have a history of abuse?	Physical Emotional Sexual None		

Please indicate if the patient has experienced any of the following events:

□ Divorce of caregivers □ Death of family member or significant person □ Exposure to violence, drugs, or sexually explicit material

□ Significant move □ Significant accident, illness, or injury □ Other: _____

Family spiritual beliefs/orientation:		**Cultural/Ethnic Issues:**	