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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 <i>non-psychiatric</i> 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 <u>N</u> ormal or <u>D</u> 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							
<b>Biological parents are:</b>	Married	Engaged	Separated	Divorced	Never married		
<b>Parent/Caregiver name:</b>				<b>Parent/Caregiver name:</b>			
Biological	Step	Adoptive	Foster/Guardian	Biological	Step	Adoptive	Foster/Guardian
<b>Home Phone:</b>		<b>Work Phone:</b>		<b>Home Phone:</b>		<b>Work Phone:</b>	
<b>Place of employment:</b>				<b>Place of employment:</b>			
<b>Occupation:</b>				<b>Occupation:</b>			
<b>Other individuals living in the patient's home? (siblings, grandparents, etc)</b>	<b>Name</b>	<b>Age</b>	<b>Gender</b>	<b>Relationship to patient?</b>			
<b>Other support systems? (grandparents, non-custodial parent/stepparent)</b>	<b>Name</b>	<b>How often?</b>		<b>Relationship to patient?</b>			

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

LIFESTYLE INFORMATION				
<b>Does the patient have a legal history or offender issues?</b>	Yes	No	Unsure	<b>If yes, please describe:</b>
<b>Does the patient have a history of neglect?</b>	Yes	No	Unsure	<b>If yes, please describe:</b>
<b>Does the patient have a history of abuse?</b>	Physical	Emotional	Sexual	None
<b>Please indicate if the patient has experienced any of the following events:</b>				
<input type="checkbox"/> Divorce of caregivers <input type="checkbox"/> Death of family member or significant person <input type="checkbox"/> Exposure to violence, drugs, or sexually explicit material <input type="checkbox"/> Significant move <input type="checkbox"/> Significant accident, illness, or injury <input type="checkbox"/> Other: _____				
<b>Family spiritual beliefs/orientation:</b>				<b>Cultural/Ethnic Issues:</b>