** CENTER HEALTH CARE**

***Psychology / Social Work & Psychiatry Background Questionnaire***

The information in this form is very important. Please fill out as completely as possible and return to our office prior to your first appointment to: **Center Health Care, Behavioral Health, 314 South Manning Blvd., Albany, NY 12208 or fax to: (518) 437-5554.** Please supply us with any relevant reports including Psychological, Psychiatric and Psycho-Social reports.

**NOTE: “Patient” refers to the person receiving services. Today’s Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_**

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| **Patient Name** | Form completed by:  Indicate relationship to patient; leave blank if same as patient: |
| Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ | Race:  Religion or spiritual practice: |
| Primary Language Spoken: 🖵 English 🖵 Spanish 🖵 Other | Other Language(s) Spoken |
| Referred by: | Referral Phone ( ) |
| **Describe the reason for referral, including questions and concerns:** | |
| **FAMILY DATA** | |
| **Parent: MOTHER** | **Parent: FATHER** |
| Name | Name |
| DOB \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_  Date of Death \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ | DOB \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_  Date of Death \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ |
| Address | Address |
| Phone ( ) | Phone ( ) |
| Occupation | Occupation |
| Marital Status **🖵** Married **🖵** Divorce  **🖵** Widowed **🖵** Never Married  **🖵** Separated **🖵** Living with Partner | Marital Status **🖵** Married **🖵** Divorce  **🖵** Widowed **🖵** Never Married  **🖵** Separated **🖵** Living with Partner |
| Schooling completed: | Schooling completed: |
| Educational difficulties: | Educational difficulties: |
| Psychological difficulties: | Psychological difficulties: |
| Does patient have contact with mother? 🖵 Yes 🖵 No | Does patient have contact with father? 🖵 Yes 🖵 No |
| **🖵** Check if patient has a **Legal Guardian**; if checked, write in individual’s name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please provide proof of guardianship to Enrollment Office for adults; bring proof of custody for children if there are custody issues. | **🖵** Check if patient has a **Legal Guardian**; if checked, write in individual’s name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please provide proof of guardianship to Enrollment Office for adults; bring proof of custody for children if there are custody issues. |

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| **Patient’s Siblings** | | | | | | | | | | | | | | | |
| **Name** | | | | | **DOB** | | | | **Address** | | | | | | **Contact with Patient (how often)** |
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| **Patient’s Spouse / Partner** | | | | | | | | | | | | | | | |
| **CURRENT: 🖵** Husband **🖵** Wife **🖵** Partner | | | | | | | **FORMER: 🖵** Husband **🖵** Wife **🖵** Partner | | | | | | | | |
| Name | | | | | | | Name | | | | | | | | |
| Address | | | | | | | Address | | | | | | | | |
| Phone | | | | | | | Phone | | | | | | | | |
| Occupation | | | | | | | Occupation | | | | | | | | |
| Marital Status **🖵** Married **🖵** Divorce  **🖵** Widowed **🖵** Never Married  **🖵** Separated **🖵** Re-Married  **🖵** Living with Partner | | | | | | | Marital Status **🖵** Married **🖵** Divorce  **🖵** Widowed **🖵** Never Married  **🖵** Separated **🖵** Re-Married  **🖵** Living with Partner | | | | | | | | |
| School Completed: | | | | | | | School Completed: | | | | | | | | |
| Educational Difficulties: | | | | | | | Educational Difficulties: | | | | | | | | |
| **Patient’s Children** | | | | | | | | | | | | | | | |
| **Name** | | | | | **DOB** | | | | **Address** | | | | | | **School or Job** |
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| Who lives in the patient’s home? | | | | | | | | | | | | | | | |
| **Patient’s Developmental History** | | | | | | | | | | | | | | | |
| **History During Pregnancy** | | | | | | | | | | | | | | | |
| At time of patient’s birth | | **Mother’s Age** \_\_\_\_\_\_ **Father’s Age** \_\_\_\_\_\_ | | | | | | | | | | | | | |
| Length of term | | **‘**  **🖵** Premature **🖵** Full Term **🖵** Post-mature (late) | | | | | | | | | | | | | |
| Maternal illness or accidents during the pregnancy: | | | | | | | | | | | | | | | |
| Maternal medications during the pregnancy: | | | | | | | | | | | | | | | |
| Parental alcoholic beverages consumed during pregnancy? | | **Mother 🖵** Yes **Father** **🖵** Yes  **🖵** No **🖵** No | | | | | | | | | | | | | |
| If yes to above, indicate type of alcohol, amount & frequency | | **Mother** Type­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_  **Father** Type­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| Parental drug use: | | **Mother 🖵** Yes **Father** **🖵** Yes  **🖵** No **🖵** No | | | | | | | | | | | | | |
| Type of drug(s), amount & frequency. | | **Mother** Type­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_  **Father** Type­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| During pregnancy, did parents smoke (nicotine)? | | **Mother 🖵** Yes **Father** **🖵** Yes  **🖵** No **🖵** No | | | | | | | | | | | | | |
| If yes, how many cigarettes each day? | | **Mother** \_\_\_\_\_\_ per day  **Father:** ­­­­­­­­­­­\_\_\_\_\_\_ per day | | | | | | | | | | | | | |
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| **Patient’s Developmental History** *(continued)* | | | | | | | | | | | | | | | |
| **Birth History** | | | | | | | | | | | | | | | |
| Birth Weight: | | |  | | | | | | | | | | | | | |
| Complications of delivery? | | | **🖵** No **🖵** Yes If yes, explain: | | | | | | | | | | | | | |
| Any birth defects? | | | **🖵** No **🖵** Yes If yes, explain: | | | | | | | | | | | | | |
| Condition after birth (color, etc): | | |  | | | | | | | | | | | | | |
| Was neonatal intensive care needed? | | | **🖵** No **🖵** Yes If yes, length \_\_\_\_\_\_\_\_\_\_\_\_ Explain: | | | | | | | | | | | | | |
| Did baby go home with the mother from the hospital? | | | **🖵** No **🖵** Yes | | | | | | | | | | | | | |
| Length of stay in the hospital for the: | | | Mother \_\_\_\_\_\_\_\_\_\_\_\_ Baby \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| Were there any feeding problems? | | | **🖵** No **🖵** Yes If yes, please describe: | | | | | | | | | | | | | |
| Were there any sleeping problems? | | | **🖵** No **🖵** YesIf yes, please describe: | | | | | | | | | | | | | |
| In infancy, was there: | | | **🖵** Diarrhea **🖵** Colic **🖵** Anemia **🖵** Reflux **🖵** Hypotonia  **🖵** Cerebral Palsy **🖵** Respiratory Problems **🖵** Seizures | | | | | | | | | | | | | |
| **Indicate items that were true for the baby in the first year of life:** (Please check **🗸** all that apply) | | | | | | | | | | | | | | | |
| **🖵** Easy to manage | | | **🖵** Irregular in sleeping / feeding | | | | | | | | | | **🖵** Fussy | | |
| **🖵** Happy | | | **🖵** Fearful of new people / situations | | | | | | | | | | **🖵** Slow to warm-up in new situations | | |
| **🖵** Adaptable to new situations | | | **🖵** Intense in reactions | | | | | | | | | | **🖵** Inactive | | |
| **🖵** Regular in sleeping / feeding | | | **🖵** Smiled | | | | | | | | | | **🖵** Not easily upset | | |
| **🖵** Nervous | | | **🖵** Difficult to comfort | | | | | | | | | | **🖵** Liked to be held | | |
| **🖵** Alert | | | **🖵** Other | | | | | | | | | | **🖵** Made eye contact | | |
| **Were there any special problems in the growth and development as a child during the first few years?**  **🖵** No **🖵** Yes If yes, explain (eg, any speech, motor delays, extremes of temperament, separation anxiety, separations from parents) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Milestones: At what AGE did patient:** | | | | | | | | | | | | | | | |
| Sit without support | | | | | | | | Begin putting words together | | | | | | | |
| Crawl | | | | | | | | Spoke in sentences | | | | | | | |
| Walk unassisted | | | | | | | | Toilet train – Day | | | | | | | |
| Speak first word | | | | | | | | Toilet train – Night | | | | | | | |
| **Did you or your doctor have any concerns about the child’s development?** (walking, talking, movement, eating, etc)  If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Did the child have a developmental evaluation?** If yes, please supply a copy to our office. **🖵** No **🖵** Yes  By Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Has there been a diagnosis of Fetal Alcohol Affect or Syndrome?**  **🖵** No **🖵** Yes  By Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Patient’s Educational History** | | | | | | | | | | | | | | | |
| Did patient attend day care? | | | **🖵** Yes **🖵** No If yes, at what age: How long: | | | | | | | | | | | | | |
| Did patient attend preschool? | | | **🖵** Yes **🖵** No If yes, at what age: How long: | | | | | | | | | | | | | |
| Age of entering kindergarten? | | |  | | | | | | | | | | | | | |
| Has patient repeated **🖵** Yes **🖵** No  any grades? | | | If yes, indicate the grades and give the reasons for retention:  Grades: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reasons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| **Schools Attended** | | | | | | | | | | | | | | | |
| **Name & Location** | | | | | **Grades** | | | **Dates** | | | | **Reason for Leaving** | | | |
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| **Has the patient received any of the following special school services?** | | | | | | | | | | | | | | | |
| **Service** | | | **Yes** | | **No** | **Locations / Grades / Ages** | | | | | | | | | |
| Reading | | |  | |  |  | | | | | | | | | |
| Math | | |  | |  |  | | | | | | | | | |
| Speech / Language Services | | |  | |  |  | | | | | | | | | |
| Occupational Therapy | | |  | |  |  | | | | | | | | | |
| Physical Therapy | | |  | |  |  | | | | | | | | | |
| Counseling in school | | |  | |  |  | | | | | | | | | |
| Social Skills Group in school | | |  | |  |  | | | | | | | | | |
| Special Education services | | |  | |  |  | | | | | | | | | |
| Psychological Evaluation  *(bring to appointment)* | | |  | |  |  | | | | | | | | | |
| Behavior Therapy / Modification *(bring Behavior Intervention Plan, if current)* | | |  | |  |  | | | | | | | | | |
| **🖵** Self-Contained **🖵** Resource Room **🖵** Consultant Teacher **🖵** Individual Aide **🖵** Shared Aide | | | | | | | | | | | | | | | |
| **What is your impression of patient’s learning ability?** | | | | | | | | | | | | | | | |
| **Patient’s Work History** *(if applicable)* | | | | | | | | | | | | | | | |
| **Occupation / Position** | | **Location** | | | | | | | | **Start / Finish** | | | | **Reason for Leaving** | |
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| **Patient’s Residential History** | | | | | | | | | | | | | | | |
| Current Residence:  Length of time at this residence: | | | | | | | | | | | | | | | |
| Previous Residence **(1)**:  Length of time at this residence: | | | | | | | | | | | | | | | |
| Previous Residence **(2)**:  Length of time at this residence: | | | | | | | | | | | | | | | |
| **Patient’s Drug / Alcohol / Legal History** | | | | | | | | | | | | | | | |
| What is the patient’s current use of alcohol? Type­­­­­­­­­­­: Frequency: | | | | | | | | | | | | | | | |
| What is the patient’s current use of drugs? Type:­­­­­­­­­­­ Frequency: | | | | | | | | | | | | | | | |
| Any past use of alcohol? **🖵** Yes **🖵** No Length of use: Frequency:­ | | | | | | | | | | | | | | | |
| Any past use of drugs? **🖵** Yes **🖵** No Length of use: Frequency­: If yes, please list: | | | | | | | | | | | | | | | |
| Treatment received for drug or alcohol use (ie, Detox, Rehab, Outpatient)? | | | | | | | | | | | | | | | |
| Does the patient smoke: **🖵** Yes **🖵** No Treatment received: | | | | | | | | | | | | | | | |
| Has the patient ever been in trouble with the law? **🖵** Yes **🖵** No If yes, please describe: | | | | | | | | | | | | | | | |
| **Social History** | | | | | | | | | | | | | | | |
| **Has the patient or any of the patient’s family experienced the following?** Please give a simple explanation. | | | | | | | | | | | | | | | |
| **Problem** | **Response** | | | **Who** | | | | | | | Describe problem | | | | |
| Drinking | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Drug use | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Fighting | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Hitting | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Yelling | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Name calling | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Threatening | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Arguing | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Sexual abuse | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Physical abuse | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Arrested | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Jail / Prison | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Separation | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Divorce | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Job changes | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Loss of income | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Hospital stay | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Suicide | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Serious illness or injury | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Military history | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Contact with Child Protective | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Contact with Adult Protective | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Placement outside the home | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Been in court | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Case management | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Other agencies | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Family problems | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Other problems | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |
| Significant deaths | **🖵** Yes **🖵** No | | |  | | | | | | |  | | | | |

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| **Patient’s Medical History**  Please check **🗸**next to any illness or conditions the patient has had. If an item is checked, also note the approximate date (or age) of the illness. | | | | | | | |
| **Check 🗸** | **Illness / Condition** | | **Dates / Ages** | | **Check**  **🗸** | **Illness / Condition** | **Dates / Ages** |
|  | Measles | |  | |  | Dizziness |  |
|  | Whooping Cough | |  | |  | Extreme Tiredness |  |
|  | Mumps | |  | |  | Cancer |  |
|  | Chicken Pox | |  | |  | Anemia |  |
|  | Pneumonia | |  | |  | Respiratory Infections |  |
|  | Broken Bones | |  | |  | Jaundice / Hepatitis |  |
|  | Ear Infections | |  | |  | High Blood Pressure |  |
|  | Asthma | |  | |  | Gonorrhea / Syphilis |  |
|  | Epilepsy / Seizures | |  | |  | Blood Disorders |  |
|  | Exposure to lead | |  | |  | Diabetes |  |
|  | Inattention | |  | |  | Miscarriages |  |
|  | Hyperactivity | |  | |  | Fainting Spells |  |
|  | Impulsivity | |  | |  | Head Injury |  |
|  | Environmental Allergies | |  | |  | Stroke |  |
|  | Bedwetting | |  | |  | Paralysis |  |
|  | Vision Problems | |  | |  | Memory Problems |  |
|  | Hearing Problems | |  | |  | Frequent Headaches |  |
|  | Tics / Tourette’s | |  | |  | Difficulty Concentrating |  |
|  | Eating Problems | |  | |  | Anxiety |  |
|  | Sleeping Problems | |  | |  | Depression |  |
|  | Fever above 104◦ | |  | |  | Suicide attempt |  |
|  | Heart Disease | |  | |  | Drug Allergies |  |
|  | Other: | |  | |  | Adverse Drug Reactions |  |
| **Psychiatric Hospitalizations / Residential Placements / Foster Care / Respite** | | | | | | | |
| **Date of Placement** | | **Placement**  **Site or Type** | | **Reason / Explanation** | | | |
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| **Other Hospitalizations** | | | | | | | |
| **Date of Stay** | | **Hospital** | | **Reason** | | | |
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**Primary Care Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

Office Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical: \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Current Medications (OR Write NONE)** | | | |
| **Medication**  **(OR Write NONE)** | **Dosage Per Administration** | **Time of Administration** | **Problems, if any** |
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| Currently taking over-the-counter herbal remedies: **🖵** Yes **🖵** No If yes, list them: | | | |
| **Past Psychotropic Medications (OR Write NONE)** | | | |
| **Past Psychotropic Medication**  **(OR Write NONE)** | **Reason For and Date of Discontinuation (if known)** | | |
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| **Medication Allergies or Adverse Drug Reactions (OR Write NONE)** | | | |
| **Medication Allergies or Adverse Drug Reactions (OR Write NONE)** | **List any allergies that required an**  **emergency medical visit or special treatment** | | |
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| **Family Medical History** | | | | | | | | |
| **Check 🗸** | **Illness / Condition** | **Relationship to Patient** | | | **Check 🗸** | **Illness / Condition** | | **Relationship to Patient** |
|  | Alcoholism |  | | |  | Tics or Tourette’s | |  |
|  | Substance Abuse |  | | |  | Required Special Ed. | |  |
|  | Cancer |  | | |  | Depression | |  |
|  | Diabetes |  | | |  | Bipolar Disorder | |  |
|  | Heart Disease |  | | |  | Attention Disorder | |  |
|  | Autism/Autism Spectrum |  | | |  | Other (Describe): | |  |
|  | Developmental Delays including or Intellectual Disabilities and Autism Spectrum Disorders – **Describe:** |  | | |  |  |
| **Patient’s Mental Health History** | | | | | | | | |
| **Has the patient ever had an evaluation with a Psychiatric Practitioner for consideration**  **of psychotropic medication? 🖵** Yes **🖵** No | | | | | | | | |
| Practitioner Name | | | | Practitioner Phone | | | | |
| Address | | | | City, State, Zip | | | | |
| What was the result? | | | | | | | | |
| If patient or family is currently seeking **psychiatric medication management**, please describe briefly why. | | | | | | | | |
| Previous Psychological Evaluations: **🖵** Yes **🖵** No If yes, please supply copies to our office or bring to your first appointment. | | | | | | | | |
| What other agencies is the patient or family involved with? | | | | | | | | |
| **Counseling History** | | | | | | | | |
| **Name of Counselor / Agency** | | | **Year** | **Reason for Counseling** | | | **Effectiveness of Counseling** | |
|  | | |  |  | | |  | |
|  | | |  |  | | |  | |
|  | | |  |  | | |  | |

**Additional Information:**

What are the patient’s **favorite** activities?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the patient’s **least** favorite activities?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any unusual experiences or events in home or history which you find would help the service provider understand the patient?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information that you feel is important:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have not already supplied our office with the following, please do so as soon as possible:**

* Previous Psychological Testing
* IEP / ICP
* Behavior Support or Intervention Plans with recent data, if available
* Summary Records from previous Mental Health Practitioners
* Proof of Guardianship
* Proof of Custody (if Shared Custody)

***All this is needed to provide you or your family with the best service we can.***

Please fill out as completely as possible and return to our office prior to your first appointment to:

**Center Health Care, Behavioral Health, 314 South Manning Blvd., Albany, NY 12208**

**OR Fax to: (518) 437-5554**