** 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 |
|  |  |
| **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 **🖵** YesBy Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Has there been a diagnosis of Fetal Alcohol Affect or Syndrome?**  **🖵** No **🖵** YesBy 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 **🖵** Noany 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** |
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**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**