Clackamas Pediatric Clinic
8645 SE Sunnybrook Blvd #200
Clackamas, OR 97015
(503) 659-1694

Oregon Pediatrics – Meridian Park
19260 SW 65th Ave #275
Tualatin, OR 97062
(503) 691-2519

Oregon Pediatrics – Happy Valley
15970 SE Misty Dr. #100
Happy Valley, OR 97086
(503) 427-2637

Oregon Pediatrics – NE Portland
5050 NE Hoyt St. #B55
Portland, OR 97213
(503) 233-5393

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PATIENT INFORMATION

Patient Name: _____ DOB: _____

Other Names Used: _____ Preferred Pronoun: _____

Preferred Language: _____ Ethnicity: _____

Referred by (Name & Number): _____

BIOLOGICAL PARENTS & CONTACT INFORMATION

Mother's Name: _____Marital Status: _____
DOB: _____ Phone: _____ May we leave a detailed message: Y N
Address: _____

Father's Name: _____ Marital Status: _____
DOB: _____ Phone: _____ May we leave a detailed message: Y N
Address: _____

PRIMARY CAREGIVER & CONTACT INFORMATION

(Complete only if Biological Parent is not the Primary Caregiver)

Guardian's Name: _____ Marital Status: _____
DOB: _____ Relationship to Child: _____ (e.g., Adoptive, Guardian, Foster, Step, Other)
Phone: _____ May we leave a detailed message: Y N
Address: _____

Guardian's Name: _____ Marital Status: _____
DOB: _____ Relationship to Child: _____ (e.g., Adoptive, Guardian, Foster, Step, Other)
Phone: _____ May we leave a detailed message: Y N
Address: _____

CURRENT LIVING SITUATION

Please note patient's current household:

Name	Age	Relationship to patient

Please note any custody arrangements, *if applicable*: _____

_____

Any history with CPS (nature of allegations, age of occurrence, offender, dependency court action, child/parent response, placement and type, services): Yes No

If yes, please describe: _____

_____

Is there any other information regarding patient's past/current living situation(s) we should be aware about or that you feel impact patient's current functioning? _____

_____

_____

FAMILY HISTORY

Have there been any major changes in your family in the past few years (e.g. moved, employment changes, deaths, family dynamic): _____

_____

_____

Briefly describe patient's relationship with mother: _____

_____

Briefly describe patient's relationship with father: _____

_____

Briefly describe patient's relationship with siblings: _____

_____

_____

Briefly describe patient's relationship with any other significant person(s): _____

_____

_____

_____

Is there any history of mental illness in the patient's family? If yes, please describe: _____

_____

_____

Is there any history of substance use in the patient's family? If yes, please describe: _____

_____

_____

REASON FOR REFERRAL/CHIEF COMPLAINT

Describe the problem(s) that brought you here today *(please include how long symptoms/concerns have been present in the chart provided below)*:

_____

_____

_____

_____

CURRENT SYMPTOMS AND BEHAVIORS

Symptoms and/or Behavioral Concerns	When did they start	How often are they experienced	Problems created from these concerns

Please check all behaviors and symptoms that you consider ***problematic:***

□ Acts younger than age
□ Aggression/fights
□ Alcohol/drug use
□ Anxiety/worry
□ Boredom
□ Change in appetite
□ Compulsive behavior
□ Computer addiction
□ Crying spells
□ Curfew violations
□ Cutting
□ Defiance
□ Delusions
□ Destroys property
□ Difficulty keeping friends
□ Difficulty making friends
□ Distractibility
□ Eating problems
□ Elevated mood
□ Family conflict
□ Fatigue
□ Fear away from home
□ Fire setting
□ Frequent arguments
□ Gambling
□ Grandiosity
□ Grief
□ Guilt
□ Hair pulling
□ Hearing voices
□ Homicidal thoughts
□ Hopelessness
□ Hyperactivity
□ Impaired Judgment
□ Impulsivity
□ Irritability/Anger
□ Lack of motivation
□ Learning Disability
□ Legal problems
□ Loneliness
□ Loss of pleasure in activities
□ Low self-worth
□ Lying
□ Manipulative behavior
□ Nightmares
□ No/few friends
□ Obsessive thoughts
□ Oppositional Behavior
□ Other (specify):

_____

□ Panic attacks
□ Peer conflict
□ Peer/sibling conflict
□ Phobias
□ Picking behaviors
□ Poor memory/confusion
□ Racing thoughts
□ Recurring, disturbing memories

□ Running away
□ Sadness/Depression
□ Self-harm behaviors
□ Sexual behavior
□ Sleep problems
□ Social discomfort
□ Somatic Complaints
□ Stealing
□ Suicidal thoughts
□ Suicide Attempts
□ Suspicion/paranoia
□ Swearing
□ Thoughts of death
□ Toileting problems
□ Visual hallucinations
□ Wide mood swings
□ Withdrawal from people
□ Work/school problems

SUICIDAL THOUGHTS/ATTEMPTS:

Self-Harm (without statement of suicidal intent – This may include thoughts and/or actions):
Yes No Unable to Assess

If yes, describe (include behavior, when started, most recent time): _____

_____

_____

Suicidal attempts: Yes No Unable to Assess

If yes, describe (include behavior, when started, most recent time): _____

_____

_____

Psychiatric Hospitalization: Yes No Date(s): _____

MENTAL HEALTH HISTORY

Prior Mental Health Records to be requested from: _____

Yes	No	Type of Treatment	When (Month/year)	Name of Provider/Program
		Outpatient Counseling (Self-help/Support Groups/ In School)		
		Drug/Alcohol Treatment		

Concerns for drug and/or alcohol use: Yes No

If yes, explain: _____

_____

_____

TRAUMA

If not applicable, please leave blank and continue to next question

Does patient have any trauma or exposure to trauma: Yes No Unable to Assess

Trauma type **(physical, emotional/verbal, sexual, witness to abuse, violence or threats of violence)**	**Dates**	**Received Therapy for this?** (Yes or No)	**Response at end of therapy**

MEDICATIONS

If not applicable, please leave blank and continue to next question

If patient is ***not*** a current Clackamas and Oregon Pediatric patient, please list "all" past and present psychotropic medications used, prescribed/non-prescribed

Medication	**Dosage/Frequency**	**Reason/Diagnosis**	**Period Taken**	**Effectiveness/Response**	**Side Effects/Reactions**

PATIENT STRENGTHS

(to assist in achieving treatment goals): athletics, clubs, affiliations, social, personal, relations, etc.

_____

_____

_____

SOCIAL/CULTURAL/SPIRITUAL

Describe any church, religious or spiritual group or community that your family is currently involved in:

_____

_____

Have you found spiritual beliefs to be helpful or a hindrance to your family?

_____

_____

How important are spiritual matters to your family? ___Not at all ___A little ___Fairly important ___Very important

SCHOOL HISTORY

School: _____ Grade Level: _____

Receiving Special Education: Yes No On IEP: Yes No

Current IEP Dates: _____ Eligibility category:_____

On 504 Accommodation Plan: Yes No Type of Accommodations:_____

Has the patient had any of the following at school?

- □ Associates with older children
- □ Associates with younger children
- □ Attendance problems
- □ Been accused of bullying
- □ Referrals or detentions
- □ Teased or picked on
- □ Gang influence
- □ Incomplete homework
- □ Learning problems (math, reading, writing)
- □ Poor grades
- □ Speech problems
- □ Suspension - reason:

  _____

Educational Comments: Performance, Grades, School Changes, any other concerns:

_____

_____

LEGAL HISTORY

Juvenile Court History (arrests/offenses, tickets/warnings, probation/stipulations, incarceration, placement:

_____

_____

Is there anything else you feel it is important for Behavioral Health to know before beginning?

_____

_____

_____