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

Central Fax (503) 659-8984

Patient Accounts (503) 427-2118

Today's Date: _____

Completed by: _____ Relation to Patient: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Other Names Used: _____Preferred Pronoun: _____

Preferred Language: _____Ethnicity: _____

Referred by (Name & Number): _____

BIOLOGICAL PARENTS & CONTACT INFORMATION

Mother's Name: _____ DOB: _____

Marital Status: _____ Occupation: _____

Phone: _____ May we leave a detailed message: Y N

Address: _____

_____

Father's Name: _____ DOB: _____

Marital Status: _____ Occupation: _____

Phone: _____ May we leave a detailed message: Y N

Address: _____

_____

If parents are separated/divorced, what is the current custody arrangement:

_____

PRIMARY CAREGIVER & CONTACT INFORMATION

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

Guardian's Name: _____ DOB: _____

Relationship to Child: _____ (e.g., Adoptive, Guardian, Foster, Step, Other)

Marital Status: _____ Occupation: _____

Phone: _____ May we leave a detailed message: Y N

Address: _____

_____

Guardian's Name: _____ DOB: _____

Relationship to Patient: _____ (e.g., Adoptive, Guardian, Foster, Step, Other)

Marital Status: _____ Occupation: _____

Phone: _____ May we leave a detailed message: Yes No

Address: _____

_____

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PRESENTING PROBLEMS & CONCERNS

Describe the problem(s) that brought you here today (please include when problem first began – Please be specific):

_____

_____

_____

_____

Please check all behaviors and symptoms that you are noticing*:*

□ Aggression/Fights
□ Agreeing on Chores
□ Alcohol/Drug Use
□ Anxiety
□ Arguing
□ Audio Hallucinations
□ Change in Appetite
□ Curfew Violations
□ Decision Making
□ Defiance (Disobedience)
□ Delusions
□ Depression
□ Destroys Property
□ Distractibility
□ Dreams/Nightmares
□ Emotional Abuse
□ Family Conflict
□ Fatigue
□ Fire Setting
□ Peer Relationships
□ Gambling
□ Grief
□ Guilt
□ Hair Pulling
□ Homicidal Thoughts
□ Hopelessness
□ Hyperactivity
□ Impulsiveness
□ Irritability/Anger
□ Lack of Motivation
□ Learning Disability
□ Loneliness
□ Low Self-worth
□ Lying
□ Manipulative Behavior
□ Mood Swings
□ Obsessive Thoughts
□ Oppositional Behavior
□ Panic Attacks
□ Perfectionism
□ Personal Appearance
□ Phobias
□ Physical Abuse
□ Picking Behaviors
□ Poor Memory/Confusion
□ Pornography
□ Pregnancy
□ Racing Thoughts
□ Recurring/Disturbing Memories
□ Running Away
□ Screen Time
□ Self-harm Behaviors
□ Sexual Abuse
□ Sexual Activity
□ Sibling Relationships

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□ Sleep Problems
□ Social Discomfort
□ Stealing/ Shoplifting
□ Suicidal Thoughts
□ Suicide Attempts
□ Suspicion/Paranoia
□ Swearing
□ Temper Tantrums
□ Thoughts of Death
□ Toileting Concerns
□ Verbal Abuse
□ Visual Hallucinations
□ Weight (loss/gain)
□ Withdrawal from People

Please check *all* areas of life these symptoms are impacting:
__ school/education __ social relationships __ home/family relationships __ physical

MENTAL HEALTH HISTORY

Has the patient ever expressed suicidal thoughts, intents or attempts? Yes No
If yes, please describe: _____
_____
_____

Has the patient ever expressed thoughts, intents or engaged in other self-harm? Yes No
If yes, please describe: _____
_____
_____

Has the patient ever expressed thoughts, intents or attempted to hurt someone else? Yes No
If so, please describe: _____
_____

Does the patient have any history of or exposure to trauma? Yes No
If so, please describe: _____
_____
_____
_____

Previous Mental Health Treatment:

Yes	No	Type of Treatment	When (Month/year)	Name of Provider/Agency
		Outpatient		

		School Counseling Center		
		Drug/Alcohol Treatment		
		Psychiatric Hospitalization		
		Other:		

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How have you tried to address the problem so far? Please describe:

_____
_____
_____

DEVELOPMENTAL HISTORY

Were there any medical or psychological problems during pregnancy or birth? Yes No

If yes, please describe: _____

_____
_____

Did the biological mother experience any post-partum depression or difficult circumstances shortly after the birth of patient? Yes No

If yes, please describe: _____

_____
_____

Did/Does the patient have any of the following developmental delays or other issues in early childhood? Check all that apply:

__ delayed speech __ delayed crawling/walking __ severe tantrums __ separation anxiety
__ excessive crying __ potty training delays __ bed wetting __ motor
__ other: _____

What other services does the patient receive (OT, PT, Speech, ABA Therapy):

_____

Do you have any other concerns about patient's development that you wish to discuss?
If yes, please describe: _____

_____
_____

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SCHOOL HISTORY

School: _____ Grade Level: _____

Has the patient had any assessment/ evaluations done through the school: Yes No

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 experienced any of the following at school?

- □ Association with older children
- □ Association with younger children
- □ Attendance problems
- □ Bullies Others
- □ Referrals or detentions
- □ Bullied
- □ Gang influence
- □ Incomplete homework
- □ Learning problems
- □ Poor grades
- □ Speech problems
- □ Suspension - Reason: _____

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

_____

_____

Current year's grades:	___ Excellent	___Good	___Fair	___Poor
Current year's behavior:	___ Excellent	___Good	___Fair	___Poor
Past year's grades:	___ Excellent	___Good	___Fair	___Poor
Past year's behavior:	___ Excellent	___Good	___Fair	___Poor

Does the patient attend daycare or have another before or after-school provider? If yes, please provide name or place: _____

_____

What are patient's strengths in school?

_____

_____

_____

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FAMILY HISTORY

Please note who currently lives in the home with patient:

Name	Age	Relationship to patient

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

_____

_____

_____

Please briefly describe patient's relationship with mother:

_____

_____

Please briefly describe patient's relationship with father:

_____

_____

Please briefly describe patient's relationship with sibling(s):

_____

_____

_____

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 drug or alcohol use in the patient's family? If yes, please describe:

_____

_____

_____

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SOCIAL/ CULTURAL /SPIRITUAL

Does patient or family identify with any cultural group? Yes No
If yes, please describe: _____
_____

Is the patient or family attend a church, religious or spiritual group? Yes No
If yes, please describe: _____
_____

Are you open to discussing cultural/spiritual matters in counseling, as applicable? Yes No

Describe patient's strengths, skills and talents:
_____
_____

Describe any special areas of interests, hobbies or activities the patient or family is interested in (e.g. art, books, sports, etc.): _____

_____

MEDICAL HISTORY

Name of Primary Provider: _____ Phone: _____

Has the patient experienced any of the following medical conditions? Check all that apply:

__ Allergies __ Chronic Pain __ Dizziness/fainting __ Serious accident __ Seizures
__ Asthma __ Concussion __ Diabetes __ Headaches __ Frequent stomach pain
__ Abortion __ Sexually transmitted infection __ Head injury __ Surgery __ Other

If patient is *NOT* a current Clackamas and Oregon patient, please list ALL past and present psychotropic medications:

Medication	Dosage/Frequency	When (Month/Year)	Reason/Diagnosis

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LEGAL HISTROY

Has the patient ever been in trouble with the law? Yes No

If yes, please give dates and circumstances:

_____

_____

Is the patient currently on probation? Yes No

If yes, please give name and number of probation officer: _____

_____

Has the patient ever been convicted of a crime? Yes No

If yes, please give dates and circumstances:

_____

_____

Is there any legal action pending? Yes No

If yes, please give dates and circumstances:

_____

_____

Is there any history or current involvement with CPS? Yes No

If yes, please give dates and circumstances:

_____

_____

COPING

In general, how does the patient relax, calm down, or deal with stress?

Please check all that apply:

__ Physical activity	__ Reading	__ TV	__ Rocking/holding
__ Meditation	__ Working	__ Jog/walk	__ Relaxation exercises
__ Prayer	__ Crying	__ Talking	__ Nothing
__ Playing	__ Other_____		

OTHER

Is there any other information about the *patient* you feel it is important for us to know?

_____

_____

Is there any other information about your *family situation* you feel it is important for us to know?

_____

_____