PATIENT AND FAMILY INVENTORY

The purpose of this inventory is to acquire information about the birth, development, and behavior of the young person who is to be seen for evaluation and/or services. It also asks questions about the medical, psychiatric, and social history of the child's family. The information you provide here will add to the information that will be collected during the upcoming intake evaluation. All of the information gathered here and during the intake evaluation adds to a complete understanding of the biological, psychological, and social factors that may affect the young person's mental health status and will assist with recommendations for treatment. You may add extra pages if you wish.

Name: _____ Birth date: _____

Patient's ethnicity: _____ Patient's primary language: _____

Name of the person completing form: _____ Phone: _____

Relationship to patient: _____ Date form was completed: _____

1. What concerns have led you to seek an evaluation?

2. Why do you think the young person has the problems that they are exhibiting?

3. Who recommended that you seek services?

Name: _____

Organization: _____

Phone #: _____

4. What do you hope will be the outcome or results of the visit(s)?

5. What kind of treatment do you believe would be most helpful? What kinds of treatment would you be opposed to?

6. Where does the young person currently reside?

c family home c non-parent relative caretaker c foster home

c group home c other:

7. Who else lives with the young person (please list name, gender, relationship, age and ethnic/cultural identity):

_____

_____

_____

_____

8. If the child was adopted or is in foster care, at what age did the she/he enter the family and what were the circumstances regarding the adoption or foster care placement?

9. Has the child ever been separated from his/her parents/primary caregivers for any significant periods of time? c Yes c No

If yes, please provide information about the child's age, circumstances of the separation, and child's response:

MEDICAL HISTORY:

1. Who is the child's current pediatrician or primary health care provider?

Name:_____ Phone#:_____

Address:_____

_____

_____

2. Does the child have any chronic medical conditions (e.g., asthma, diabetes, cystic fibrosis, etc.)?

c Yes c No

If yes, please explain:

3. Has the child been prescribed any medications in the past to treat emotional or behavioral problems? c Yes c No

If yes, please list the medications and whether they had any effect:

Medication	Effect
_____	_____
_____	_____
_____	_____

4. Is the child currently taking any other medications or alternative medicines (vitamins, herbal treatment, homeopathic remedies, etc.)? c Yes c No

If yes, please list the medications/alternative medicines:

5. Has the child had any previous surgeries or hospitalizations? c Yes c No

If yes, please explain:

6. Has the child had any history of seizures or head trauma? c Yes c No

If yes, please explain:

7. Does the child have any past or current substance use (alcohol, drugs, cigarettes)?

c Yes c No

If yes, please explain:

8. Does the child have any history of bedwetting or soiling him/herself?

c Yes c No

If yes, please explain:

9. Have you noticed any change in the last six months in any of the following areas:

c Weight loss or gain?

c Problems with getting off to sleep, remaining asleep or waking up too early, nightmares? comment:_____

c Mood, including mood swings, unusually happy or very sad feelings? Comment:

_____

c Types of and contact with friends?

c Loss of interest or participation in previously enjoyed activities? Comment:

_____

10. Is there any skill which your child used to have that she/he NO LONGER has? Do you suspect any deterioration or loss of skills previously attained? Please provide specifics:

BIRTH/PRENATAL HISTORY

1. Was this pregnancy:

c planned c unplanned c wanted c unwanted

Any difficulty becoming pregnant? If so, please explain:

2. Did the mother experience any of the following illnesses or complications during pregnancy?

c Swelling of hands/feet/face c Flu c Skin Rash c Fever

c Spotting/Bleeding c Kidney Infections c Vaginal Infections c Headaches

c High blood pressure c Dizzy spells c Convulsions c Blurred vision

c Vomiting c Other Illnesses

comments:

3. Was the mother exposed to any of the following during pregnancy?

c Medications c Substance of Abuse c Alcohol c Tobacco c X-Rays

If yes for any of the above, please list specific substances, amount, and approximate month of pregnancy:

4. Length of pregnancy (weeks):_____ Age of mother:_____Weight gain:_____

5. Labor with this child was: c easy, no problems c difficult: please explain

6. Type of delivery: c natural (vaginal) c c-section c forceps

Problems with the delivery? c Yes c No

If yes, please explain.

7. Birth statistics: Weight_____Length_____Head size_____

Apgar scores (if known)_____

8. Hospital where the child was born:_____

Address:_____

Physician's Name:_____

9. Were there any problems noted while the baby was still in the hospital? (For example, serious jaundice, need for incubator/oxygen, infections, feeding problems, convulsions):

10. Were there any difficulties during the baby's first year of life (excessive crying, illness, feeding problems, etc.)?

DEVELOPMENTAL HISTORY

1. When did you child first complete these tasks **(fill in approximate age in months and/or years).**

MOTOR TASKS ACHIEVED AT AGE:		*LANGUAGE ACHIEVED AT AGE:*
Sit Alone _____	Ride a bicycle _____	Babble _____
Crawl _____		Say Mamma/Dadda___
Walk Alone _____		Use first Words _____
Throw a Ball _____		Put two words together _____
Ride a tricycle _____		Use full sentences____

SOCIAL ACHIEVED AT AGE:

Smile/laugh _____

Recognize strangers____

SELF-CARE AGE

Take clothes off _____

Put clothes on _____

Drink from a cup_____

TOILETING ACHIEVED AT AGE:

Bowel _____

Bladder (day) _____

Bladder (night) _____

COGNITIVE AGE

Recognize colors_____

Recognize #/letters____

1700 SEVENTH AVENUE, SUITE 210
SEATTLE, WA 98101
VOICE (206) 624-3800 / FAX (206) 624-3801

2. Please describe your child's development in the following areas:

Areas of Development	**When compared to other children his/her age, does child's development seem:**	**Please comment on areas of strength or weakness in your child's development:**
Gross Motor Skills (use of large muscles, such as for running, bicycling, throwing ball)	c about the same as other children c slower than other children c faster than other children	**Notes:**
Fine Motor Skills (hand use such as for coloring, drawing, writing, using scissors)	c about the same as other children c slower than other children c faster than other children	**Notes:**
Social Skills (sharing, cooperating, asking for help, compromising, taking turns)	c about the same as other children c slower than other children c faster than other children	**Notes:**
Self-Control Skills (impulse control, paying attention, delaying gratification)	c about the same as other children c slower than other children c faster than other children	**Notes:**
Self-Concept (child's opinion of self, abilities, worth)	c about the same as other children c slower than other children c faster than other children	**Notes:**
Cognitive Skills (memory, ability to understand information, comprehension)	c about the same as other children c slower than other children c faster than other children	**Notes:**

1700 SEVENTH AVENUE, SUITE 210
SEATTLE, WA 98101
VOICE (206) 624-3800 / FAX (206) 624-3801

3. Can your child currently perform the following tasks without help? (c Yes to all of the tasks listed below)

c Eat using a spoon and fork?

c Drink from a glass?

c Undress?

c Dress alone?

c Tie shoelaces?

c Toilet him/herself?

c Bathe him/herself?

4. Has your child had any formal developmental testing? c Yes c No

If yes, please provide details:

5. Has your child received any early intervention services? c Yes c No

If yes, please provide details about where the services and provider(s):

_____

_____

_____

_____

1700 SEVENTH AVENUE, SUITE 210
SEATTLE, WA 98101
VOICE (206) 624-3800 / FAX (206) 624-3801

FAMILY HISTORY

1. Has anyone in your family had any of the following conditions or life circumstances? Please put an X in all categories that apply both in the past and at the present time. Your clinician will ask more about these conditions and circumstances during the intake evaluation.

Condition	Child	Mother	Father	Siblings	Mother's Family	Father's Family
Mental Retardation						
Learning Disorder						
Attention Deficit						
Eating Disorder						
Epilepsy						
Neurological Disorders						
Alcohol Abuse						
Drug Abuse						
Physical/Emotional Abuse						
Sexual Abuse						
Depression						
Suicide Attempts						
Anxiety Disorders						
Specific Fears or Phobias/OCD						
Panic Attacks						
Schizophrenia						
Visual Disability/Problems						
Deaf/Hard of Hearing						
Tics/Tourette's Syndrome						
Chronic Illnesses						
Juvenile Delinquency						
Arrests/Incarceration						
Harassment by peers						
Homelessness						
Teen pregnancy						

School suspension/expulsn.						
Special Education						
Birth Defects						
Other:_____ (please specify)						

FAMILY HISTORY (continued)

2. *Mother/Maternal Caregiver Information:*

Relationship to child: c biological c adoptive c foster c step c other

Date of Birth:_____ Place of Birth:_____Ethnicity:_____

Occupation: _____Employer_____

Marital Status: c Single c Married c Divorced c Separated c Remarried

Years of Education:_____

History of Mental Illness, History of Substance Abuse? Present Status for each:

_____

_____

_____

3. *Father/Paternal Caregiver Information:*

Relationship to child: c biological c adoptive c foster c step c other

Date of Birth:_____ Place of Birth:_____Ethnicity:_____

Occupation: _____Employer_____

Marital Status: c Single c Married c Divorced c Separated c Remarried

Years of Education:_____

History of Mental Illness, History of Substance Abuse? Present Status for each:

_____

_____

_____

4. Has there been any domestic violence in the household in which the child resides? c Yes c No

If yes, please provide details and effect on child.

5. Is there any family conflict currently in the household in which the child resides? c Yes c No

If yes, please provide details and effect on child:

6. How many times have the child and his/her family moved in the past year? _____

Please provide details on reasons for moves and effect on child.

EDUCATIONAL HISTORY

1. Current School Information: Is the child currently enrolled in school? c Yes c No

School District:_____

School Name: _____

School Address:_____

Phone#:_____

Teacher's Name:_____

Child's Grade: _____

1. Is the child in Special Education? c Yes c No

(If yes, please attach present IEP)

If yes, child qualifies under:

c Learning Disordered c Seriously Behaviorally Disturbed

c Health Impaired c Multiply Handicapped c Other:

If the child is not currently in Special Education, was she/he in the past? c Yes c No

2. Has the child been suspended, expelled or had detentions from school in the past year?

c Yes c No

If yes, please list number of times and reasons

3. How is your child's academic performance currently?

4.How is your child's behavior/citizenship at school currently?

1700 SEVENTH AVENUE, SUITE 210
SEATTLE, WA 98101
VOICE (206) 624-3800 / FAX (206) 624-3801

CHILD BEHAVIORAL HISTORY

1. Has your child ever seen a counselor, therapist, social worker, psychologist or psychiatrist for emotional or behavioral problems? c Yes c No

If yes, please provide details about the provider, dates, and outcomes/effectiveness of previous treatment:

2. Does your child have behavior problems at home? c Yes c No

If yes, please specify:

3. Does your child have behavior problems in the community (grocery store, daycare, public places, etc.)? c Yes c No

If yes, please specify:

4. Please describe forms of discipline which have been used in the home and their effectiveness.

1700 SEVENTH AVENUE, SUITE 210
SEATTLE, WA 98101
VOICE (206) 624-3800 / FAX (206) 624-3801

5. The closest relationship is between the patient and _____

Please explain:

6. The most troubled relationship is between the patient and _____

Please explain:

7. How have the patient's problems affected family members (as applicable)?

Mother/maternal caregiver:

Father/paternal caregiver:

Siblings:

8. Describe sleeping or roommate arrangements in the family:

9. Briefly describe the parents'/primary caregivers' own relationship

1700 SEVENTH AVENUE, SUITE 210
SEATTLE, WA 98101
VOICE (206) 624-3800 / FAX (206) 624-3801

10. Please list those qualities about your child that you consider to be strong positive points:

11. Please list those qualities about your child that you consider to be strong negative points:

SOCIAL SUPPORT AND HISTORY

1. What is your current housing situation?

2. Do you consider your housing situation adequate to meet your family needs? c Yes c No

If no, please describe how it is not adequate.

3. Does your child participate in any community activities (e.g. sports, boys & girls, church)?

c Yes c No

If yes, please list the activities/groups:

4. Does your child have as many friends as most other children his/her age? ` c Yes c No

5. Does your child have friends come over and play at your house? c Yes c No

6. Does your child play at the houses of his/her friends? c Yes c No

7. Has your child had any friends stay overnight at your house, or has she/he stayed overnight at another friend's house? c Yes c No c Not age appropriate

8. Do you have any family members in the area that you can rely on for help? c Yes c No

9. Do you have any friends in the area that you can rely on for help? c Yes c No

10. Do you have any other adults in the area that you can rely on for help? c Yes c No

11. Does your family have any identified religion or spiritual beliefs and practices? c Yes c No

If yes, please describe:

12. What types of activities does your family like to do together?

13. Is your child or family currently involved with any of the following agencies?

c Not applicable

c Family Reconciliation Services (FRS)

c Child Protective Services (CPS)

c Developmental Disabilities (DDD)

c At-risk youth petition (ARY)

c Substance abuse counseling

c Juvenile Court/probation

Please provide details:

How long did it take to complete this form?

Was the time adequate?

Do you have suggestions or comments regarding the adequacy of this inventory?

1700 SEVENTH AVENUE, SUITE 210
SEATTLE, WA 98101
VOICE (206) 624-3800 / FAX (206) 624-3801