PALOUSE PSYCHIATRY & BEHAVIORAL HEALTH

PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

Welcome to our clinic!

Attached are the registration documents that we will need for you to complete and bring with you to your appointment.

It is required that you show up 15 minutes early for your appointment. If paperwork is not completed, or you are unable to arrive early, your appointment may need to be rescheduled.

Our office is located in the Corporate Point Building (on the 2nd floor), across the street from Pullman Regional Hospital and next to Zeppoz.

Thank you and we look forward to seeing you.
Psychiatry & Behavioral Health
840 SE Bishop Blvd., #203
Pullman, WA 99163
509-339-2394 (Phone)
509-336-7484 (Fax)

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CHILD AND FAMILY INFORMATION FORM

List parents, brother, sisters and others living in the home: (Specify whether full, half, step, or foster.)

First & Last Name	Sex	Age	School Grade / Occupation	Relationship to Child
Parent/Guardian:				☐ Full ☐ Step ☐ Foster ☐ Other_____
Parent/Guardian:				☐ Full ☐ Step ☐ Foster ☐ Other_____
				☐ Full ☐ Step ☐ Half ☐ Foster ☐ Other_____
				☐ Full ☐ Step ☐ Half ☐ Foster ☐ Other_____
				☐ Full ☐ Step ☐ Half ☐ Foster ☐ Other_____

What behavior(s) is your child exhibiting that is of concern to you? _____

_____

Which is the most troublesome? _____

Was alcohol, drugs or tobacco used during pregnancy? ☐ No ☐ Yes (If yes, see below.)

a. Which substance? _____
b. Quantity and frequency? _____
c. How long/Still currently using? _____

Did the mother experience any high stress levels or illness during pregnancy? ☐ No ☐ Yes

(If yes, please describe the illness and any treatment, medication or special diet the mother received.)_____

_____

Where was the child born? _____

Was the child born prematurely? ☐ No ☐ Yes if yes, number of weeks: _____

How long did labor last? _____ Birth Weight: _____

How was the child born? ☐ Head first ☐ Feet first ☐ Breech (buttocks first) ☐ C-Section ☐ Other_____

Were there any difficulties or peculiarities in the child's appearance or behavior at birth or during infancy?

☐ No ☐ Yes If yes, describe: _____

Was the infant given oxygen? ☐ No ☐ Yes -If yes, for how long? _____

Blood transfusions? ☐ No ☐ Yes

Placed in an incubator? ☐ No ☐ Yes -If yes, for how long? _____

Other medical treatment? ☐ No ☐ Yes - Describe: _____

At what age did your child first smile? _____ Walk alone? _____

Say his/her first word? _____ Speak in sentences? _____

At what age was bowel training complete? _____ Urinary training? _____

Was there any difficulty in training? ☐ No ☐ Yes - Describe: _____

Any past or present problems in bowel or urinary control? ☐ No ☐ Yes - Describe: _____

_____

Has your child ever experienced serious illness, injury, or hospitalization, or does he/she have any physical disabilities?
☐ No ☐ Yes - If yes, please describe and state age when problem occurred: _____

_____

_____

Has your child had:
Head injuries? ☐ No ☐ Yes Describe: _____
Seizures? ☐ No ☐ Yes Describe: _____
Abnormal motor twitches? ☐ No ☐ Yes Describe: _____
Is your child currently taking any medication? ☐ No ☐ Yes
Please list all medications, including herbal supplements/over the counter drugs:

Name of Medication:	Dose:	Purpose:	Effect:	Prescribing Doctor:

Child's Physician/Pediatrician: _____
Physician's Phone Number: _____ /Physician's Address: _____
Date of Last Complete Check-Up: _____
Has your child had any difficulties with:
Eating? ☐ No ☐ Yes – Describe: _____
Sleeping? ☐ No ☐ Yes – Describe: _____
→Does he/she nap? ☐ No ☐ Yes – Sleep / Wake Schedule: _____
Speaking? ☐ No ☐ Yes– Describe: _____
Menstruating? ☐ No ☐ Yes– Describe: _____
Substance Abuse? ☐ No ☐ Yes– Describe: _____
How long have these problems existed? (Specify which problem and duration.) _____

_____

Other sleep behavior not noted above (i.e. walking, terrors, etc.) _____
Has your child received a mental health diagnosis or treatment previously? ☐ No ☐ Yes
If yes, where? _____

_____

_____

Have others expressed concern about your child (i.e. friends, school, police)? ☐ No ☐ Yes
If yes, please describe: _____

_____

Is there any other information you can think of that might pertain to your child's problems that might help us in understanding him/her better? _____

_____

PATIENT/FAMILY MEDICAL HISTORY

	Patient	Mother	Father	Sister	Brother	Sister 2	Brother 2
Heart Attack							
Adverse Reaction to Anesthesia							
Allergies (dust, pollen, pets, foods)							
Anemia							
Asthma							
Atherosclerosis							
Autoimmune Disorder							
Cancer of the Breast							
Colon Cancer							
Congenital Anomaly							
Coronary Artery Disease							
Dementia							
Diabetes							
Eczema							
Genetic Disorder							
Hyperlipidemia							
High Blood Pressure							
Huntington's Disease							
Kidney Disease							
Lung Cancer							
Malignant Hyperthermia							
Mild Cognitive Impairment (MCI)							
Multiple Sclerosis							
Obesity							
Other Blood Disorder							
Other Cancer							
Ovarian Cancer							
Parkinson's Disease							
Prostate Cancer							
Rheumatoid Arthritis							
Seizures							
Skin Cancer							
Thyroid Disease							
Tobacco Abuse							
Tuberculosis							
Stroke							

Any other health conditions not listed above? _____

PATIENT FAMILY/MEDICAL HISTORY CONTINUED

	Patient	Mother	Father	Sister	Brother	Sister 2	Brother 2
Anxiety							
Attention Deficit /Hyperactivity Disorder							
Bipolar Disorder							
Dementia							
Depression							
Learning Difficulties/SLD							
Intellectual Disability							
Personality Disorder							
Post-Traumatic Stress Disorder							
Schizophrenia							
Suicidal Behavior/Ideation							
Violent Behavior/Ideation							

If anyone has been diagnosed with any of the above mental health disorders, please list the relation to the patient, the diagnosis, and whether or not treatment has been received, including medication prescribed:

Relation to Patient:	Diagnosis:	Treatment Received:	Medications:

INFANCY & NEWBORN

By whom was the child raised? _____

Looking back on your child's early years, would you say your child was:
(Check any that apply.)

- ☐ Difficult to Sooth
- ☐ Easy-Going
- ☐ Slow to Warm

Please describe: _____

_____

Have you noticed any problems in the child's development? ☐ No ☐ Yes

Describe: _____

_____

_____

EARLY CHILDHOOD

Does the child have difficulty with expressing his/her emotions? ☐ No ☐ Yes

Describe: _____

Does the child take a long time to warm up to new situations or new people? ☐ No ☐ Yes

Describe: _____

Does the child react *strongly/not at all* to physical pain? ☐ No ☐ Yes
(Circle one)

Describe: _____

Does the child react strongly to other things? ☐ No ☐ Yes Explain: _____

CHILD'S EARLY SOCIALIZATION:

Describe your child's early socialization skills with others within and outside the home: _____

_____

_____

What parenting strategy/style has been implemented at home (i.e. Time-Out, Positive Reference, etc.)

Describe: _____

_____

_____

CURRENT SOCIAL HISTORY

Raised by: _____

Any life transitions within the home or child's general environment? ☐ No ☐ Yes

Describe: _____

Is the parent or legal guardian of the child involved in any litigation currently? ☐ No ☐ Yes

If yes, describe: _____

Do any of the following problems apply to the child's current living situation?

Marital or relationship problems between the child's major caregivers	☐ No ☐ Yes
Problems with siblings or other persons living at home	☐ No ☐ Yes
Problems with present living situation	☐ No ☐ Yes
Recent major changes or stressors in the child's living situation or family	☐ No ☐ Yes
Violence in the home or neighborhood	☐ No ☐ Yes
Alcohol or drug problems in the home or neighborhood	☐ No ☐ Yes
Other problems, such as legal issues, financial strain, etc.	☐ No ☐ Yes

If yes to any of the above, please describe: _____

_____

_____

Does the child currently have any pets? ☐ No ☐ Yes Describe: _____

What sorts of hobbies does the child enjoy? _____

Is the child currently assigned any household or outdoor chores? ☐ No ☐ Yes

Describe: _____

Are there any other factors in the child's current social/living situation that you would like to discuss?

_____

_____

_____