

# New Patient Information Form

# FAS Clinic

<b>Office Use:</b> Date received ___/___/___ Deadline ___/___/___ ASAP ___ Response Let. ___/___/___ Photo ___ Screen Code ___ G ___ F ___ B ___ A ___ M ___: 1 2 3 4
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## Patient Identification

Patient's Social Security Number (optional) \_\_\_\_\_  Female  Male Race \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_  
*First Middle Last*

Patient's Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ cell ( ) \_\_\_\_\_ email \_\_\_\_\_

## Caregiver Identification

Name of patient's primary caregiver(s) \_\_\_\_\_

Relationship to patient:  birth,  adoptive,  foster parent,  other (specify \_\_\_\_\_)

Caregiver's Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ cell ( ) \_\_\_\_\_ email \_\_\_\_\_

## Person Completing the Form

Name of person completing this form \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient:  birth,  adoptive,  foster parent,  caseworker,  medical provider,  \_\_\_\_\_

Referred by (person/organization who told you about the clinic) \_\_\_\_\_

Phone: work ( ) \_\_\_\_\_ cell ( ) \_\_\_\_\_ email \_\_\_\_\_

## Who Should Correspondence be Sent To?

Name \_\_\_\_\_

Relationship to patient:  birth,  adoptive,  foster parent,  other (specify \_\_\_\_\_)

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ cell ( ) \_\_\_\_\_ email \_\_\_\_\_

## Legal Guardian (REQUIRED Information)

Name of patient's legal guardian \_\_\_\_\_

Phone: work ( ) \_\_\_\_\_ cell ( ) \_\_\_\_\_ email \_\_\_\_\_

Guardian's address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Guardian's relationship to patient:  family,  caseworker,  other (specify: \_\_\_\_\_)



## Growth

### Birth Measures

1. Birth weight: lbs / oz \_\_\_\_\_ or gms \_\_\_\_\_  
 Birth length: inches \_\_\_\_\_ or cm \_\_\_\_\_  
 Birth head circumference: inches \_\_\_\_\_ or cm \_\_\_\_\_  
 Gestational age (*length of pregnancy*): weeks \_\_\_\_\_ or months \_\_\_\_\_

### Please provide additional height, weight and head measures if available\*

2. Date \_\_\_\_\_ Weight: lbs \_\_\_\_\_ or kg \_\_\_\_\_  
 Age \_\_\_\_\_ Height: inches \_\_\_\_\_ or cm \_\_\_\_\_  
 Head Circumference: inches \_\_\_\_\_ or cm \_\_\_\_\_

3. Date \_\_\_\_\_ Weight: lbs \_\_\_\_\_ or kg \_\_\_\_\_  
 Age \_\_\_\_\_ Height: inches \_\_\_\_\_ or cm \_\_\_\_\_  
 Head Circumference: inches \_\_\_\_\_ or cm \_\_\_\_\_

4. Date \_\_\_\_\_ Weight: lbs \_\_\_\_\_ or kg \_\_\_\_\_  
 Age \_\_\_\_\_ Height: inches \_\_\_\_\_ or cm \_\_\_\_\_  
 Head Circumference: inches \_\_\_\_\_ or cm \_\_\_\_\_

5. Date \_\_\_\_\_ Weight: lbs \_\_\_\_\_ or kg \_\_\_\_\_  
 Age \_\_\_\_\_ Height: inches \_\_\_\_\_ or cm \_\_\_\_\_  
 Head Circumference: inches \_\_\_\_\_ or cm \_\_\_\_\_

- Birth Parents' Heights:** Birth Mother: inches \_\_\_\_\_ or cm \_\_\_\_\_  
 Birth Father: inches \_\_\_\_\_ or cm \_\_\_\_\_

\* This information may be available from the patient's physician or school nurse. If growth charts are available and can be photocopied and attached to this form, you need not fill out this section.

## Physical Appearance and Health

1. **Photographs of the patient's face are very helpful to us.** The best photos are ones where the face fills the photo and the patient is not smiling. Pictures between ages 1 and 12 years are best.

- Are such photographs available?    \_\_\_ yes    \_\_\_ no
- Are one or two included with this form?    \_\_\_ yes    \_\_\_ no
- Can others be brought to the clinic?    \_\_\_ yes    \_\_\_ no

**Please staple photo(s) here:**

*Photo may be bigger than this space*

2. **Was the patient born with (or later discovered to have) any birth defects (things like cleft lip, congenital heart defects, club foot, etc.)?**    \_\_\_ yes    \_\_\_ no    \_\_\_ unknown

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

3. **Has this patient ever had:**

	yes	no	unknown		yes	no	unknown
Allergies	___	___	___	Chronic illness of the heart	___	___	___
Multiple ear infections	___	___	___	Chronic illness of the kidneys	___	___	___
Chronic sinusitis	___	___	___	Chronic illness of the joints/limbs	___	___	___
Chronic hearing loss	___	___	___	Chronic illness of the stomach/ bowels	___	___	___
Visual problems	___	___	___				

4. **Has this patient ever had:**

A. **Operations (since birth)**    \_\_\_ yes    \_\_\_ no    \_\_\_ unknown

Describe Operation

Surgeon's Name

Patient's Age

\_\_\_\_\_  
 \_\_\_\_\_

B. **Any other hospitalizations**    \_\_\_ yes    \_\_\_ no    \_\_\_ unknown

Reason for Hospitalization

Hospital/Doctor

Patient's Age

\_\_\_\_\_  
 \_\_\_\_\_

C. **Physical abuse**    \_\_\_ yes    \_\_\_ no    \_\_\_ unknown

Age(s): \_\_\_\_\_

Was this evaluated by a physician?    \_\_\_ yes    \_\_\_ no    \_\_\_ unknown

D. **Sexual abuse**    \_\_\_ yes    \_\_\_ no    \_\_\_ unknown

Age(s): \_\_\_\_\_

Was this evaluated by a physician?    \_\_\_ yes    \_\_\_ no    \_\_\_ unknown

## Neurological Issues

### 1. Has this patient ever had:

#### A. Seizures

\_\_\_ yes \_\_\_ no \_\_\_ suspected \_\_\_ unknown

Type: \_\_\_\_\_

Age when seizure(s) started: \_\_\_\_\_

Name(s) of medication(s) given? \_\_\_\_\_

#### B. Loss of specific motor skills such as standing, walking, running, etc.

\_\_\_ yes \_\_\_ no \_\_\_ unknown

If yes, please describe \_\_\_\_\_

#### C. Bed wetting or soiling after 8 years of age.

\_\_\_ yes \_\_\_ no \_\_\_ unknown \_\_\_ not 8 years old yet

### 2. Has this patient ever had a head injury leading to unconsciousness or evaluation by a doctor?

\_\_\_ yes \_\_\_ no \_\_\_ unknown

If yes, please describe \_\_\_\_\_

### 3. Has the patient ever had a CT scan or MRI scan of the brain

\_\_\_ yes \_\_\_ no \_\_\_ unknown

If yes, was it described to be abnormal? \_\_\_ yes \_\_\_ no \_\_\_ unknown

## Attention Deficit and Hyperactivity

### 1. Has the patient ever been evaluated for attention deficit/hyperactivity disorder (ADD / ADHD)

\_\_\_ yes \_\_\_ no \_\_\_ unknown

If yes:

When was the evaluation done? Age: \_\_\_\_\_ Date: \_\_\_\_\_

Was the patient diagnosed with ADD or ADHD? \_\_\_ yes \_\_\_ no \_\_\_ unknown

Was the patient ever treated for ADD or ADHD? \_\_\_ yes \_\_\_ no \_\_\_ unknown

What medications have been tried?

<u>Drug</u>	<u>Dose</u>	<u>Ages</u>	<u>Response</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Mental Health Issues**

**1. Has the patient ever been evaluated by a psychiatrist, psychologist, or mental health counselor?**

\_\_\_ yes \_\_\_ no \_\_\_ unknown

**If yes, please list each psychiatrist, psychologist and/or counselor.**

**A. Type of professional:** \_\_\_\_\_

Reason for assessment: \_\_\_\_\_

Type of therapy (i.e., behavioral, individual counseling, group counseling, family counseling, medicine): \_\_\_\_\_

Age at the time of therapy: \_\_\_\_\_ Did the therapy help? \_\_\_ yes \_\_\_ no \_\_\_ unknown

If yes, how did it help? \_\_\_\_\_

\_\_\_\_\_

**B. Type of professional:** \_\_\_\_\_

Reason for assessment: \_\_\_\_\_

Type of therapy (i.e., behavioral, individual counseling, group counseling, family counseling, medicine): \_\_\_\_\_

Age at the time of therapy: \_\_\_\_\_ Did the therapy help? \_\_\_ yes \_\_\_ no \_\_\_ unknown

If yes, how did it help? \_\_\_\_\_

\_\_\_\_\_

**2. Has the patient ever been evaluated for mood problems (depression, anxiety, etc.) or phobia?**

\_\_\_ yes \_\_\_ no \_\_\_ unknown

If yes:

When was the evaluation(s) done? Age(s): \_\_\_\_\_ Date(s): \_\_\_\_\_

**3. What medications have ever been tried and how well did they work?**

Drug	Dose	Response	Currently Using?

**School Issues**

1. List ALL schools the patient has attended and the grades of attendance:

<u>School</u>	<u>City</u>	<u>Grades Attended</u>	<u>Received Special Education, Resource Room, Tutoring, etc.</u>		
			yes	no	unknown
_____	_____	_____	___	___	___
_____	_____	_____	___	___	___
_____	_____	_____	___	___	___
_____	_____	_____	___	___	___
_____	_____	_____	___	___	___
_____	_____	_____	___	___	___
_____	_____	_____	___	___	___
_____	_____	_____	___	___	___
_____	_____	_____	___	___	___
_____	_____	_____	___	___	___

2. What learning problems does the patient have?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. What behavioral problems does the patient have?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





## Information about the Patient's Biological Parents

**Birth mother's name** \_\_\_\_\_ **Birth date** \_\_\_\_\_

*First*                      *Middle*                      *Last*

**Mother's Race**     White     Black     American Indian     Alaskan Native     Hispanic  
 Asian     unknown     other (specify) \_\_\_\_\_

Education level attained (last year of school completed) \_\_\_\_\_ Age at birth of patient \_\_\_\_\_

Does she have a history of learning problems? \_\_\_\_\_

Birth mother's Address \_\_\_\_\_  
*Street*                      *City*                      *State*                      *Zip*

When was the last contact with the birth mother? \_\_\_\_\_

**Birth father's name** \_\_\_\_\_ **Birth date** \_\_\_\_\_

*First*                      *Middle*                      *Last*

**Father's Race**     White     Black     American Indian     Alaskan Native     Hispanic  
 Asian     unknown     other (specify) \_\_\_\_\_

Education level attained (last year of school completed) \_\_\_\_\_ Age at birth of patient \_\_\_\_\_

Does he have a history of learning problems? \_\_\_\_\_

When was the last contact with the birth father? \_\_\_\_\_

## Medical History of the Biological Family

Has anyone in this patient's biological family ever had any of these conditions? *Check all that apply.*

	Birth Mother	Birth Father	Mother's Family	Father's Family	Siblings of patient
Alcoholism	_____	_____	_____	_____	_____
Birth Defects	_____	_____	_____	_____	_____
Stillbirths	_____	_____	_____	_____	_____
Miscarriages	_____	_____	_____	_____	_____
Mental retardation	_____	_____	_____	_____	_____
Other developmental disabilities	_____	_____	_____	_____	_____
Learning disorders	_____	_____	_____	_____	_____
Attention deficit	_____	_____	_____	_____	_____
Hyperactivity	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Neurological disease	_____	_____	_____	_____	_____
Child abuse	_____	_____	_____	_____	_____
Sexual abuse	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Suicide	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____
Vision problems	_____	_____	_____	_____	_____
Hearing problems	_____	_____	_____	_____	_____
Chronic illnesses	_____	_____	_____	_____	_____
Tourette syndrome	_____	_____	_____	_____	_____
Delinquency	_____	_____	_____	_____	_____
Any specific genetic condition	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

**Pregnancies of Birth Mother**

1. Please list **all** of the birth mother's pregnancies **including miscarriages, abortions**, in the order of their occurrence:

Year	Length of Pregnancy	First name of child if applicable	Live born Child		Normally Developed		If not normal, please explain <i>Include FAS / FAE diagnosis, if known</i>
			yes	no	yes	no	
_____	_____	_____	___	___	___	___	_____
_____	_____	_____	___	___	___	___	_____
_____	_____	_____	___	___	___	___	_____
_____	_____	_____	___	___	___	___	_____
_____	_____	_____	___	___	___	___	_____
_____	_____	_____	___	___	___	___	_____
_____	_____	_____	___	___	___	___	_____
_____	_____	_____	___	___	___	___	_____
_____	_____	_____	___	___	___	___	_____
_____	_____	_____	___	___	___	___	_____

Office Use:	Total Parity	Total Gravity	Patient Parity	Patient Gravity	FASD diagnoses
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**Pregnancy, Labor, and Delivery of this Patient**

1. Did the birth mother experience any difficulties during pregnancy?  Yes  No  Unk.

If yes, please describe: \_\_\_\_\_

2. Did the birth mother receive prenatal care?  Yes  No  Unknown

3. Were there complications during the labor or delivery?  Yes  No  Unknown

If yes, please explain: \_\_\_\_\_

4. Was the delivery:  Natural  By C-section  Unknown

5. Where was patient born? Hospital Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

6. APGAR scores: (at 1 minute \_\_\_\_\_) (at 5 minutes \_\_\_\_\_) (at 10 minutes \_\_\_\_\_)

7. How many days did the infant stay in the birth hospital? \_\_\_\_\_

8. Did the patient have any of the following problems while still in the birth hospital?

	Yes	No	Unknown		Yes	No	Unknown
Feeding problems	___	___	___	Infections	___	___	___
Apnea / breathing difficulties	___	___	___	Jaundice	___	___	___
Supplemental oxygen required	___	___	___	Convulsions	___	___	___

**List of ALL Professionals Currently Involved in Patient's Care**

**Primary Care Physician:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_

**Other Professionals Providing Care** (other doctors, therapists, psychiatrists, mental health counselors, school psychologists)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty: \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty: \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty: \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty: \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty: \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty: \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_

## Placements

**1. List all of the placements the patient has had from birth through today.**

Type of placement (i.e., foster, adoptive, etc.)	Duration of placement	Age of patient when placement started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Office Use:	Total	First	Last
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**A. How long has the patient been in your care?** \_\_\_\_\_

## Next Step

When we receive your completed New Patient Information Form, we will review it and send you a letter within 2 weeks informing you of the status of your appointment request.