Rogue Mental Health ***SOLUTIONS***
15 Crater Lake Ave
Medford, Oregon 97504
Phone: (541) 770-5100
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CHILD PATIENT REGISTRATION:

Child's Name: ______________________________ Date of Birth: ____________________

Gender at Birth: ☐ Male ☐ Female

Which Gender Do You Most Identify With: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male

☐ Gender Variant/Non-Conforming ☐ Not Listed ☐ Prefer Not to Answer

Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Sie/Hir/Hirs ☐ Other ________________

Primary Care Physician: ___________________________________ Phone: ______________________________
PCP Address: ____
Referred by: ________________________________ Phone: _______________________________________
Custodial Parent's Name: ____
Mother: ___________________________________ Social Security #: ______________________________
Address: _________________________________ City: _______________ State: _________ Zip: ______________
Best Contact Number: ____
May we leave messages on your phone? ☐ Yes ☐ No
Email: _______________________________________ May we email you? ☐ Yes ☐ No
Father: ___________________________________ Social Security #: ______________________________
Address: _________________________________ City: _______________ State: _________ Zip ______________
Best Contact Number: ____
May we leave messages on phone? ☐ Yes ☐ No
Email: ____ May we email you? ☐ Yes ☐ No

Was Patient adopted? ☐ Yes ☐ No

Emergency Contact: ___________________________________ Phone: ______________________________
ER Contact Mailing Address: _________________________________ City: ___________ State: _________
Zip: _____________

PHARMACY INFORMATION

Name: Phone: Location:

____

Please list all others living in the home w/the patient:

Name DOB Relationship to the patient

____
____
____
____
____
____

Grade in School: _________ Name of School: ______________________________________ Phone: ______________

CHILD INITIAL BACKGROUND QUESTIONNAIRE:

Caregivers: Mother: ______________________________ Age: _______________ Employment: _________________________
Education: ☐ HS Diploma ☐ College ☐ Graduate School ☐ Other

Father: ______________________________ Age: _______________ Employment: _________________________
Education: ☐ HS Diploma ☐ College ☐ Graduate School ☐ Other

Briefly describe the problem(s) that brought you here today: ____
____
____
____
____

Please check all the symptom(s) your child is having:

☐ Distractible
☐ Impulsive
☐ High Energy
☐ Talks non-stop
☐ Problems with peers
☐ Trouble with Organization
☐ Anger outbursts
☐ Steals
☐ Annoys others
☐ Blames others
☐ Refuses to comply
☐ Aggressive/Violent
☐ Fire-setting
☐ Harms Animals
☐ Sudden feels of pain
☐ Alcohol/Drug Abuse

☐ Problems with Family
☐ Running Away
☐ Depressed/Extreme Sadness
☐ Feels Hopeless
☐ Low Self-Esteem
☐ Isolation/Withdrawal
☐ Problems with Eating
☐ Easily tearful
☐ Extreme Sadness
☐ Lack of Energy
☐ Memory Problems
☐ Thoughts of Self-harm
☐ Has hurt or tried to hurt self
☐ Weight/Appetite changes
☐ Thoughts of harming others
☐ Feeling Fearful

☐ Irritability
☐ Problems with Sleep
☐ Headaches; Stomachaches
☐ Trouble Concentrating
☐ Lots of Worries
☐ Nervousness
☐ Perfectionistic
☐Bed-wetting
☐ Feelings of Guilt
☐ Problems separating from caregiver
☐ Problems eliminating bowels/bladder
☐ Speech and language problems

Has your child been counseling in the past? ☐ Yes ☐ No
If yes, with whom ____ Start and End Date: _________________________________
Is the patient currently taking any medication(s), including over-the-counters? ☐Yes ☐No

Please list all Medications and the Dose including vitamins:

Medication: Dose: Frequency: I.E "1X daily":
____
____
____
____
____
____
____
____

Past Psychiatric Medications: *If your child has ever taken any of the following medications, please indicate the dates, dosage and how helpful they were. If you cannot remember all the details, just write in what you do remember.*

Antidepressants: Dates: Dosage: Response/Side-Effects:

Prozac (Fluoxetine) ______________________________
Zoloft (Sertraline) ______________________________
Luvox (Fluvoxamine) ______________________________
Paxil (Paroxetine) ______________________________
Celexa (Citalopram) ______________________________
Lexapro (Escitalopram) ______________________________
Effexor (Venlafaxine) ______________________________
Cymbalta (Duloxetine) ______________________________
Wellbutrin (Bupropion) ______________________________
Remeron (Mirtazapine) ______________________________
Serzone (Nefazodone) ______________________________
Anafranil (Clomipramine) ______________________________
Pamelor (Nortrptyline) ______________________________
Tofranil (Imipramine) ______________________________
Elavil (Amitriptyline) ______________________________
Other ______________________________

Mood Stabilizers:

Tegretol (Carbamazepine) ______________________________
Lithium ______________________________
Depakote (Valproate) ______________________________
Lamictal (Lamotrigine) ______________________________
Tegretol (Carbamazepine) ______________________________
Topamax (Topiramate) ______________________________
Other ______________________________

Substance Abuse History:

Tobacco History:

Has your child ever smoked cigarettes? ☐ Yes ☐ No ☐ Suspected

Currently? ☐ Yes ☐ No How many packs per day on average? ________ For how long? _________

In the Past? ☐ Yes ☐ No For how long? _______ When did you quit? _____________

Pipes, Cigars or Chewing Tobacco:

Currently? ☐ Yes ☐ No ☐ Suspected In the Past? ☐ Yes ☐ No ☐ Suspected

What Kind? _____________ How often per day on average? ____________ For how long? _________

How many caffeinated beverages does your child drink a day? Coffee _______ Soda _______ Tea _________

How much alcohol consumed in a week? __________ ☐ Beer ☐ Wine ☐ Liquor

Recreational Drugs? ☐ Yes ☐ No ☐ Suspected In the Past? ☐ Yes ☐ No ☐ Suspected

What Kind? ___________ How often on average per day? ____________ For how long? ____________

When did you quit? _________________

Medical Information:

Has your child seen the doctor in the past year? ☐ Yes ☐ No
How is your child's general health? ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Has your child had any chronic illness? ☐ Yes ☐ No If yes, what? ___________________________________
Does your child have allergies? ☐ Yes ☐ No If yes, what? ____

Developmental History:

Complications during pregnancy? ☐ Yes ☐ No If yes, please describe: _______________________________
Duration of pregnancy: ☐ Premature ☐ Full Term ☐ Post Term
Child's birth weight: _____________________ Pounds _______________________ Ounces
Complications during delivery? ☐ Yes ☐ No If yes please describe: ________________________________
Did your child require a stay in the Neonatal Intensive Care Unit (NICU)? ☐ Yes ☐ No
How long? ________________________ Reason? ____
____

Was your child breast-fed? ☐Yes ☐ No

<u>As an infant, your child was your child? (*Please check ALL that apply*)</u>

☐ Usually easy to feed
☐ Often fussy or irritable
☐ Good sleeper
☐ Usually difficult to feed
☐ Liked to be held and cuddled
☐ Difficulty Sleeping
☐ Usually easy going
☐ Was hard to hold
☐ Played peek-a-boo
☐ Happy and Content
☐ Sad
☐ Cried a lot

School History:

Please check all the concerns your child's teacher has reported:

☐ Separation Problems ☐ Aggression ☐ Opposition ☐ Tantrums
☐ Poor peer relationships ☐ Distractibility ☐ Hyperactivity ☐ Impulsiveness
☐ Destructive behavior ☐ Anxiety ☐ Clinginess ☐ Excessive crying
☐ Learning problems ☐ Other

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for the following?

Bipolar Disorder:	☐ Yes	☐ No	Who? ______________________________
Depression:	☐ Yes	☐ No	Who? ______________________________
Anxiety:	☐ Yes	☐ No	Who? ______________________________
Anger:	☐ Yes	☐ No	Who? ______________________________
Suicide:	☐ Yes	☐ No	Who? ______________________________
Schizophrenia	☐ Yes	☐ No	Who? ______________________________
Post-Traumatic Stress	☐ Yes	☐ No	Who? ______________________________
Alcohol Abuse:	☐ Yes	☐ No	Who? ______________________________
Other Substance Abuse:	☐ Yes	☐ No	Who? ______________________________
If yes to above, what type of substance(s)? ______________________________			
Violence:	☐ Yes	☐ No	Who? ______________________________

Have any family member(s) been treated with a Psychiatric Medication? ☐ Yes ☐ No

If yes, who was treated? ____

What Medication did they take? ____

How effective was the treatment? ____

Family History:

	You	Family	Family Members Relation to Patient?
Thyroid Disease	☐	☐	______________________
Anemia	☐	☐	______________________
Liver Disease	☐	☐	______________________
Chronic Fatigue	☐	☐	______________________
Kidney Disease	☐	☐	______________________
Diabetes	☐	☐	______________________
Asthma/Respiratory Problems	☐	☐	______________________
Stomach or Intestinal Problems	☐	☐	______________________
Cancer (Type) ______________	☐	☐	______________________
Fibromyalgia	☐	☐	______________________
Heart Disease	☐	☐	______________________
Epilepsy or Seizures	☐	☐	______________________
Chronic Pain	☐	☐	______________________
High Cholesterol	☐	☐	______________________
High Blood Pressure	☐	☐	______________________
Head Trauma	☐	☐	______________________
Liver Problems	☐	☐	______________________
Other ____________________	☐	☐	______________________