Bartlett Regional Hospital
Bartlett Outpatient Psychiatric Services
3268 Hospital Drive Ste. A
Juneau, AK 99801
Phone: (907) 796-8498
Fax: (907) 796-8497

Date: _____

Patient Information

Patient: _____
Last Name First Name Middle Initial

Preferred Name: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Social Security #: _____-_____-_____ Primary Care Physician: _____

Employer: _____Occupation: _____

Veteran Status: ☐ Active Duty ☐ Non Veteran ☐ Veteran ☐ N/A

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Provide

Race: ☐Alaska Native or Native American ☐Black or African American ☐Caucasian
☐ Hispanic ☐ Decline to Provide ☐ Other_____
Organ Donor: ☐Yes ☐No

Contact Information

Mailing Address: _____

Phone: _____ Email: _____

Parent or Legal Guardian Name (if applicable): _____

Preferred method of contact for appointment ***reminder calls***: ☐ Call ☐ Text ☐ Email

Emergency Contact Name: _____ Phone: _____

Relationship: _____

Insurance Information

Please provide all insurance policies.

Primary Policy: _____Policy #: _____Group #:_____
Subscriber: _____ Subscriber Date of Birth: _____
Subscriber Social Security #: _____-_____-_____

Secondary Policy: _____Policy #: _____ Group #:_____
Subscriber: _____ Subscriber Date of Birth: _____
Subscriber Social Security #:_____-_____-_____

Tertiary Policy: _____Policy #:_____Group #:_____
Subscriber: _____ Subscriber Date of Birth: _____
Subscriber Social Security #:_____-_____-_____

Please present insurance cards to front office staff.

Bartlett Regional Hospital Outpatient Services
3260 Hospital Drive, Juneau, Alaska 99801 Telephone (907) 796-8426

Personal History — Children and Adolescents (<18)

Client's name:_____ Date:_____/_____/_____

Gender: _____Date of birth:_____ Age:_____Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____

Primary reason(s) for seeking services:

☐ Anger management ☐ Depression ☐ Mental confusion ☐ Addictive behaviors

☐ Anxiety ☐ Eating disorder ☐ Sexual concerns ☐ Alcohol/drugs

☐ Coping ☐ Fear/phobias ☐ Sleeping problems ☐ Hyperactivity

☐ Other mental health concerns (specify): _____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If yes, who has legal custody? _____

Were the child's parents ever married? ☐ Yes ☐ No

Is there any significant information about the parents' relationship or treatment toward the child, which might be beneficial in counseling? ☐ Yes ☐ No

If yes, describe: _____

Client's Mother

Name: _____ Age: _____ Occupation: _____ ☐ FT ☐ PT

☐ Natural parent ☐ Step-parent ☐ Adoptive parent ☐ Foster home

☐ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother? ☐Yes ☐ No

If Yes, please explain: _____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother?_____

Client's Father

Name: _____ Age: _____ Occupation: _____ ☐ FT ☐ PT

☐ Natural parent ☐ Step-parent ☐ Adoptive parent ☐ Foster home

☐ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father? ☐ Yes ☐ No

If Yes, please explain: _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	____	☐F ☐M	☐ home ☐ away	☐ poor ☐ average ☐ good
_____	____	☐F ☐M	☐ home ☐ away	☐ poor ☐ average ☐ good
_____	____	☐F ☐M	☐ home ☐ away	☐ poor ☐ average ☐ good
_____	____	☐F ☐M	☐ home ☐ away	☐ poor ☐ average ☐ good

Others living in the household	Age	Gender	Relationship (e.g., cousin, foster child)	Quality of relationship with the client
_____	____	☐F ☐M	_____	☐ poor ☐ average ☐ good
_____	____	☐F ☐M	_____	☐ poor ☐ average ☐ good
_____	____	☐F ☐M	_____	☐ poor ☐ average ☐ good
_____	____	☐F ☐M	_____	☐ poor ☐ average ☐ good

Childhood/Adolescent History

Developmental History

Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: ☐ slow ☐ average ☐ fast

Age for following developments (fill in where applicable):

Began puberty: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.):

_____

Education

Current school: _____ School phone number: _____

Type of school: ☐ Public ☐ Private ☐ Home schooled ☐ Other (specify): _____

Grade: ____ Teacher: _____ School Counselor: _____

In special education? ☐ Yes ☐ No If Yes, describe: _____

In gifted program? ☐ Yes ☐ No If Yes, describe: _____

Has child ever been held back in school? ☐ Yes ☐ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? ☐ Yes ☐ No

If Yes, describe: _____

Has the child been tested psychologically? ☐ Yes ☐ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child:

Feelings about School Work:

☐ Anxious ☐ Passive ☐ Enthusiastic ☐ Fearful

☐ Eager ☐ No expression ☐ Bored ☐ Rebellious

☐ Other (describe): _____

Approach to School Work:

☐ Organized ☐ Industrious ☐ Responsible ☐ Interested

☐ Self-directed ☐ No initiative ☐ Refuses ☐ Does not complete assignments

☐ Sloppy ☐ Disorganized ☐ Cooperative ☐ Does only what is expected

☐ Other (describe): _____

Performance in School (Parent's Opinion):

☐ Satisfactory ☐ Underachiever ☐ Overachiever

☐ Other (describe): _____

Child's Peer Relationships:

☐ Spontaneous ☐ Long-time friends ☐ Shares easily ☐ Difficulty making friends

☐ Follower ☐ Leader ☐ Makes friends easily

☐ Other (describe): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ☐ Poor ☐ Average ☐ Good ☐ Excellent

Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? ☐ Lower ☐ Same ☐ Higher

How many previous jobs or placements has the child had? ____ Usual length of employment: _____

Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

List any allergies: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___/week	_____	☐ No	☐ Low	☐ Med	☐ High
Lunch	___/week	_____	☐ No	☐ Low	☐ Med	☐ High
Dinner	___/week	_____	☐ No	☐ Low	☐ Med	☐ High
Snacks	___/week	_____	☐ No	☐ Low	☐ Med	☐ High

Comments: _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Pharmacy:_____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ☐ Yes ☐ No

If Yes, describe: _____
_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	☐	☐	_____	_____	_____
Suicidal thoughts/attempts	☐	☐	_____	_____	_____
Drug/alcohol treatment	☐	☐	_____	_____	_____
Hospitalizations	☐	☐	_____	_____	_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

☐ Affectionate	☐ Frustrated easily	☐ Sad
☐ Aggressive	☐ Gambling	☐ Selfish
☐ Alcohol problems	☐ Generous	☐ Separation anxiety
☐ Angry	☐ Hallucinations	☐ Sets fires
☐ Anxiety	☐ Head banging	☐ Sexual addiction
☐ Attachment to dolls	☐ Heart problems	☐ Sexual acting out
☐ Avoids adults	☐ Hopelessness	☐ Shares
☐ Bedwetting	☐ Hurts animals	☐ Sick often
☐ Blinking, jerking	☐ Imaginary friends	☐ Short attention span
☐ Bizarre behavior	☐ Impulsive	☐ Shy, timid
☐ Bullies, threatens	☐ Irritable	☐ Sleeping problems
☐ Careless, reckless	☐ Lazy	☐ Slow moving
☐ Chest pains	☐ Learning problems	☐ Soiling
☐ Clumsy	☐ Lies frequently	☐ Speech problems
☐ Confident	☐ Listens to reason	☐ Steals
☐ Cooperative	☐ Loner	☐ Stomachaches
☐ Cyber addiction	☐ Low self-esteem	☐ Suicidal threats
☐ Defiant	☐ Messy	☐ Suicidal attempts
☐ Depression	☐ Moody	☐ Talks back
☐ Destructive	☐ Nightmares	☐ Teeth grinding
☐ Difficulty speaking	☐ Obedient	☐ Thumb sucking
☐ Dizziness	☐ Often sick	☐ Tics or twitching
☐ Drugs dependence	☐ Oppositional	☐ Unsafe behaviors
☐ Eating disorder	☐ Overactive	☐ Unusual thinking
☐ Enthusiastic	☐ Overweight	☐ Weight loss
☐ Excessive masturbation	☐ Panic attacks	☐ Withdrawn
☐ Expects failure	☐ Phobias	☐ Worries excessively
☐ Fatigue	☐ Poor appetite	☐ Quarrels
☐ Fearful	☐ Psychiatric problems	☐ Frequent injuries

☐Other:_____

Please describe any of the above (or other) concerns: _____

_____

How are problem behaviors generally handled? _____

_____

What does the child/adolescent do with unstructured time? _____

_____

Has the child/adolescent experienced death? (friends, family, pets, other) ☐ Yes ☐ No

At what age? ____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

☐ Yes ☐ No If Yes, describe: _____

_____

Any additional information that you believe would assist in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? ☐ Yes ☐ No

If Yes, explain: _____

_____

For Staff Use

Therapist's comments: _____

_____

Therapist's signature/credentials: _____ Date: _____/_____/_____