SIERRA VISTA HOSPITAL & CLINICS
800 East 9th Avenue, Truth or Consequences
Hospital: 575.894.2111 Clinics: 575.894.3221

NEW PEDIATRIC PATIENT

Behavioral Health

Today's Date: _____ / _____ / _____

Form filled out by: ☐ Self ☐ Other Name _____ Relationship:_____

Name: _____ Date of Birth: _____/_____/_____

Social Security Number: _____ Phone Number: _____

Accompanied by: _____ Relationship: _____

Is there a custody agreement? ☐ Yes ☐ No

Gender of minor: ☐ Male ☐ Female

Current Address: _____

Primary Language: _____ Criminal Justice Referral: ☐ Yes ☐ No

Legal Guardian

Name: _____ Phone Number: _____

Relationship: _____ Address: _____

Emergency Contact

Name: _____ Phone Number: _____

Relationship: _____ Address: _____

Primary Care Doctor

Name: _____ Phone Number: _____

Clinic Name: _____ Address: _____

Referred by (if any): _____

Is your child currently or is there a chance your child may be pregnant? ☐ Yes ☐ No

Has your child been arrested in the last 30 days? ☐ Yes ☐ No

What is your Primary Source of Income? _____

What is your Primary Source of Payment? _____

History

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No

If yes, who was your child's previous therapist/practitioner? _____

Is your child currently taking any prescription medications? ☐ Yes ☐ No

If yes, please list: _____

Has your child had any extended separation from parents? ☐ Yes ☐ No

If yes, please describe: _____

Does your child have any allergies to medications? ☐ Yes ☐ No

If yes, please list the medications: _____

Safety

Has your child had any suicidal/self-harm thoughts in the past month? ☐ Yes ☐ No

Has your child had any suicidal thoughts? ☐ Yes ☐ No

Has your child ever attempted suicide? ☐ Yes ☐ No

Has any immediate family or "extended family" (i.e., aunts, uncles, cousins, grandparents) or close friends ever attempted suicide? ☐ Yes ☐ No

If you answered yes to any of the above, please explain:

_____

_____

Family History

Members of Household

Name	Age	Occupation	Relationship

Additional Significant Family Members

Name	Age	Occupation	Relationship

Development History

Mother's health during pregnancy:

_____

Parental use of drugs, alcohol, or cigarettes during pregnancy: ☐ Yes ☐ No

Prenatal Care: ☐ Yes ☐ No Postnatal Care: ☐ Yes ☐ No

Were there any complications during pregnancy or delivery? _____

_____

Were there any health problems noted at birth? _____

_____

Was your child a full-term pregnancy? ☐ Yes ☐ No

Did your child have any of the following (please check):

☐ Delayed/Advanced sitting up ☐ Delayed/Advanced speech

☐ Delayed/Advanced walking ☐ Coordination difficulties ☐ Bed-wetting

Other: _____

How is your child's appetite? ☐ Very good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

How is your child sleeping? ☐ Very good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

How are your child's friendships? ☐ Very good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

How is your child's activity level? ☐ Inactive ☐ Average ☐ Overactive

How is your child nurtured? _____

How is your child disciplined? _____

Personal Medical History ☐ None

✓	Disease / Condition	Date of Diagnosis
	Alcoholism/Drug use	
	Asthma	
	Cancer (type: _____)	
	Depression / Anxiety	
	Suicidal / Bipolar	
	Diabetes	
	COPD	
	Heart disease (heart attack, murmur, abnormal rhythm)	
	High blood pressure	
	High cholesterol	
	Kidney disease	
	Kidney stones	
	Thyroid disease	
	Migraine/headache	
	Stroke	
	Anemia	
	Stomach issues (ulcers, heartburn, etc.)	
	Liver disease	
	Seizures/Epilepsy	
	Crohn's Disease/Ulcerative Colitis	
	Bleeding issues	
	Prostate issues	

Family Psychiatric History ☐ None ☐ Unknown

Please check all that apply	Alcohol/drug use	Anxiety	Depression	Domestic Violence	Eating Disorders	Obesity	Obsessive Compulsive Disorder	Schizophrenia	Suicide Attempts	Other: _____
Mother										
Father										
Brother										
Sister										
Child										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

Social History

Occupation: ☐ Student ☐ Disabled ☐ Retired ☐ Unemployed

Employer / School:

Years of Education / Highest Degree:

Does your child enjoy work / school?

Is there anything stressful about your child's work / school?

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Does your child have children? ☐ NA ☐ Yes ☐ No

If yes, how many: _____

Do they live with your child? ☐ Yes ☐ No

Does your child use tobacco? ☐ Yes ☐ No

☐ Cigarettes ☐ Cigars ☐ Vaping ☐ Chewing tobacco

Answer if CURRENT USER	Answer if FORMER USER
How many per day? _____	Quit date: _____
How many years? _____	How many per day? _____
Are you interested in quitting? ____	How many years? _____

Does your child drink alcohol? ☐ Yes ☐ No

If yes, how many drinks per day? _____

Does your child use any recreational substances? ☐ Yes ☐ No

Has your child ever used needles to inject drugs? ☐ Yes ☐ No

Is your child sexually active? ☐ Yes ☐ No

Birth control method: ☐ None ☐ Condom ☐ Pill ☐ Patch ☐ Ring ☐ Nexplanon ☐ IUD ☐ Depo Provera

Does your child exercise regularly? ☐ Yes ☐ No

How long? _____ How often? _____

Behavioral / Habitual Concerns (Please check all that apply):

☐ Temper Tantrums	☐ Stealing	☐ Fears
☐ Disobedience	☐ Mood Swings	☐ Anxiety
☐ Fine Motor Skills	☐ Attention Span	☐ Eating
☐ Easily Frustrated	☐ Awareness of Danger / Safety Issues	☐ Language / Speech
☐ Clumsiness	☐ Gross Motor Control	☐ Interrupts Adults
☐ Sleeping	☐ Attachment Concerns	☐ Self-Esteem
☐ Restless / Overactive	☐ Memory	☐ Disruptive at School
☐ Hurts Animals	☐ Fighting	☐ Lack of Empathy
☐ Aggression	☐ Accident Prone	

Other Providers/Specialists ☐ None

Providers/Facility	Specialty	Phone Number

What would you, or others, consider to be your child's strengths? _____

_____

What would you, or others, consider to be your child's weaknesses? _____

_____

What does your child want to accomplish during therapy sessions? _____

_____

_____