

New Patient Information Form

FASD Clinic

Office Use: Date received ___/___/___ Deadline ___/___/___ ASAP ___ Response Let. ___/___/___ Photo ___ Screen Code _____ G ___ F ___ B ___ A ___ M ___ : 1 2 3 4

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 code _____

Patient's Telephone Home () _____ Work () _____

Caretaker Identification

Name of patient's primary caretaker(s) _____

Relationship to patient: birth, adoptive, or foster parent other (specify _____)

Caretaker's Address _____

City _____ County _____ State _____ zip code _____

Telephone Home () _____ Work () _____

Name of patient's legal guardian(s) _____

Person Completing the Form

Name of person completing this form _____ Date _____

Relationship to patient: birth, adoptive, or foster parent, caseworker, medical care provider
 other relationship (please specify _____)

Referred by (e.g., who or what organization told you about the clinic ?) _____

Who Should Correspondence be Sent To?

Name _____

Relationship to patient: birth, adoptive, or foster parent other (specify _____)

Address _____

City _____ County _____ State _____ zip code _____

Telephone Home () _____ Work () _____

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.

Please staple photo(s) here:

Photo may be bigger than this space

- 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

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

<u>Describe Operation</u>	<u>Surgeon's Name</u>	<u>Patient's Age</u>
_____	_____	_____
_____	_____	_____

B. **Any other hospitalizations** ___ yes ___ no ___ unknown

<u>Reason for Hospitalization</u>	<u>Hospital/Doctor</u>	<u>Patient's Age</u>
_____	_____	_____
_____	_____	_____

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 MH 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
Reason for C-Section, if performed _____
5. **Where was the patient born?** Hospital _____ City _____ State _____
6. **Apgar scores** _____ 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 Professionals Currently Involved in Patient's Care

Primary Physician Name: _____ Phone: _____
Address: _____

Other Physicians Name: _____ Phone: _____
Specialty: _____
Address: _____

Name: _____ Phone: _____
Specialty: _____
Address: _____

Name: _____ Phone: _____
Specialty: _____
Address: _____

Mental Health Name: _____ Phone: _____

Consultants Specialty: _____

(includes Psychiatrists Address: _____

Psychologists, and

Counselors) Name: _____ Phone: _____

Specialty: _____

Address: _____

School Name: _____ Phone: _____

Address: _____

Contact Person (*teacher, nurse, counselor, etc.*):

Other Name: _____ Phone: _____

Profession: _____

Address: _____

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? _____

What to bring to Clinic

If the patient has had any of the following assessments, please bring them to Clinic on the day of your appointment. This information is very important to the patient's diagnostic evaluation.

_____ Facial photographs of the patient from birth to 12 years of age, without a smile.

_____ Medical records which document the problems you have reported above.

_____ School Assessments including:

- Achievement tests
- IQ tests
- Language assessments
- Social Skills assessments
- Behavior assessments

_____ Psychological Assessments

_____ Developmental Assessments including:

- Motor Development (fine and gross motor)
- Occupational Therapy assessments
- Mental (cognitive) assessments