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 sex at birth _____ Gender identity _____ Race(s) _____

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 (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 ( ) _____

Please complete this form to the best of your ability. We realize you will not have the answers to all questions. All information requested in this form is important in allowing us to provide you with the most accurate diagnosis and most appropriate referrals for care. Thank you for taking the time to complete it.

Reasons for Evaluation What are the patient's primary problems? Please be specific.

What do you hope to gain from the evaluation?

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.

   - 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 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

Neurological Issues

1. Has this patient ever had:

Seizures

____ yes ____ no ____ suspected ____ unknown

Type: _____

Age when seizure(s) started: _____

Name(s) of medication(s) given? _____

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?

Drug	**Dose**	**Ages**	**Response**

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 <u>ALL</u> schools the patient has attended and the grades of attendance:

School	**City**	**Grades Attended**	**Received Special Education, Resource Room, Tutoring, etc.** yes	no	unknown
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____

2. What <u>learning</u> problems does the patient have?

_____
_____
_____
_____
_____
_____
_____

3. What <u>behavioral</u> problems does the patient have?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Prenatal Alcohol Exposure

Please fill in this information as completely as possible.
This information is critical to the evaluation of the patient.

Alcohol use by the birth mother

- **Before pregnancy**: Average number of drinks consumed at one time: _____
  Maximum number of drinks consumed at one time: _____
  Average number of days per week (1 to 7) that alcohol was consumed: _____
  Type(s) of alcohol: __wine __beer __liquor __unknown ___other (specify) _____

- **During pregnancy:** Average number of drinks consumed at one time: _____
  Maximum number of drinks consumed at one time: _____
  Average number of days per week (1 to 7) that alcohol was consumed: _____
  Type(s) of alcohol: __wine __beer __liquor __unknown ___other (specify) _____

Which trimester(s) did the mother drink alcohol? ___ 1st ___2nd ___3rd ___unknown

	No	Yes	Unknown
Was the birth mother ever reported to have a problem with alcohol?	____	____	_____
Was the birth mother ever diagnosed with alcoholism?	____	____	_____
Did the birth mother ever receive treatment for alcohol addiction?	____	____	_____

If the above information is unknown, please provide any information that might help describe the mother's level of ALCOHOL USE DURING THIS PREGNANCY _____

_____

_____

_____

_____

What is the source(s) of this information on alcohol use? _____

_____

_____

Did the birth mother use any of the following substances during pregnancy?

Yes	No	Unknown	Type	Please List Specific Substance(s)	Month(s) of Pregnancy
___	___	___	Drugs	_____	_____
___	___	___	Tobacco	_____	_____
___	___	___	Medications	_____	_____
___	___	___	X-rays	_____	_____

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? _____

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
Alcoholism	_____	_____
Birth Defects	_____	_____
Stillbirths	_____	_____
Miscarriages	_____	_____
Intellectual disability	_____	_____
Other developmental disabilities	_____	_____
Learning disorder	_____	_____
Attention deficit	_____	_____
Hyperactivity	_____	_____
Epilepsy	_____	_____
Neurological disease	_____	_____
Tourette syndrome	_____	_____
Depression	_____	_____
Delinquency	_____	_____
Suicide	_____	_____
Mental health issues	_____	_____
Vision problems	_____	_____
Hearing problems	_____	_____
Chronic illnesses	_____	_____
Any specific genetic condition	_____	_____
Other (specify)	_____	_____
Other (specify)	_____	_____
Other (specify)	_____	_____
Other (specify)	_____	_____

Pregnancies of Birth Mother

1. Please list **all** 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 yes	Live born Child no	Normally Developed yes	Normally Developed no	If not normal, please explain *Include FASD diagnosis, if known*
_____	________	________________	___	___	___	___	______________________________
_____	________	________________	___	___	___	___	______________________________
_____	________	________________	___	___	___	___	______________________________
_____	________	________________	___	___	___	___	______________________________
_____	________	________________	___	___	___	___	______________________________
_____	________	________________	___	___	___	___	______________________________
_____	________	________________	___	___	___	___	______________________________
_____	________	________________	___	___	___	___	______________________________
_____	________	________________	___	___	___	___	______________________________

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. **What was the gravity _____ and parity _____of the birth mother**?

6. **Where was the patient born?** Hospital _____ City, State

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 Consultants *(includes Psychiatrists Psychologists, and Counselors)* Name: _____ Phone: _____

Specialty: _____

Address: _____

Name: _____ Phone: _____

Specialty: _____

Address: _____

School Name: _____ Phone: _____

Address: _____

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

_____

Other Name: _____ Phone: _____

Profession: _____

Address: _____

Home Placements

1. List all home 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

How many years has the patient been in your care? _____

Patient Trauma

Please report the age range for all traumatic events experienced by the patient. If age is unknown, place a check mark in the box if the trauma occurred.

Trauma	age range	Trauma	age range	Trauma	age range
placed out of home		sexual abuse		natural disaster	
abandonment		physical abuse		war, terrorism	
homelessness		emotional abuse		*Other (specify below)*	
food insecurity		physical neglect			
suicide attempt		emotional neglect			
serious medical issue		family death			
school violence		family incarceration			
bullying		family mental health			
serious accident		parental drug abuse			
home fire		parental divorce			
animal attack		domestic violence			

Other Details: _____

_____

_____

_____

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 if you have copies of the results. The Clinic will also make every effort to collect this information with your consent. This information is very important to the patient's diagnostic evaluation.

_____ Facial photographs of the patient from birth to 18 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

_____ Neuropsychological Assessments

_____ Developmental Assessments (birth to 3 years of age) including:

- Motor Development (fine and gross motor)
- Cognitive Development