TLC PARENT QUESTIONNAIRE

PARENT or Guardian: In order to offer the most comprehensive services, we will need additional information concerning your current situation and concerns. Use separate sheets of paper if more space is required. This record will remain confidential in compliance with HIPAA regulation and confidentiality notice consent form.

Today's date:	Primary Care Provider:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Work phone no.: ( )

Mobile Phone (for parent and or patient): _____

Email Address:

INSURANCE INFORMATION

Name/Address of insurer:

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for fees related to my care as discussed with Dr. Peterson and Touchstone Life Center.

Patient/Guardian signature *Date*

BRIEF EXPLANATION OF THE SITUATION/PROBLEM FOR WHICH YOU ARE SEEKING HELP:

Thank you for taking the time to fill this information out.

BEHAVIORAL HEALTH

Have you been treated for behavioral/mental/emotional problems in the past? ☐ YES ☐ NO (If Yes, please complete a Release of Information so that we may obtain the treatment records)		
When?:	Where?:	By Whom?

Type of Previous Treatment

☐ Psychotherapy/Counseling:

☐ Psychiatric hospitalization:

☐ Residential treatment:

SUBSTANCE USE

Have you used or currently been using the following substances? ☐ YES ☐ NO (If Yes, please complete the following information)

	Started	Frequency	Remarks
Cigarettes			
Alcohol			
Marijuana			
Other:			

SOCIAL HISTORY

Please list all family (children/adults) living in the home and their relationship to you

Name	Age	Relationship

Do you currently have weapons in your home? ☐ Yes ☐ No

- If yes, how are the weapons secured? _____

MEDICAL HISTORY

Primary care provider (PCM):	Location:
Date of last physical examination:	

MEDICAL HISTORY (continued)

REVIEW OF SYSTEMS: *Check* all significant symptoms your child has had recently:

	Agitation		Appetite change		Blurred Vision		Confusion
	Constipation		Diarrhea		Dizziness		Dry Mouth
	Fever		Headaches		Indigestion		Irritability
	Nausea		Nervousness		Restlessness		Sleepiness
	Seizures		Sleep disturbance		Slurred Speech		Sore Throat
	Stomach issues/ indigestion		Racing Heart/skipped beats		Sexual Issues		Tics/abnormal movements or vocalizations
	Bruising easily		Snoring		Weight gain/loss		Spaciness/seems like a ”space cadet”
	Other:						

CHRONIC/SEVERE MEDICAL ILLNESSES:
Describe:

SURGERIES (PE tubes, tonsils, appendix, oral surgery)
Describe:

HOSPITALIZATION: Age Reason Reaction

ALLERGIES: ☐ Yes What type?: ☐ NONE

CURRENT MEDICATIONS	Dose	Used for?	How Effective?	Side Effects?
PAST PSYCHIATRIC MEDICATIONS	Dose	Used for?	How Effective?	Side Effects?

FAMILY BEHAVIORAL HEALTH HISTORY

-Has the patient or anyone in your biological family had any of the following problems?

	Patient (SELF) or Relationship to Patient	**Description**
ADD/ADHD		
Reading Problems		
Mental Retardation		
School/Learning Problems		
Speech & Language Problems		
BEHAVIORAL HEALTH		
Alcoholism/Alcohol Abuse		
Anxiety/Panic Disorder		
Autism/Asperger's Syndrome		
Bipolar/Manic Depression		
Dementia/Alzheimer's Disease		
Depression		
Drug Abuse		Which Drugs?
Obsessive Compulsive Disorder		
Personality Disorder		
Schizophrenia		
Homicidal/intent to harm others		
Suicide/Self-harm		
Psychiatric Treatment		
Psychiatric Hospitalizations		
LEGAL		
Aggression or Criminal Activity		

ADDITIONAL INFORMATION:

Is there anything else you would like us to know about your situation?