Pediatric Assessment Form

Behavioral Health Questionnaire
for Patients Under 20 Years Old

Please provide as much detail as possible so that we can accurately assess your child. If you have already compiled information that we are requesting (for example, medication history), please attach it to this form and proceed to the next section. If a question does not apply to your child or family, mark with a "NA" for "not applicable."

If you feel that your child is a danger to him/herself or others, or is gravely disabled, go to the nearest emergency room immediately or call 911.

Helpful patient information to gather prior to completing this form:

- Primary and secondary care physician's name and contact information
- Insurance card(s)
- Parent/guardian contact information
- Medical history (physical health)
- Psychiatric care history
- Medication history

How to submit this form when complete:

Email:
apply@aris-clinic.com

OR

Fax:
651-259-9790

OR

Mail/In Person:
7616 Currell Blvd #100
Woodbury, MN 55125

Typed responses are preferred for legibility. If completing by hand, please use black ink.

Name of person completing this form and relationship to patient

Date

How did you learn about Aris Clinic?

☐ Pediatrician ☐ Therapist ☐ School ☐ Friend Other

Who Referred You:

Treatment Interest: ☐ Psychiatry Clinic Appointment ☐ Intensive Outpatient Program (IOP)

Communication Needs (such as hearing impairment or non-English speaking patient or family member(s))

Pediatric Assessment Form

1. CONTACT INFORMATION

PATIENT

Patient Name _____ Date of Birth _____ Age _____

Gender (Biological) _____ (Identifies As) _____ Race _____

Occupation _____ Employer _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Primary Physician and/or Clinic _____ Phone Number _____

Date Last Seen _____ Date of Last Labs Drawn _____

Pharmacy Name _____ Phone Number _____

PARENT/GUARDIAN 1

Parent/Guardian Name _____ Date of Birth _____

Relationship to Patient _____ Occupation _____

Employer _____

☐ Same address as patient

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Preferred Communication Method _____

Is parent/guardian is financial guarantor for patient? ☐ No ☐ Yes

If financial guarantor, please provide social security number _____

1. CONTACT INFORMATION (cont.)

PARENT/GUARDIAN 2

Parent/Guardian Name _____ Date of Birth _____

Relationship to Patient _____ Occupation _____

Employer _____

☐ Same address as patient

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Preferred Communication Method _____

Is parent/guardian is financial guarantor for patient? ☐ No ☐ Yes

If financial guarantor, please provide social security number _____

2. PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Carrier _____ Insurance Phone Number _____

Policy # _____ Group # _____

Policy Holder Name _____

Date of Birth _____ Relationship to Patient _____

Please attach a copy of patient's insurance card(s) (front and back)

SECONDARY INSURANCE (if applicable)

Insurance Carrier _____ Insurance Phone Number _____

Policy # _____ Group # _____

Policy Holder Name _____

Date of Birth _____ Relationship to Patient _____

Please attach a copy of patient's insurance card(s) (front and back)

3. PATIENT'S CURRENT PROBLEM(S)

What difficulties is your child or family having that have caused you to seek help?

When did these difficulties begin? How have they changed over time?

List all previous diagnosis your child has received:

4. PATIENT'S CURRENT GENERAL MEDICAL HISTORY

Please check all health issues that apply to the patient:

General
- ☐ Allergies (to medication)
- ☐ Allergies (other)
- ☐ Appetite/eating disorder
- ☐ Fatigue
- ☐ Injuries
- ☐ Poor sleep
- ☐ Sensory Issues
- ☐ Surgeries
- ☐ Weight

Cardiovascular
- ☐ Chest pain
- ☐ Dizziness
- ☐ Leg cramps
- ☐ Swollen feet

Ears/Nose/Throat
- ☐ Congestion
- ☐ Dry Mouth
- ☐ Headache
- ☐ Ringing

Eyes
- ☐ Blurry
- ☐ Dry
- ☐ Flashes
- ☐ Pain

Endocrine
- ☐ Sweating
- ☐ Thirst
- ☐ Too cold
- ☐ Too warm

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea

GenitoUrinary
- ☐ Hesitancy
- ☐ Retention
- ☐ Menses
- ☐ Sexual

Hematological
- ☐ Anemia
- ☐ Bleeding
- ☐ Bruising
- ☐ Nodes

Immunologic
- ☐ Congested
- ☐ Hives
- ☐ Infections
- ☐ Rashes

Musculoskeletal
- ☐ Aches
- ☐ Injury
- ☐ Stiffness
- ☐ Swelling

Neurological
- ☐ Movements
- ☐ Seizure
- ☐ Tremor
- ☐ Weakness

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Skin
- ☐ Dry
- ☐ Hair loss
- ☐ Itching
- ☐ Rashes

Please describe the checked symptoms:

Other diagnoses, conditions, injuries, series illnesses or additional details you wish to provide:

5. PATIENT'S PAST OR CURRENT PSYCHIATRIC TREATMENT

Therapist / Psychologist, Psychiatrist / CNP / Nurse Practitioner (Other than primary doctor who prescribed medications), Inpatient or ER Hospitalizations, Partial Hospitalization / Day Treatment, Occupational Therapy, Case Manager / County Case Workers, Other Providers Not Listed Above.

Provider Type	Provider Name / Facility	Approximate Start/End of Care Dates	Experience was Positive (+) or Negative (-)	Child Received Testing (yes) or (no)	Testing Completed (Type)
Example: Therapist	*Dr. Jane Doe / Clinic Name*	*MM/YY to MM/YY*	*+*	*Yes*	*Test Name*

6. PATIENT'S CURRENT MEDICATIONS

(Include all prescription, over-the-counter, herbal remedies, etc.) The following section will ask you to list past medications.

Current Medications (NAME / DOSAGE)	When Started	Doctor /Prescriber	Positive/Negative Effects or None

7. PATIENT'S PAST TRIAL MEDICATIONS

(Include all prescription, over-the-counter, herbal remedies, etc.)

Past Medications (NAME / DOSAGE)	When Started	When Ended	Doctor / Prescriber	Positive / Negative Effects or None

8. PATIENT EDUCATION INFORMATION

Currently attending school? ☐ No ☐ Yes Where? _____ Current grade _____

Contact person _____

Phone _____ Email _____

Please check all that apply to the patient's education information:

☐ Special Services ☐ IEP ☐ 504 ☐ Learning disabilities

Please describe the checked item(s):

Extracurricular involvement at school:

9. PATIENT HISTORY AND SIGNIFICANT LIFE EVENTS

Please check all that apply to the patient's history:

- ☐ Alcohol or street drugs
- ☐ Cigarette or tobacco use
- ☐ Legal issues
- ☐ Racial identity issues
- ☐ Self-injury
- ☐ Suicidal actions

Please describe the checked item(s):

Was the patient exposed to, or a victim of, any type of abuse?

- ☐ Emotional
- ☐ Physical
- ☐ Sexual
- ☐ Verbal
- ☐ Other:

Please describe type, by whom, duration:

Please check all that apply to the patient's history:

- ☐ Break-up of a major relationship (patient)
- ☐ Change in family's financial status/employment
- ☐ Death in the family/other losses
- ☐ Divorce or separation
- ☐ Moves
- ☐ Terminal illness in the family
- ☐ Witness to traumatic event(s)?

Please describe the checked item(s):

Are there any significant events that have occurred in the parent's upbringing that would be important for us to know in working with the family (chronic family fighting, abuse, chemical dependency, etc.)?

10. OTHER

List any other information you feel is important for us to know:

List questions you would like answered at this point, if possible:

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Woodbury, MN 55125

Stay Informed

Would you like to learn more about pediatric behavioral health? Email info@aris-clinic.com to begin receiving our e-newsletter.

Stay connected with Aris via social media: