WaKeeney Family Care Center Ph: 785-743-2124 Fax: 785-261-9606

333 N 14th - WaKeeney, KS 67672

Name: _____ DOB: _____

DEMOGRAPHIC INFORMATION – Patient

Patient name:		Age:	Date of Birth:
Gender	(circle): Male Female TG M to F TG F to M Other:_____		
Pronoun	(circle): He/Him She/Her They/Them It Other:_____		
DCF involvement:	(circle): No Yes current Yes prior _____year		

DEMOGRAPHIC INFORMATION – Parent 1

Custodial Parent 1:	Cell: Other:	Is this the child's biological parent? Y N
Military: None Active Retired	May we leave voicemails for this parent? **messages will always be brief & respect privacy*	Yes / No
Employer:	Occupation:	
This child lives in my home: All of the time Some of the time Part of the time None of the time		
This parent's marital status: Single Married / Spouse name: _____		
List all persons living in your home:		
Siblings from this parent:	___full brothers ___full sisters ___half-brothers ___half-sisters ___step-siblings	

DEMOGRAPHIC INFORMATION – Parent 2

Custodial Parent 2:	Cell: Other:	Is this the child's biological parent? Y N
Military: None Active Retired	May we leave voicemails for this parent? **messages will always be brief & respect privacy*	Yes / No
Employer:	Occupation:	
This child lives in my home: All of the time Some of the time Part of the time None of the time		
This parent's marital status: (circle) Single Married / Spouse name: _____		
List all persons living in your home:		
Siblings from this parent:	___full brothers ___full sisters ___half-brothers ___half-sisters ___step-siblings	

Name of the person completing this form: _____ Relationship:_____

Briefly describe why you are seeking care (depression, anxiety, trauma, relationships, stress etc.):

_____

_____

_____

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How long has this issue been concerning?_____

Did something specific cause these symptoms? (death, trauma, divorce, accident etc.):

_____

_____

Circle any prior or current mental health diagnoses: Other: _____

Anxiety or Panic	ADHD / ADD	Addiction	Autism Spectrum	Depression
Eating Disorder	Hallucinations	Harm to others	Harm to self	Oppositional Defiance
Obsessive-Compulsive	Paranoia	PTSD	Rage/Anger	Suicidal acts /thoughts

Please list any mental health care from other facilities including facility, reason, & approx. year.
Include outpatient & psychiatric admissions for mental health crisis or addiction:

Facility: _____ Reason: _____ Year: _____

Facility: _____ Reason: _____ Year: _____

Ever been arrested or had involvement with law enforcement: YES NO

Alcohol & substance use review. Please consider any time in your lifetime for the following:

Alcohol	(circle): None Current Recreational Current Problematic Past Problematic Sobriety date: _____ Interest in quitting or support? YES NO
Tobacco Nicotine	(circle): Never Former (Quit year):_____ Current Interest in quitting? YES NO (circle): Cigarettes Cigars Chew Snuff Vape ____pack/can/pkg per day
Substance Use	(circle): **prior use**. Include prescription meds taken incorrectly or without valid order): Marijuana THC K2 Cocaine Crack Opiates Fentanyl Heroin Cough Syrup Mushrooms PCP LSD Acid Methamphetamine ADHD Stimulants Bath Salts MDMA Molly Ecstasy Benzodiazepines Huffing fumes Canned "Duster" "Whippets" Any history of IV drug use: YES NO Sobriety date: _____
	CURRENTLY using:_____ Interest in quitting or support? YES NO

Please list or attach your current medications. Include prescription, herbal, OTC & supplements.

DRUG NAME, STRENGTH, & DIRECTION	PROVIDER NAME

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List all previously attempted psychiatric meds (antidepressants, antipsychotics, mood stabilizers etc.). Include OTC, herbal & prescription. Attach additional pages as needed.

DRUG NAME, STRENGTH, & DIRECTION	EFFECT OR REACTION

List medication allergies & reaction type if possible. Attach additional pages as needed.

DRUG	REACTION

Please circle & list any current or prior health diagnoses. Attach additional pages as needed.

Wolff-Parkinson-White Irregular EKG or pulse Hypertension Hyperlipidemia Thyroid Disease

UTI Asthma Diabetes Cancer Frequent illness Strep Mono Migraine Constipation

Concussion Seizure (Last:_____) Other:_____

Surgeries:

Currently Pregnant: YES NO **Breast Feedings**: YES NO **Using Birth Control**: YES NO

Current primary care provider: _____ **Facility**:_____

Currently up to date on exams: (circle) Wellness Dental Eye Hearing Vaccines

Please list family mental health issues. Include conditions like ADHD, anxiety, panic, autism, bipolar, depression, addiction, OCD, PTSD, insomnia, schizophrenia, suicidal-homicidal behaviors, & rage.

Mother	
Father	
Grandparents	
Siblings	
Aunts/Uncles	
Other	

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Does your child have access to social media or use the following apps?: (circle)

SnapChat Discord Facebook Instagram Twitch KIK Omegle Other: _____

Adult monitoring: Yes No

Approx daily screentime:

_____minutes

Experiencing bullying: No Yes - Online In-person

If yes, please explain: _____

_____

Birth history:

(circle): Full term or Premature delivery at ____ weeks	Delivery (circle): vaginal or C-section
Child rolled over, sat up, babbled, talked, potty trained on time: YES NO	
Uterine exposure to: Nicotine Alcohol Illicit substances_____	

ADULT: Circle any of the following symptoms you've observed in the **last 3 months**.

Excessive sadness or crying
Being withdrawn or less social
Negative self-opinion or low self-esteem
Anger or irritability
Statements of death or suicide
Harming others or threats
Reduced interest in activity
Sleeping too much
Trouble sleeping or nightmares
Bed wetting or incontinence
Restlessness or fidgeting
Too much or too little energy
Poor eye contact
Distraction or poor focus/concentration
Being forgetful
Poor self-care
Refusal to be independent
Talking too much or too fast
Impulsivity
Reckless or risky behaviors
Hallucination or paranoia
Mood swings
Sexual behaviors
Thumb sucking
Tantrums or outbursts
Defiance or sneaking out
Nervousness
Panic attacks
Flashbacks or intrusive thoughts or memories
Startle easily or jumpy
Excessively watchful in public
Hair pulling, nail biting, or skin picking
Obsessive / compulsive behaviors
Self-injury (biting, burning, cutting)
Eating more or less than usual
Vomiting or restricting food
Using drugs or alcohol
Fire starting
Cruelty to animals
Witness to domestic abuse
Experienced abuse or neglect
No imagination or pretend play
Poor school performance
Frequent school absence

Medical Symptoms:

Seizure (last _____)
Illness or fever (in the last 14 days)
COVID or Strep (in the last 6 months)
Broken, decaying, painful teeth
New major medical conditions
Nausea or vomiting

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Patient (if able): **Circle any of the following** symptoms you've had in the **last 3 mo.**

Sadness or crying
Feeling empty or lonely
Anger or irritability
Thoughts of harming yourself
Thoughts of harming others
Less interest in things you like
Unintended weight loss or gain
Trouble sleeping
Nightmares
Restlessness or fidgeting
Too much energy
Feeling tired or drained
Feeling hopeless or worthlessness
Poor concentration or distracted
Being forgetful
Not wanting to shower or care for yourself
Thinking or talking badly about yourself
Talking too much or too fast
Racing thoughts or feeling confused
Doing things without thinking
Reckless or risky behaviors
Getting in trouble or being arrested
Mood swings
Being quiet or less social

Worrying too much
Feeling nervous
Panic attacks
Flashbacks of bad things from the past
Thinking of bad memories
Being jumpy
Being afraid
Hair pulling, nail biting, or skin picking
Doing things over & over
Self-injury (biting, burning, cutting)
Eating more than usual
Eating less than usual
Vomiting or avoiding food
Using drugs or alcohol
Fire starting
Being mean to animals
Not feeling safe or being abused
Not feeling heard
Being bullied or treated badly

Medical Symptoms:

Pain
COVID or Strep throat (in the last 6 months)
Broken, decaying, painful teeth

Other symptoms or concerns not listed: _____

_____

_____

_____

_____

Do you feel safe in your home: YES NO