FRONTIER HEALTH AND WELLNESS

Patient Registration Form – Pediatric/Under Guardianship

Date				
Patient Full Legal Name (First, Middle Initial, Last)	Prefix	Suffix	Previous Name(s)/Alias:	
Date of Birth	Age	Sex	Gender Identity	Preferred Pronoun
School			Grade	Contact Number

Guardianship (If guardianship is anything other than shared or 50/50 FHW Must had legal documentation on file prior to any appointment)

Parent/Guardian Name (G1): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole		Parent/Guardian Name (G2): Guardian listed above guardianship status: ☐ Shared ☐ Primary ☐ Sole	
G1 Preferred Phone Number Can we leave a Voicemail? ☐ Yes ☐ No		G2 Preferred Phone Number Can we leave a Voicemail? ☐ Yes ☐ No	
G1 Secondary Contact Number: ☐ Home ☐ Work ☐ Other		G2 Secondary Contact Number: ☐ Home ☐ Work ☐ Other	
G1 Address		G2 Address	
City, State	Zip Code	City, State	Zip Code

Reason for choosing Frontier Health and Wellness ☐ Recommendation from Family/Friend ☐ Location/Convenience ☐ Referral from Provider ☐ Search Engine ☐ Insurance ☐ Other		
If referred by hospital or provider, please list who:		
Preferred Pharmacy	Address	Contact Number
Emergency Contact	Relationship	Contact Number

We Do Not Bill/Accept Denali KidCare, Medicaid, or Medicare

Financially Responsible Party	Address	Contact Number	
Primary Insurance Carrier	Subscribers Name		
Policy Number/Member ID	Group Number		
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4	
Secondary Insurance Carrier	Subscribers Name		
Policy Number/Member ID	Group Number		
Patients Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4	

I certify that my answers are true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to my provider. I understand that I am financially responsible for any balance accrued. I also authorize Frontier Health and Wellness and/or its Contracted Providers to release any information required to process my claims.

Patient Signature: _____ Date: _____

Frontier Health and Wellness

Full Legal Name: _____ Date of Birth: _____ Age: _____

Primary Language: _____ Race/Ethnicity: _____

Gender at Birth: _____ Identified Gender: _____

Sexual Orientation: _____ Dominant Hand: _____

Person Completing Form: _____ Relationship to Patient: _____

Please provide a summary of your understanding of the reason for your referral, as well as the symptoms/concerns that led to the initiation of Neuropsychological Testing**:** _____

_____

_____

PRIMARY REASON FOR REFERRAL

Primary Symptoms	Severity of Symptom
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating
	☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Exceedingly Severe ☐Completely Debilitating

FAMILY INFORMATION

Please include all family members whether they be biological, adoptive, step etc.

Family Member	First Name	Biological/Step/ Adopted	Age	Occupation/ Grade	Custody Agreement. Living arrangement (with patient 100%, 50%, 0% Contact etc.)
Mother					
Father					
Step/adoptive mother					
Step/adoptive Father					

Sibling:					
Sibling:					
Sibling:					
Other:					
Other:					
Other:					

Please list the moves/relocations the patient has experienced since birth (If Any):

Moved From (City, State)	Moved To (City, State)	Age of pt

Custody/Guardianship

Are the patients' biological parents separated? ☐Yes ☐No If yes, how old was the patient at the time of separation? _____

Please describe the patient's custody status since birth.

Primary Custodian	Secondary Custodian	Time frame of custody	Age of patient	Was Custody mandated by an outside entity (court, OCS, Tribe etc.)?

Religion

Is the patient active in a religious practice? ☐Yes ☐No If yes, which religion: _____

How active is the patient with religion? ☐Daily ☐Weekly ☐Monthly ☐3-4 times/year ☐ 1-2 times a year ☐ Yearly ☐ N/A

Has the patient actively participated in other religions? ☐Yes ☐No If yes, which religion(s) and when:

_____

_____

BIRTH HISTORY

Please select the way in which the patient was delivered.

☐Vaginal Birth
☐ Induced Labor
☐ Beech Birth
☐ Forceps Used
☐ Planned Cesarean
☐ Emergency Cesarean
☐ Unknown

Duration of Labor? _____ Apgar Scores: _____ Birth Weight: _____ Birth Length: _____

Was the patient born premature? ☐Yes ☐No (If Yes) How many weeks early?_____

Was the patient admitted to the NICU? ☐Yes ☐ No (If Yes) For How Long? _____

Are you aware of any complications that occurred during/at the time of the patient's birth?

☐ Labor did not progress
☐ Abnormal Heartrate
☐ Umbilical Cord Issues
☐ Blood Transfusion(s)
☐ Needed Oxygen
☐ Jaundice
☐ Extended Hospital Stay
☐ Brain Bleed
☐ Difficulty Breathing
☐ Immature Lungs

Other:

_____

_____

Are you aware of any medical problems/conditions the patients birth mother experienced while pregnant with (i.e., gestational diabetes, hospitalizations, surgeries, etc.)? _____

_____

_____

_____

Are you aware of any substance abuse by the patient's birth mother while pregnant? ☐Yes ☐ No

(If Yes) What substance(s):_____

How Much? _____

INFANCY/TODDLER

Did the patient experience any delays in meeting your developmental milestones? ☐Yes ☐No

(If yes) what was the delay? ☐ Speech/Language ☐ Toilet Training ☐Motor skills ☐ Walking

Other: _____

Medical Concerns

Prior to 4 years of age did the patient experience any of the following:

☐ Delayed Growth	☐ Surgical Interventions	☐ Childhood Meningitis
☐ Seizures	☐ Ear pain or infections	☐ Anemia
☐ Malnourished Severe	☐ Impaired Hearing	☐ Ear Tubes
☐ Allergies	☐ Impaired Vision	

Other Medical Conditions: _____

_____

_____

Any other concerns or experiences that occurred prior to 4 years of age that you feel has affected the patient's life negatively in any way?

_____

_____

_____

Head Trauma/Concussions/Brain Injury

Has the patient experienced any trauma to the head, concussion or other potential brain injury?
☐Yes ☐ No

If Yes, then please answer the following:

How many head injuries? _____ At what age(s), (respectfully)? _____

Did any of the injuries result in loss of consciousness? ☐ Yes ☐ No If Yes:

How many times? _____ At what age(s), (respectfully)? _____

Behavioral Concerns

Prior to 4 years of age did the patient experience any of the following:

- ☐ Easy to anger
- ☐ Frequent tantrums
- ☐ Property destruction
- ☐ Violence towards others
- ☐ Trouble with attention
- ☐ Hyperactivity
- ☐ Picky Eating Habits
- ☐ Frequently forgetful
- ☐ Anxiety
- ☐ Social Isolation
- ☐ Separation Anxiety
- ☐ Frequent nightmares
- ☐ Difficulty Sleeping
- ☐ Difficulty with change
- ☐ Difficulty with authority
- ☐ Sensitive to Sound
- ☐ Sensitive to Touch

Other behavioral concerns during this time: _____

_____

_____

Between the ages 5-10 did the patient experience/exhibit any of the following:

- ☐ N/A
- ☐ Easy to anger
- ☐ Frequent tantrums
- ☐ Property destruction
- ☐ Violence towards others
- ☐ Trouble with attention
- ☐ Hyperactivity
- ☐ Picky Eating Habits
- ☐ Frequently forgetful
- ☐ Anxiety
- ☐ Social Isolation
- ☐ Separation Anxiety
- ☐ Frequent nightmares
- ☐ Difficulty Sleeping
- ☐ Difficulty with change
- ☐ Difficulty with authority
- ☐ Lying
- ☐ Compulsion to need screen time
- ☐ Self-Injurious Behavior
- ☐ Poor Impulse Control
- ☐ Failure to respond to discipline
- ☐ Difficult Social Interactions
- ☐ Sexualized Behavior
- ☐ Low Self Esteem
- ☐ Quick to blame others

Other behavioral concerns during this time: _____

_____

_____

Between the ages 11-15 did the patient experience/exhibit any of the following:

- ☐ N/A
- ☐ Easy to anger
- ☐ Frequent tantrums
- ☐ Property destruction
- ☐ Violence towards others
- ☐ Trouble with attention
- ☐ Hyperactivity
- ☐ Picky Eating Habits
- ☐ Frequently forgetful
- ☐ Anxiety
- ☐ Social Isolation
- ☐ Separation Anxiety
- ☐ Frequent nightmares
- ☐ Difficulty Sleeping
- ☐ Difficulty with change
- ☐ Lying
- ☐ Compulsion to need screen time
- ☐ Self-Injurious Behavior
- ☐ Poor Impulse Control
- ☐ Failure to respond to discipline
- ☐ Difficult Social Interactions
- ☐ Sexualized Behavior
- ☐ Low Self Esteem
- ☐ Quick to blame others
- ☐ Refusal to comply with authority
- ☐ Lack of empathy
- ☐ Running away from home
- ☐ Skipping School
- ☐ Stealing
- ☐ Vandalism

Other behavioral concerns during this time: _____

_____

_____

Was the patient ever hospitalized as a result of any of the referenced head injuries? ☐ Yes ☐ No If yes. please explain: _____

_____

_____

PERSONAL MEDICAL HISTORY

Height: ____ feet _____ inches **Weight:** _____pounds

Eyesight: Does the patient require corrective lenses or contacts? ☐Yes ☐ No (If Yes) Do the lenses or contacts fully correct the impairment? ☐Yes ☐ No Please explain: _____

_____

Hearing: Does the patient have a hearing impairment? ☐ Yes ☐ No (If yes)? Does the patient have any type of implant or hearing device? ☐Yes ☐ No Please explain: _____

_____

Eating/Appetite: Has the patient had any type of significant weight gain or wight loss within the last year?

☐Yes ☐ No Please explain: _____

_____

Does the patient exhibit any of the following behaviors regarding food?

☐ Picky Eating Habits
☐ Continual Hunger
☐ Hiding Food
☐ Binge Eating
☐ Refusal to Eat
☐ Rapid Appetite Fluctuations
☐ Texture/Color/appearance-based food preferences or refusals

Sleep: On an average night, how would you describe the patient's sleep:

☐ Heavy/Deep ☐ Restless ☐ Frequent Nightmares
☐ Light ☐ Difficulty getting to sleep ☐ Other: _____
☐ Broken/Wakes Up a Lot

Please Explain: _____

_____

What time does the patient typically go to bed: _____ Wake-Up: _____

Has the patient ever completed a sleep study? ☐ Yes ☐ No If yes. please list the name of the clinic and the provider: _____

Surgery: Please list any past surgical procedures:

Surgery	Date of Surgery	Hospital/Clinic	Doctor/Surgeon	Complications
				☐Yes ☐No

				☐Yes ☐No
				☐Yes ☐No

If you listed yes to complications, please explain here: _____

_____

Hospitalizations: Please list any past overnight hospitalizations

Reason for Hospitalization	Dates Inpatient	Hospital/Clinic	Complications
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

If you listed yes to complications, please explain here: _____

_____

Medication: Please list all medications the patient is currently taking:

Medication Name	Dosage	Frequency which it is taken	Date when 1st prescribed	Prescribed for	Prescribing Doctor

Please list all supplements the patient is currently taking:

Supplement Name	Dosage	Frequency which it is taken	Date when 1st started taking	Taken for

Please list all psychiatric medications the patient has taken in the past:

Medication Name	Dosage	Frequency which it is taken	Prescribed for	Reason for stopping	Prescribing Doctor

Psychiatric

Please check all current and previous psychiatric conditions that patient has or is currently experiencing:

ADHD	☐Current ☐Past	Insomnia	☐Current ☐Past
Difficulty Paying Attention	☐Current ☐Past	Fatigue	☐Current ☐Past
Anxiety	☐Current ☐Past	Difficulty Staying Asleep	☐Current ☐Past
Feelings of Panic	☐Current ☐Past	Frequent Nightmares	☐Current ☐Past
Panic Attacks	☐Current ☐Past	Loss of Appetite	☐Current ☐Past
Social Anxiety	☐Current ☐Past	Binge Eating	☐Current ☐Past
Depression	☐Current ☐Past	Over-Eating	☐Current ☐Past
Bipolar Disorder	☐Current ☐Past	Anorexia	☐Current ☐Past
Periods of Mania	☐Current ☐Past	Bulimia	☐Current ☐Past
Periods of Hypomania	☐Current ☐Past	Suicidality	☐Current ☐Past
Schizophrenia	☐Current ☐Past	Self-Deprecating Thoughts	☐Current ☐Past
Emotional Dysregulation	☐Current ☐Past	Self-Harm	☐Current ☐Past
Obsessive Compulsive Disorder	☐Current ☐Past	Homicidal Thoughts	☐Current ☐Past
Debilitating Phobias	☐Current ☐Past	Chronic Headaches	☐Current ☐Past
Noise sensitivity	☐Current ☐Past	Intermittent dizziness	☐Current ☐Past

Please describe any other psychiatric conditions or symptoms that the patient currently or has previously experienced: _____

_____

_____

Please list all current or previously diagnosed psychiatric conditions:

Diagnosis	Age of diagnosis	Provider who made diagnosis	Current or Previous
			☐Current ☐Previous
			☐Current ☐Previous
			☐Current ☐Previous
			☐Current ☐Previous

Additional Information: _____

_____

_____

SUBSTANCE USE/ABUSE HISTORY (If applicable)

Please list any/all substances the patient has used/consumed:

Substance	Frequency of use (Daily/weekly/socially, etc.)	Average amount used/consumed	Age 1st exposed	Date of last use	Date stopped/quit (if applicable)

Caffeine					
Tobacco/Nicotine					
Alcohol					
Marijuana					
Opioids/Prescription Drugs					
Inhalants					
Hallucinogens (Mushrooms, LSD)					
Amphetamines/Stimulants (Crack, Cocaine, meth)					
Other: _____					

Has the patient experienced any legal problems due to consumption/use of substances? ☐Yes ☐No If yes, which substance(s)? _____

Please Explain: _____

_____

FAMILY MEDICAL HISTORY

Condition	Person(s) who was/is affected by condition	Maternal or Paternal Side
Cancer	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
High Blood Pressure	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Stroke	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Diabetes	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
High Cholesterol	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Blood Disorder/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Heart Problems/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal
Kidney Problems/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐Maternal ☐ Paternal

Liver Problems/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Lung Problems/Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Alzheimer's Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Dementia	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Seizure Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Sleep Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Thyroid Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Multiple Sclerosis	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Parkinson's Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Huntington's Disease	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Other Neurological Disorder(s) - _____	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Other Genetic Disorder(s) - _____	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal

Please list any other significant family medical history that is not listed above and/or please provide any significant details regarding any of the responses above: _____

_____

_____

FAMILY PSYCHIATRIC HISTORY

Condition	Person(s) who was/is affected by condition	Maternal or Paternal Side
ADHD	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Anxiety	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Depression	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal

Bipolar Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Obsessive Compulsive Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Schizophrenia	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
PTSD	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Autism	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Learning Disabilities	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Speech/Language Disorder(s)	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Drug Abuse/Addiction	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Alcoholism	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal
Other behavioral problems/disorders – _____	☐ Mother ☐ Father ☐ Sibling ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ First Cousin	☐ Maternal ☐ Paternal

Please list any other significant family psychiatric history that is not listed above and/or please provide any significant details regarding any of the responses above: _____

_____

_____

SCHOOL/EDUCATION

List the schools the patient has attended from preschool current:

School Name	Public or Private	City	State	Grades Attended

Has the patient ever been suspended/expelled? _____ ☐Yes ☐ No How Many Times? _____

Please explain: _____

_____

How much time does to patient allocate to homework each day? _____ How much of that time does the patient need assistance? _____

What is the patient's general opinion about school?

☐ Loves it
☐ It is ok
☐ Neutral
☐ Likes it only for the socialization
☐ Dislikes it
☐ Has to be forced/bribed to go

Educational Modifications/Supports: Please check the following that applied to the patients experience in school.

☐ IEP.
If yes, what grades(?) _____
☐ 504
If yes, what grades(?) _____
☐ Held back.
If yes, what grades(?) _____
☐ Skip grade(s).
If yes, what grades(?) _____

☐ Disorganization
☐ Talking Too Much
☐ Interrupting Others
☐ Frequently Late
☐ Missing Assignments
☐ Special Education Classes
☐ Diagnosed Learning Disability
☐ Speech Therapy

☐ Poor/Failing Grades
☐ Repeated Classes/Summer School
☐ Tutoring
☐ Lack of Motivation
☐ Problems Concentrating
☐ Gifted Program
☐ Poor Time Management

Other modifications or supports the patient has in school? _____

_____

Other factors that detracted from the patient's ability to be successful in school? _____

_____

Does the patient do any recreational reading? ☐Yes ☐ No How Many Minutes Per Week? _____

How often is the patient read to by a family member? _____ minutes per week.

What would you consider the patients strongest academic area(s)? _____

What would you consider the patients weakest academic area(s)? _____

Extracurricular activities the patient participates in (Sports, Music, Arts, Clubs etc.): _____

_____

_____

Current Behavioral Concerns: Please check any of the boxes below that you are currently concerned about in regards to the patient.

- ☐ Easy to anger
- ☐ Frequent tantrums
- ☐ Property destruction
- ☐ Violence towards others
- ☐ Trouble with attention
- ☐ Hyperactivity
- ☐ Substance Abuse
- ☐ Frequently forgetful
- ☐ Anxiety
- ☐ Social Isolation Separation
- ☐ Anxiety
- ☐ Frequent nightmares
- ☐ Difficulty Sleeping
- ☐ Difficulty with change
- ☐ Difficulty with authority
- ☐ Headaches/Migraines
- ☐ Stomach pain
- ☐ Poor Self-Esteem
- ☐ Sexual Trauma/Abuse
- ☐ Physical Trauma/Abuse
- ☐ Often Tearful
- ☐ Constant Whining
- ☐ Lack of special/body awareness
- ☐ Oppositional defiance
- ☐ Lying
- ☐ Stealing
- ☐ Memory concerns
- ☐ Lack of Empathy
- ☐ Inability to accept change
- ☐ Inappropriate friends/relationships
- ☐ Inappropriate sexualized behavior
- ☐ Inappropriate Amount of Screen Time
- ☐ Distorted Body Image

Does the patient require disciplinary interventions? ☐Yes ☐ No If yes, what type of discipline is implemented? _____

_____

How does the patient respond to discipline? _____

_____

Social/Recreational

Please list any leisure activities/hobbies the patient enjoys: _____

_____

Please list any sporting/recreational activities the patient participates in: _____

_____

Please list any additional areas of interest talent or topics that the patient is very knowledgeable about:

_____

Please list any family activities the patient enjoys participating in:

_____

Please check the following that applies to the patient's social situation:

- ☐ Small (3-5) consistent friend group
- ☐ Large social network
- ☐ 1-2 close friends
- ☐ Friends did not attend same school
- ☐ Little to no social interactions
- ☐ Did not enjoy socializing

What are the patients' main social deficiencies when it comes to getting along with others and/or making new friends? _____

_____

What are the patient's main responsibilities/chores at home? _____

Does the patient have difficulty completing these? _____

_____

ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

_____

FRONTIER HEALTH AND WELLNESS
Release of Information Prep Form: Neuropsychological Testing Intake Packet

Please provide the following information to the best of your knowledge and ability

Hospital of Birth	Facility Name:	Address	Phone: Fax:	Dates in Hospital
Current School	School Name	Address	Phone: Fax:	Dates of attendance (MM/YY-MM/YY)
Any Previous School Attendance	School Name	Address	Phone: Fax:	Dates of attendance (MM/YY-MM/YY)
Any Previous School Attendance	School Name	Address	Phone: Fax:	Dates of attendance (MM/YY-MM/YY)
Pediatrician ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Occupational Therapist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Speech Therapist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Mental Health Therapist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Psychiatrist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)

FRONTIER HEALTH AND WELLNESS
Release of Information Prep Form: Neuropsychological Testing Intake Packet

Previous Neuropsychological or Psychological Testing	Clinic: Provider:	Address	Phone: Fax:	Year of Evaluation
Neurologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Gastroenterologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Endocrinologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Allergist/Immunologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Pulmonologist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Nutritionist ☐ Current ☐ Previous	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Other Specialist	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Other Specialist	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)

FRONTIER HEALTH AND WELLNESS
Release of Information Prep Form: Neuropsychological Testing Intake Packet

Urgent Care/Walk-In Clinic	Clinic: Provider:	Address	Phone: Fax:	Dates of Service
Hospital (admissions)	Facility Name	Address	Phone: Fax:	Admission Dates (MM/DD/YY-MM/DD/YY)
Psychiatric Hospital (Admissions)	Facility Name	Address	Phone: Fax:	Admission Dates (MM/DD/YY-MM/DD/YY)
Residential Treatment Center	Facility Name	Address	Phone: Fax:	Admission Dates (MM/DD/YY-MM/DD/YY)
Therapeutic Foster Care	Agency Used	Address	Phone: Fax:	Admission Dates (MM/DD/YY-MM/DD/YY)
Office of Children's Services	State Case Worker(s)	Address	Phone: Fax:	Date of Case Opening (MM/YY) Closed? ☐ Yes ☐ No
Department of Juvenile Justice	State Probation Officer(s)	Address	Phone: Fax:	Date of Case Opening (MM/YY) Closed? ☐ Yes ☐ No

Any Other Medical/Mental Health Treatment Providers or Facilities Not Listed Above

Provider/Facility Type	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Provider/Facility Type	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)
Provider/Facility Type	Clinic: Provider:	Address	Phone: Fax:	Dates under care of clinic: (MM/YY-MM/YY)