UT Physicians™
A Part of UTHealth

PATH
INTEGRATIVE FAMILY HEALTH

Please fill out this form before your child's first PATH appointment. You can email or fax it back to us prior to the appointment, or bring it with you that day.

IDENTIFYING INFORMATION:

Child's Name: _____ Date of Birth: _____

Age: _____ Gender: _____

Person completing form: _____ Today's date: _____

Relationship to child: _____

Parent's Name: _____ Parent's Name: _____

Primary Address:_____ Primary Address: _____

_____ _____

Phone: *(Home):* _____ Phone: *(Home):* _____

(Cell): _____ *(Cell):* _____

Email: _____ Email: _____

Occupation: _____ Occupation: _____

Parents are: _____ Married _____ Divorced _____ Separated _____ Never married

If applicable, what is your custody arrangement? _____

Please provide the names of any others who have a significant caregiving role in your child's life (e.g., step-parent(s), grandparent(s), adult sibling(s), close family friend(s), etc.):

Name: _____ Role: _____ Occupation: _____

Name: _____ Role: _____ Occupation: _____

Name: _____ Role: _____ Occupation: _____

Which of the following best describes your child? (optional; **check all that apply**)

_____ White

_____ African American/Black

_____ Hispanic/Latino(a)

_____ American Indian/Alaska Native

_____ Asian/Asian American

_____ Native Hawaiian/Other Pacific Islander

_____ If none of these describes you, please tell us how you identify:_____

Who referred you to PATH?

_____ Physician Name: _____ Phone: _____

_____ Psychologist Name: _____ Phone: _____

_____ School/Teacher Name: _____ Phone: _____

_____ Other Name: _____ Phone: _____

_____ Self-referred

Referral Reason(s):

_____

_____

_____

_____

Please provide any other details describing the problem(s) affecting your child and how you hope PATH can help:

_____

_____

_____

_____

PREVIOUS EVALUATIONS/INTERVENTIONS:

Has your child participated in any of the following?

Occupational therapy:	_____ Yes	_____ No	Age(s): _____
Physical therapy:	_____ Yes	_____ No	Age(s): _____
Speech/language evaluation/therapy:	_____ Yes	_____ No	Age(s): _____
School-based evaluation:	_____ Yes	_____ No	Age(s): _____
Psychological or other mental health evaluation/treatment:	_____ Yes	_____ No	Age(s): _____
Neuropsychological evaluation:	_____ Yes	_____ No	Age(s): _____
Psychiatric evaluation/treatment:	_____ Yes	_____ No	Age(s): _____
Inpatient psychiatric hospitalization:	_____ Yes	_____ No	Age(s): _____
Intensive outpatient program:	_____ Yes	_____ No	Age(s): _____
Residential treatment program:	_____ Yes	_____ No	Age(s): _____

PREGNANCY & NEWBORN HISTORY:

Biological mother's age at delivery: _____ Length of pregnancy (how many weeks)?: _____

Did mother and infant leave the hospital at the same time? _____ Yes _____ No

Complications during pregnancy:	_____ Yes	_____ No	If yes: _____
Complications during delivery:	_____ Yes	_____ No	If yes: _____
Complications after birth:	_____ Yes	_____ No	If yes: _____
NICU/hospital stay:	_____ Yes	_____ No	If yes: _____

DEVELOPMENTAL HISTORY:

At what age did your child:	Age(s):	Comments/Problems:
Walk independently	_____	_____
Speak first words	_____	_____
Speak in two-word sentences	_____	_____
Toilet train (bladder, day)	_____	_____
Toilet train (bladder, night)	_____	_____
Toilet train (bowels)	_____	_____

Have there been any periods of time when you and your child were separated for weeks/months? ___Yes ___No

If yes, please explain: _____

MEDICAL HISTORY:

Please list your child's medical diagnoses:

_____

_____

Allergies: _____ Yes _____ No If yes, to what?: _____

Pediatrician's name/practice: _____

Other treating providers: Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Current medications: Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Has your child ever been hospitalized (medical or psychiatric)?: _____ Yes _____ No

If yes, date: Reason for hospitalization:

_____ _____

_____ _____

Has your child ever had surgeries?: _____ Yes _____ No

If yes, date: Type of surgical procedure:

_____ _____

_____ _____

Are your child's immunizations up to date?: _____ Yes _____ No _____ I don't know

EDUCATIONAL HISTORY:

Current grade: _____ Current school: _____

Currently, how many days of school does your child miss PER MONTH? _____

Has your child ever been retained/held back? _____ Yes _____ No If yes, what grade(s): _____

Has your child ever been suspended or expelled from school? _____ Yes _____ No

If yes, please explain: _____

Has your child ever received the following services?

Early Childhood Intervention (ECI) and/or PPCD ____Yes ____No Age(s): _____

Special Education/Individualized Education Program (IEP) ____Yes ____No Age(s): _____

Section 504 Plan ____Yes ____No Age(s): _____

Response to Intervention (RTI) monitoring ____Yes ____No Age(s): _____

Other ____Yes ____No Age(s): _____

FAMILY HISTORY:

Who currently lives in the home with your child?

Name:_____ Age: _____ Relationship: _____

Name:_____ Age: _____ Relationship: _____

Name:_____ Age: _____ Relationship: _____

Name:_____ Age: _____ Relationship: _____

Has anyone in your family ever experienced the following?

Depression	____Yes	____No	If yes, who: _____
Anxiety and/or panic attacks	____Yes	____No	If yes, who: _____
ADHD/ADD or related symptoms	____Yes	____No	If yes, who: _____
Bipolar disorder	____Yes	____No	If yes, who: _____
Schizophrenia	____Yes	____No	If yes, who: _____
Autism or other developmental delays	____Yes	____No	If yes, who: _____
Speech/language problems	____Yes	____No	If yes, who: _____
Learning difficulties/differences	____Yes	____No	If yes, who: _____
Substance abuse	____Yes	____No	If yes, who: _____
Physical/sexual/emotional/other abuse	____Yes	____No	If yes, who: _____
Suicide or attempted suicide	____Yes	____No	If yes, who: _____
Diabetes	____Yes	____No	If yes, who: _____
Hypertension	____Yes	____No	If yes, who: _____
Heart disease	____Yes	____No	If yes, who: _____
Seizures	____Yes	____No	If yes, who: _____

Other (e.g., other chronic medical illness; *please describe*):

_____

Has the primary caregiver(s) ever received treatment (e.g., with a mental health provider) for any issue? If yes:

_____

Has there ever been an open CPS case involving your child or one of your child's siblings? ____Yes ____No

EMOTIONAL/BEHAVIORAL HISTORY:

Does your child <u>currently</u> exhibit any of the following behaviors or symptoms?

	Aggression		Excessive dieting/exercise		Lying		Sleep problems
	Anxiety/worry		Feeding problems		Obsessions/compulsion		Specific fears/phobias
	Appetite changes		Headaches		Mood swings		Stealing
	Argues often		Hyperactivity		No/few friends		Stomachaches/pain
	Body image issues		Impulsivity		Peer conflicts		Substance use/abuse
	Chronic pain		Irritability		Prolonged sad mood		Suicidal thoughts
	Defiance		Legal problems		Running away		Tics
	Depression		Low energy/fatigue		Self-harm (ex: cutting)		Withdrawal
	Distractibility		Low self-esteem		Seizures		

Does your child currently exhibit any other concerning behaviors or symptoms?

_____

ADDITIONAL INFORMATION:

Are you able to provide transportation for your child to/from the program (Monday-Friday, drop-off at 7:30-8:00 AM + pickup at 3:00 PM, for approximately 4-5 weeks)? _____ Yes _____ No

If no, are you interested in trying to receive any of the following?

_____ Medicaid transportation (Medicaid only)

_____ Gas reimbursement (Medicaid only)

_____ Bus passes

Are there any barriers that could make it difficult for you and/or your child to participate in the program (e.g., parent/caregiver's work schedule, lack of childcare for other children, etc.)?

_____

_____

_____

Please list your child's strengths:

_____

_____

_____

Please list your child's interests and/or extracurricular activities:

_____

_____

_____

Please provide any additional information about your child you feel the PATH team should know:

_____

_____

_____

Reminders:

- Please bring any relevant records (e.g., school records, any prior testing/evaluations, divorce decree, other custody and/or guardianship arrangements, if applicable) to your child's first PATH Program appointment
- ***You can email or fax this completed form back to us prior to your appointment:***
    - **Email:** PATHProgram@uth.tmc.edu
    - **Fax:** (713) 486-0860
    - **Phone:** (713) 500-7840

Thank you for completing this form. Your responses help our team learn more about your child and how best to meet your child's needs.