Date: _____

CHRONOLOGICAL RECORD OF MEDICAL CARE
Behavioral Medicine Associates, Inc.
1010 North Virginia Avenue
Roswell, NM 88201

Instructions: Please fill this form out completely. All items must be responded to. Any item left blank may result in a delay in treatment.

Identifying Information:
Patient Name: _____ Date of Birth: _____
Age: _____ Sex: M/F # of Siblings: _____ # of Children: _____ Marital: _____
How would you describe your Family Situation?: (i.e. intact family, foster family, stepparents, stepsiblings, etc.)
_____
Race: __African American __ Alaskan Native __American Indian __ Asian
__ Native Hawaiian/ Other Pacific Islander __Two or More Races __White __Unknown
Ethnicity: __Cuban __Hispanic(unspecified) __Mexican __Not Hispanic __Other Hispanic(Specific)
__ Puerto Rican __Unknown

History:
Mother's Health During Pregnancy? _____Complications? Yes No
If yes explain: _____
Weeks Gestation: ____Delivery: Normal/C-Section
What age was the patient when he/she was able to do the following:
_____Crawling _____Walking _____1st Word _____2 Words _____ Dress Self
_____ Potty Trained _____ Tricycle _____Bicycle _____Basic Colors

Education:
Currently in school? Yes No Name of School: _____
Current Grade or Highest Completed: _____Speech Therapy: _____
Occupational Therapy: _____Special Education: _____
Repeated a Grade: Yes No _____ Skipped a Grade: Yes No _____

Date: _____

Work History:

Number of Previous Jobs: _____Current Employer: _____ Time at Job: _____

How would you describe the stress related to work?: _____

Do you find the work you do satisfying? : _____

Previous Mental Health Providers and Treatment Dates:

	Problem	Dates	Outcome
Emergency Room:			
	Problem	Dates	Outcome
Inpatient:			
	Problem	Dates	Outcome
Residential:			

Outpatient treatment (counselors, school counselors, psychiatrists, psychologists etc.):

Provider:	Dates Seen:	What was helpful?	Outcome:

Family Psychiatric History:

_____

_____

_____

Is Patient currently seeing another behavioral health clinician, including school counselors or at BMA? Yes No

Name of provider: _____ Address: _____

Phone Number: _____ Permission to communicate? Yes No *Initial* _____

Medical History:

Patient's overall health described as: Poor Fair Good Excellent

Primary Care Provider(s):_____

Permission to obtain/release information from/to PCP given? Yes No *Initial* _____

Date: _____

Patient's Medical Conditions (Past and Current):

Condition:	Dates:	Treating Provider:	Treatment and Response:	Ok to Communicate?

Allergies: Yes No (If yes, describe) _____

_____

Current Medications:

Medication	Dosage	Last Taken	Prescribed for What

Previous Medications:

Medication	Dosage	Last Taken	Prescribed for What

Has Patient had or at risk for any of the following?

Head injury Yes No Seizures Yes No Pregnancy Yes No

If yes, please explain: _____

Date: _____

Family Medical History: Check all that apply

___Heart Disease ___High Blood Pressure ___Stroke ___Diabetes ___Cancer ___Lung Problems
___Digestion Problems ___Liver Problems ___Muscle or Joint Problems ___Seizures ___Headaches
___Dizziness ___Double Vision ___Recent Weight Loss ___Night Sweats ___Cough ___Breathing Problems
___Binging ___Purging ___Laxative Use ___Nausea ___Easy Bruising ___Bone Disease ____Other

Please explain all that are checked: _____
_____

Alcohol/Drug Use:

Does Patient drink alcohol? Yes No If yes, When was Last Drink: _____ Amount:_____ How often?: _____
Nicotine: Yes No Amount: _____Frequency: _____
Has patient **ever** used any of the following?

____Amphetamines ____ Marijuana ____Cocaine ____Opiates ____ Hallucinogens
____ Inhalants ____ SPICE ____ Heroin ____ Other

Has patient used any of the following **in the last year**?

____Amphetamines ____ Marijuana ____Cocaine ____Opiates ____ Hallucinogens
____ Inhalants ____ SPICE ____ Heroin ____ Other

Is patient **currently** using any of the following?

____Amphetamines ____ Marijuana ____Cocaine ____Opiates ____ Hallucinogens
____ Inhalants ____ SPICE ____ Heroin ____ Other

Are there any periods in patient's life in which any of the above drugs were used for an extended period of time?
_____
Describe how much and how often for each drug checked: _____
_____
_____

I certify that I have answered these questions regarding alcohol and drug use truthfully and honestly.

_____
Patient signature if over 12 Date

Patient Information

Date: _____

Other Information:

Residence – where does the patient live and who does he/she live with: _____

_____

What is the patient's religious and/or spiritual affiliation if any: _____

Past Legal Issues? Yes No (If yes, please describe)_____

_____

Current Legal Issues? Yes No (If yes, please describe)_____

_____

Is there any past or present CYFD involvement? Yes No (If yes, please describe)

_____

_____

Does patient have a parenting plan, power of attorney, or any other guardianship arrangements? Yes No *Initial* _____
If yes, please provide support staff with applicable copies.

Please describe patient's support system, i.e. immediate family, extended family, how many friends, etc. :

_____

What are the patient's strengths?: _____

Community Resources Used(i.e. Medicaid, WIC, city bus, cash assistance, church assistance, etc.) : _____

_____

This form was filled out by: _____ Relationship to patient: _____

_____ _____

Signature Date

Due to inaccuracies and incompleteness, this form has been reviewed and modified by:

_____ _____

Signature Date

Patient Information