Diagnostic Guide for Fetal Alcohol Spectrum Disorders: The 4-Digit Diagnostic Code, Astley 2004

Office Use: Date received ___/___/___ Deadline ___/___/___ ASAP ____ Response Let. ___/___/___ Photo ___

New Patient Information Form FAS Clinic

Patient Identification

Patient's Name: _____Birth date :___/___/____Age: _____
First Middle Last

[ ]Female [ ]Male [ ]Decline Race _____ [ ]Decline

Patient's Address _____

City: _____ County:_____ State:_____ Zip_____

Phone: Home (___) ___-_____ Cell (___) ___-_____email _____

Insurance Policy holder: _____Birth date:___/___/___

Policy number:_____ Group number:_____

Name of patient's primary caregiver(s):_____

Relationship to patient: □ birth, □ adoptive, □ foster parent, □ other (specify:_____)

Caregiver's Address:_____

City:_____ County:_____ State:_____ Zip:_____

Phone: Home (___)___-_____Cell (___)___-_____ email_____

Name of person completing this form: _____Date ___/___/___

Relationship to patient: □ birth, □ adoptive, □ foster parent, □ caseworker, □ medical provider, □_____

Referred by (person/organization who told you about the clinic):_____

Phone: Office(___)___-_____Fax(___)___-_____ email_____

Who Should Correspondence be Sent To?

Name of patient's primary caregiver(s):_____

Relationship to patient: □ birth, □ adoptive, □ foster parent, □ other (specify:_____)

Caregiver's Address:_____

City:_____ County:_____ State:_____ Zip:_____

Phone: Home (___)___-_____Cell (___)___-_____ email_____

Legal Guardian (REQUIRED Information)

Name of patient's primary caregiver(s):_____

Relationship to patient: □ birth, □ adoptive, □ foster parent, □ other (specify:_____)

Caregiver's Address:_____

City:_____ County:_____ State:_____ Zip:_____

Phone: Home (___)___-_____Cell (___)___-_____ email_____

Office Use: Date received ___/___/___ Deadline ___/___/___ ASAP ____ Response Let. ___/___/___ Photo ___

Please complete this form to the best of your ability. We realize you will not have the answers to all questions. All information requested in this form is important in allowing us to provide you with the most accurate diagnosis and most appropriate referrals for care. Thank you for taking the time to complete it.

Reasons for Evaluation What are the patient's primary problems? Please be specific.

What do you hope to gain from the evaluation?

Medical History Questionnaire II

Name:_____ Age_____ Today's Date:_____

Please circle "NO" or "YES" or give the appropriate answer in the space provided. If there are any questions that you do not understand, leave them blank and ask the doctor or nurse about them.

PRENATAL

During the pregnancy did you/child's mother have:		
Any Illness	No	Yes
Bleeding or spotting	No	Yes
Excessive Vomiting	No	Yes
Diabetes	No	Yes
High Blood Pressure / Pre - eclampsia	No	Yes
Excessive Weight Gain	No	Yes
Poor Weight Gain	No	Yes
A lot of emotional stress	No	Yes
During the Pregnancy did you/child's mother:	No	Yes
Take any Prescription or Non Prescription Medications	No	Yes
Drink any alcohol	No	Yes
Smoke	No	Yes
Use any recreational drugs e.g. marihuana, etc.	No	Yes
Were there any other problems during this pregnancy?	No	Yes
If "Yes", please describe		

PERINATAL

Was labor unusually long or difficult?	No	Yes
Was labor induced?	No	Yes
How was the baby born? (circle one)	Vaginal	Cesarean
Was the delivery difficult?	No	Yes
Baby's birth weight lbs. oz.		
Was baby premature?	No	Yes
Was baby overdue?	No	Yes
Did the baby have any problems as a newborn such as?		
Difficulty getting started / need resuscitation	No	Yes
Need oxygen	No	Yes
Jaundice	No	Yes
Cyanosis (look blue)	No	Yes
Convulsions (seizures)	No	Yes
Difficulty sucking	No	Yes
Infection	No	Yes
Hypoglycemia (low blood sugar)	No	Yes
In hospital longer than mother / went to NICU	No	Yes
Have any other problems? If "Yes", please describe		
Was baby breast or bottle fed? *(circle)* Breast Bottle Both		

GROWTH AND DEVELOPMENT

At approximately what age did your child:

Begin to smile	Mos	Year
Roll over both ways	Mos	Year
Sit unsupported	Mos	Year
Crawl	Mos	Year
Pull up on furniture	Mos	Year
Walk alone	Mos	Year
Feed himself/herself	Mos	Year
Use single words	Mos	Year
Use 2 - 3 word phrases or sentences	Mos	Year
Talk clearly enough to be understood by non - family members	Mos	Year
Become fully toilet trained	Mos	Year

Does this child/youth have a problem with:

Speech or language use	No	Yes
Habits which bother you	No	Yes
Getting along with other children	No	Yes
Discipline or behavior	No	Yes
Attends school?	No	Yes
Current grade level? -------> _____		
Does this child/adolescent have any learning/behavior problems in school?	No	Yes
Receives Special Education Services? 504 Plan?	No	Yes
IEP Eligibility if known _____		
Typical school performance is - *(circle one)* below average average above average		

HEALTH PROBLEMS

Has this child / youth ever been hospitalized, had surgery, or had a serious injury? If Yes, Please describe below.	No	Yes

Does this child/youth have now or have they ever had problems in the following areas?
Circle all that apply.

Growth	Heart murmur	Other bone or joint problem
Unexplained fevers	Other heart / cardiac problems	Anemia
Sleeping	Reflux / vomiting	Swollen glands
Feeding	Abdominal pain	Bleeding problem
Poor / Picky diet	Constipation	Immune problem
Ear infections	Diarrhea	Other blood, lymph, or immune problem
Hearing	Other stomach or bowel problem	Eczema
Vision	Bedwetting	Acne
Dental problems	Daytime wetting	Other skin problem
Frequent colds	Urinary tract infection	Headaches / Migraine
Thyroid problem	Other urinary tract problem	Head Injury
Asthma / wheezing	*If female:*	"Spells"
Hay fever / allergic rhinitis	Has Breast Development	Seizures
Other Respiratory problems	Started menstruation	Other neurological problem
Any of the following:	Menstrual problems	Depression
Measles Rubella	Fractures	Anxiety
Mumps Chickenpox	Arthritis	Learning problems
Meningitis Roseola	Wears brace	ADHD
HIV/Aids		

Does this child / youth have any health probems not covered above? If "Yes" , please describe below. Use back of last page if necessary.

Eats a "well balanced" diet	No	Yes
If on a formula product, please indicate kind_____		
Has this child / youth ever had a positive TB test or ever had contact with a case of TB (tuberculosis)	No	Yes
Does anyone in the family smoke?	No	Yes
Does this child/youth always use a restraint device or seatbelt in the car?	No	Yes
Wears a helmet for activities like bike riding, skateboarding, 4 wheeling, etc.	No	Yes
Do you have a working smoke detector in your home?	No	Yes
Do you have a family escape plan in case of fire?	No	Yes
Is your hot water temperature set at 125 or less	No	Yes
About how many hours/week does this child/youth spend viewing screens (eg. TV, video games)?	Hours	
Engages in vigorous play/exercise daily	No	Yes
Do you have concerns about this youth's use of tobacco marijuahna, alcohol, or other substances?	No	Yes

MEDICATIONS

Please list any prescription medication currently being taken by this child/youth on regular or occasional basis

Please list any non-prescription medication being taken by this child / youth on a regular or occasional basis (e.g. vitamins, melatonin, various supplements)

ALLERGIES

	No	Yes
Does this child/adolescent have any allergies to foods, medications, or other substances? If "Yes" please list below.		

IMMUNIZATIONS

Please indicate this child/youth's immunization status.

	Aren't Sure	No	Yes
He/she has had all "required" vaccinations for his or her age or school status			
He/she has also had the following recommended vaccinations.			
Meningococcal B Vaccine	Aren't Sure	No	Yes
HPV (human papilloma vaccine)	Aren't Sure	No	Yes
Covid - 19 vaccine	Aren't Sure	No	Yes

	No	Yes
Has this child/adolescent had a serious reaction to a vaccine? If "Yes", please describe below.		

SOCIAL HISTORY

This child/youth lives with: (circle)

Biological Mother / Biological Father / Adoptive Mother
Adoptive Father / Step Mother / Step Father / Foster Parent(s)
Brother(s) / Sister(s) / Step Brother(s) / Step Sister(s) / Other

Is either birth parent deceased?	No	Yes

Has this child/youth ever experienced any of the following?
Please circle all that apply

Emotional Abuse	Family Separation / Divorce
Physical Abuse	Domestic Violence
Sexual Abuse	Parental Mental Illness / Suicide Attempt
Emotional Neglect	Family Member Drug Use
Physical Neglect	Family Member Incarcerated (jail / prison)

FAMILY HISTORY

Parent, grandparent, aunt, or uncle of this child/youth had a heart attack or stroke under 55 if male or under 65 if female	No	Yes
Parent of this child/youth has a high cholesterol or takes cholesterol lowering medications	No	Yes

Do any relatives of this child/adolescent have any of the following?
Please circle any that apply.

Birth defects	Bleeding Disorders
Genetic disorders	HIV /Aids
Thyroid problem	Rheumatoid arthritis
Diabetes	Other bone / joint problem
Severe allergies	Kidney / urinary tract disease
Eye / Ear disorders	Drug or alcohol problem
Asthma	Seizures / convulsions
Other Lung Disorders	Autism / Autism spectrum disorder
Tuberculosis	Intellectual disability / *(formerly*
Heart disease	*called mental retardation)*
Rheumatic fever	Learning disorder / disability
Hypertension	ADHD/Attentention Deficit Disorder
Stomach / Bowel Problem	Depression
Hepatitis	Bipolar Disorder
Cancer	Anxiety
Anemia	Schizophrenia
	Other Mental Health Problem

Are there any other problems not mentioned above that occur in the family? If YES, please list below	No	Yes

IF THERE IS ANYTHING ELSE THAT YOU WOULD LIKE TO ADD PLEASE DO SO BELOW OR ON THE REVERSE. **THANK YOU**.

Name of person completing form:	Relationship to child/youth: