MEDICATION MANAGEMENT MINOR INTAKE

Patient's Full Legal Name: _____ Date: _____

Preferred Name: _____ Pronouns: _____

DOB: _____ Age: _____ Gender Identity: _____

Parent/Guardian #1 Name: _____ Parent/Guardian DOB: _____

Parent/Guardian Phone: _____ Parent/Guardian Email: _____

Parent/Guardian #2 Name: _____ Parent/Guardian DOB: _____

Parent/Guardian Phone: _____ Parent/Guardian Email: _____

School Information

School Name: _____ Current Grade: _____

IEP or 504 Plan? ☐ Yes ☐ No

Are there any concerns at school?

Primary Physician Information

Does patient have a Primary Physician? ☐ Yes ☐ No

Name of Primary Physician: _____

Name of Clinic: _____

Clinic City: _____ Clinic State: _____ Date of last exam? _____

Primary Pharmacy Information

As a benefit to our patients, we have partnered with Capsule to offer free, same day delivery of your medications – they accept all major insurance plans and identify coupons to save you money. Capsule services the Twin Cities and the greater surrounding area. To verify your zip code is within service range, please copy and paste this link: https://bit.ly/3DBenSa. For more information, please speak with your provider.

☐ Yes – I would like to try Capsule

☐ No – I would like to use an alternative pharmacy (listed below)

Name of Preferred Pharmacy: _____

Pharmacy Address: _____

Pharmacy City: _____ Pharmacy State: _____

Therapist Information (if outside of Ellie Mental Health)

Name of Therapist: _____ Clinic: _____

Clinic City: _____ Clinic State: _____

Mental and Medical Health Concerns/History

What concerns are you seeking to treat with medications, and how do you think they can help?

Has the patient been diagnosed with any conditions (medical and/or mental health) in the past?

☐ Yes ☐ No

If yes, list all previous diagnoses client has received (medical and/or mental health):

Does the patient have a medical history of hospitalizations, surgeries, major injuries/illnesses, chronic health concerns, seizure/neurological concerns, etc?

Current Life Stressors:

Is the patient currently taking any medications (prescribed or over-the-counter)?

☐ Yes ☐ No

Please list all mental health medications (prescribed or over-the-counter) the client is currently taking:

Medication	Dosage	Since when?	Adverse effects (if any)

Has the patient taken any mental health medications (prescribed or over-the-counter) in the past?

☐ Yes ☐ No

Please list all past mental health medications (prescribed or over-the-counter) and reasons for stopping:

Medication	Max Dosage	Frequency	Month/Year Started	Adverse Effects (if any)

Name of previous medication management clinic: _____

Name of previous medication management provider: _____

Is the patient allergic to any medications or drugs? ☐ Yes ☐ No

If yes, list medication and reaction:

Please provide information regarding patient's blood relatives. **NOTE: This section can be blank IF the patient is adopted or information is unknown.

Mother:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Father:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Brother(s):
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Sister(s):
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Children:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Maternal Grandmother:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Maternal Grandfather:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Paternal Grandmother:
☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Paternal Grandfather: ☐ Living ☐ Deceased
☐ Bleeding/Clotting Disorders or Stroke ☐ Diabetes
☐ Heart Disease/Arrhythmia ☐ Mental Illness ☐ Suicide

Other: _____

Gestational/Developmental History

Any history of pregnancy or birth complications for patient's mother? ☐ Yes ☐ No

If yes, please explain: _____

Was patient born at term? ☐ Yes ☐ No

Did patient meet developmental milestones within normal range? ☐ Yes ☐ No

If no, please explain: _____

Chemical/Substance Use History

Please provide information on past and/or current chemical use history (if applicable):

	Never	Current	Past
Caffeine			
Alcohol			
Nicotine			
Marijuana			
Cocaine/Crack			
Heroin/Opiates			
Inhalants			
Hallucinogens			
Methamphetamine			
Prescription Drugs			
Valium/Librium/Xanax/Benzodiazepines			
Over-the-Counter			

Please list any others not in the above list:

Mental Health Treatment History

Please provide patient's history with the following treatments or conditions:

	Yes	No	Month/Year(s)	Facility/Clinic	Reaction
Counseling/Psychotherapy					
Drug/Alcohol Treatment					
Inpatient Treatment					
Groups, PHP or IOP					
Genetic Testing					
Psychological Testing					
Case Management					

Please list any others not in the above list:

Please provide patient's history with the following:

	Yes	No	Month/Year(s)
Self-Harm			
Suicidal Ideation			
Suicide Attempts			

Personal History

Please tell us a little more about the patient.

Tell us about the patient's family (names/ages):

Who does the patient live with?

Are the patient's parents together, separated/divorced?

Tell us about the patient's current friends/relationship connections:

What are the patient's favorite hobbies/sports/activities?

Tell us about the patient's typical nutrition/diet:

Tell us about the patient's sleep habits:

Tell us about the patient's exercise/physical activity habits:

Tell us about the patient's current employment:

Does the patient have any history of trauma, abuse or neglect?

Is there any history of CPS involvement or foster care?