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Minor Patient Background Information

Today's Date _____

Name _____ Age _____ Date of Birth _____

Male _____ Female _____ School attending _____ Grade level _____

After school jobs _____

Extracurricular activities _____

Family Status:

Mother's Name _____ Age _____ Occupation _____

Father's Name _____ Age _____ Occupation _____

Legal Guardian (if not parent) _____

Parents currently married _____ Separated _____ Divorced _____ Not married _____

Both parents living: Yes _____ No (explain) _____

Live with (if not both parents) _____

Who else lives there?

Brothers (names, ages)

Sisters (names, ages) _____

Others (names, ages, relationship)

Siblings who don't live with you:

Brothers (names, ages)

Sisters (names, ages) _____

Health Status:

Current health problems: None ___ Yes (specify) _____

Chronic health problems: None ___ Yes (specify) _____

Medications currently taken: None ___ Yes (specify) _____

Mental Health Status:

Previous Counseling: None _____ Yes (dates, location, therapist) _____

Previous Hospitalizations for emotional or substance abuse problems:

None _____ Yes (dates, facility, reason) _____

History of medications taken for emotional or substance abuse problems:

None _____ Yes (medications, dates taken) _____

Which of the following are of concern to you at this time? (Check all that apply)

Emotional Health: Self _____ Other _____ Abuse/violence _____

Substance use/abuse: Self _____ Other _____ Health-Related _____

Suicide Risk: Self _____ Other _____ School-Related _____

Behavior problems: _____ eating disorder _____

Family relationships _____ Peer/Social relationship _____

Other (specify) _____

Current substance use: (write # in blank: 0=no use; 1=occasional use; 2=moderate use; 3=heavy use; 4=addiction, loss of control; 5=currently in treatment)

Alcohol _____ Other drugs _____

Past Use/Abuse: None _____ Yes explain) _____

Tobacco use: None _____ Yes (how much?) _____

Caffeine use: None _____ Yes (how much?) _____