

Hasbro Children's Hospital Gender & Sexuality Program New Patient Form

Please complete this form before arrival for your appointment and bring it with you

If you have questions before your visit, please contact Donna Perry at 401-444-4712

Patient Information

Chosen name:	Pronouns:	Gender identity:
Legal name:		Sex assigned at birth:
Date of birth:	Age:	
Address:		
Cell phone: ()	Home phone: ()	
Email:		
Preferred method of communication: home phone cell phone e-mail		
Name of school/work (or both):		

Parent/Guardian (if <18) Information or Emergency Contact (if 18+) Information

Name:	Pronouns:
Address (check ___ if same as above):	
Cell phone: ()	Home phone: ()
Email:	
Preferred method of communication: home phone cell phone e-mail	
Name:	Pronouns:
Address (check ___ if same as above):	
Cell phone: ()	Home phone: ()
Email address:	
Preferred method of communication: home phone cell phone e-mail	

Current Provider Information

<i>Pediatrician/Primary Care Provider:</i>	
Address:	
Phone: ()	Fax: ()
Email:	
<i>Therapist:</i>	
Address:	
Phone: ()	
Email:	
<i>Psychiatrist:</i>	
Address:	
Phone: ()	
Email:	
<i>Other Specialist:</i>	
Address:	
Phone: ()	
Email:	

If you have more providers, please continue on the last page (blank)

Current Medications (prescriptions, supplements, and over the counter)

Medication Name	Dose	Frequency

Medical History

	No	Yes (please explain)
Allergies (medication/food/environmental)		
Past medical hospitalizations		
Past surgery		
Complications with pregnancy or delivery		
Delays in early childhood development		
Immunizations up to date		

Mental Health History

	No	Yes (please explain)
Past psychiatric hospitalizations		
Past therapists or medication prescribers		
Psychiatric medications in the past		
History of testing for learning disabilities, ADHD, Autism, etc.		
IEP or 504 plan in school		
Suicide attempts or self injurious behaviors		
Current or past substance use		

Please indicate if the patient has had any of these conditions and age of onset:

	No	Yes	Age		No	Yes	Age
Irritable Bowel Syndrome				Anxiety			
Inflammatory Bowel Disease				Depression			
Celiac Disease				Obsessive/Compulsive Disorder			
Hepatitis/Liver Disease				Bipolar Disorder			
Other gastrointestinal disease				Substance Abuse			
Asthma				Suicidal thoughts/self-harm			
Respiratory problems				Bullying/Being Bullied			
Anemia/Blood Disorder				Trauma (physical, sexual, emotional)			
Cancer				Broken Bones/Stress Fracture			
Diabetes				Scoliosis			
Epilepsy/Seizures				Skin Problems			
Thyroid Disease				Overweight/Obesity			
Migraines				Underweight/Failure to Thrive			
Heart Disease				Eating Disorder			
Fainting episodes				Other:			
Urinary/Kidney problems				Other:			

Social History

Who lives at home	
Who is in your family	
Marital Status (or Parents' Marital Status if <18 years old)	Single Married Widowed Divorced Separated Other:
Employment (and Parents' Employment if <18 years old)	
Family circumstances or stressors	
Child protective services involvement (e.g. DCYF)	
Out-of home placement history (foster care, group home, etc.)	
School	
Grade	
Interests/Activities	
School Refusal or Truancy	
Legal Problems	

Family History (place an “X” in the appropriate box)

	Parent 1	Parent 2	Paternal grandfather	Paternal grandmother	Maternal grandfather	Maternal grandmother	Sibling (specify)
Irritable Bowel Syndrome							
Inflammatory Bowel Disease							
Celiac Disease							
Other gastrointestinal disease							
Osteoporosis							
Anemia (severe)							
Cancer							
Diabetes							
Thyroid Disease							
Heart Disease							
High Blood Pressure							
Urinary/Kidney problems							
Overweight/Obesity							
Underweight							
Eating Disorder							
Depression							
Anxiety							
Obsessive/Compulsive Disorder							
Substance use							
Suicide/Self-harm							
Other (physical or mental health concerns):							
Other:							

Is there anything else you would like us to know?

What are your expectations and goals for the first appointment and your ongoing care with us?

Youth Questionnaire

My name is:
I describe my gender identity as:
My pronouns are:
I think gender is...
The communities I'm a part of are:
I experience gender in my communities as:
What I think people don't realize is:
What I am hoping to get out of this appointment is:
Questions I have are: