**Reason for Visit:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you to us:**

|  |  |
| --- | --- |
| Physician / Other Name: | Physician / Other Fax Number: |
|  |  |
|  |  |

**Family information-** Please list ALL legal guardians of the patient

|  |  |  |  |
| --- | --- | --- | --- |
| Name & Relationship to child | Date of Birth | Contact Number | Can give consent to treatment? Y/N |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**GUARANTOR NAME-** Please provide the patient’s guarantor’s information.

Guarantor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female

Primary Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy-** All your medication will be e-scribed to your pharmacy. Please provide your pharmacy information below.

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacy Name | Full Address including **zip** | Phone | Fax |
|  |  |  |  |

**Patient information**

Home Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policies and Benefit Assignment- Read and Sign**

I authorize Georgia Psychiatry & Sleep to furnish information as necessary to my insurance carrier regarding my illness and treatment, and I assign to Georgia Psychiatry & Sleep all insurance payments for medical services rendered. I understand that I am responsible for providing all necessary information to the office or submitting charges to the insurance company for payment. If I fail to provide this information, I accept the financial responsibility of payment for services rendered. This office has a cancellation policy that requires 24 - hour advance notification. I understand that if I cancel with less than 24 hour notice, a charge will be made for the time reserved. This charge is not covered by insurance and is not payable from any insurance company.

**Consent for treatment and for the use of psychotropic medications**

The indications for the medication(s) that are a part of my treatment plan have been discussed with me. I understand that, on occasion, some psychotropic medications may be used for psychiatric conditions or symptoms, despite a lack of FDA approval for these uses. I accept this, and accept the advantages and disadvantages of this treatment. Based on the information provided, I agree to comply with the instructions provided by my physician.

If I have further questions or concerns about the medication(s) or treatment, I understand that I should contact the prescribing physician as soon as possible.

**Signature of Parent/Guardian for consent** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office policies**

Listed below are all office policies. All office policies must be acknowledged and agreed to prior to the initial evaluation. Compliance with office policies are required. Please check each box after reading for acknowledgement.

* New patient no-show fee of $100 will be required before our staff is able to reschedule an initial evaluation 
* New patient same-day cancellation fee of $75 will be required before the initial appointment is rescheduled 
* Existing patient no-show fee of $50 for medication management & $100 for talk therapy 
* Existing patient same-day cancellation fee of $50 for talk therapy, and $25 for medication management 
* A urine drug screen is required for **ALL medication management new patients** and can be requested at any time at a follow-up visit for medication management, at the discretion of your provider. The UDS cost is $15 
* Patients with 3 or more missed/cancelled appointments may be considered for possible termination

from our practice 

* Patient responsibility is due at the time of service 
* Any medication refill requests will be considered on a case-to-case basis, and if approved by the provider, will be a cost of $25 if refilled without an appointment. 
* Insurance, address, phone number and pharmacy changes need to be updated with our office. 
* Any disability cases must be discussed in session and may require additional treatment programs. Disability paperwork will not be filled out at initial evaluations. 

I have received and read the office policies, financial policy and patients’ rights and responsibilities. A copy of these forms have been emailed and can be provided by request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature Date

ADHD Questionnaire

**Directions:** Each rating should be considered in the context of what is appropriate for the age of your child. Please think of your child’s behaviors as well as include input from the child/adolescent when completing the form:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Symptoms** | **Never** | **Occasionally** | **Often** | **Very Often** |
| 1. Does not give close attention to details or make careless mistakes in school, work or other activities
 |  |  |  |  |
| 1. Has difficulty sustaining attention in tasks or play activities (other than video games)
 |  |  |  |  |
| 1. Does not seem to listen when spoken to directly
 |  |  |  |  |
| 1. Does not follow through on instructions and fails to finish school work, chores or duties (not due to oppositional behavior or failure to understand directions)
 |  |  |  |  |
| 1. Has difficulty organizing tasks and activities
 |  |  |  |  |
| 1. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework)
 |  |  |  |  |
| 1. Loses things necessary for tasks or activities, such as toys, assignments, books or tools
 |  |  |  |  |
| 1. Is often easily distracted
 |  |  |  |  |
| 1. Is often forgetful in daily activities
 |  |  |  |  |
| 1. Fidgets with hands or feet or squirms in seat
 |  |  |  |  |
| 1. Leaves seat in classroom or in other situations in which remaining in seat is expected
 |  |  |  |  |
| 1. Runs about or climbs excessively in situations in which it is inappropriate (adolescents or adults may have feelings of restlessness)
 |  |  |  |  |
| 1. Has difficulty playing or engaging in leisure activities quietly (other than video games)
 |  |  |  |  |
| 1. Is often “on the go” or often acts as if “driven by a motor”
 |  |  |  |  |
| 1. Talks excessively
 |  |  |  |  |
| 1. Blurts out answers before questions are completed
 |  |  |  |  |
| 1. Has difficulty waiting turn
 |  |  |  |  |
| 1. Interrupts or intrudes on others, such as butting into conversations or games
 |  |  |  |  |

**Please get your child/teen’s input in answering the assessment questions in the rest of this paperwork**

 **(if developmentally appropriate)**

Over the last 2 weeks, how often has your child/teen been bothered by any of the following problems?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several days | More than half the days | Nearly every day |
| 1. Little interest or pleasure in doing things
 | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, or hopeless
 | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much
 | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy
 | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating
 | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself- or that you are a failure or have let yourself or your family down
 | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television
 | 0 | 1 | 2 | 3 |
| 1. Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual
 | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead or hurting yourself in some way
 | 0 | 1 | 2 | 3 |

Please total your score. Total Score:\_\_\_\_\_\_ = \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for your child/teen to do school work, do activities at home, or get along with other people?

Not difficult Somewhat Very Extremely

 at all difficult difficult difficult

Has your child/teen been more irritable than usual? Yes No

Has your child/teen been isolating from friends or family? Yes No

Have your child/teen’s grades dropped from their baseline? Yes No

Does your child/teen have behaviors that are of concern? Yes No

 If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child/teen have access to any weapons in their home(s)? Yes No

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Development**

Does this child/teen live with both biological parents? Yes No

 If not, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If parents are separated or divorced, how often does the child/teen see the other parent?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who currently lives in the home with this child/teen?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current marital status of parent/legal guardian? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If MARRIED, how many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If DIVORCED, how many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal guardian’s number of prior marriages? \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal guardian’s number of children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information of siblings/step-siblings

|  |  |  |
| --- | --- | --- |
| Name | Age | Live in home(s) with your child/teen? |
|  |  |  |
|  |  |  |
|  |  |  |

Parent/Legal guardian’s employment status? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MOM:** If EMPLOYED, what is their position/employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If DISABLED, for medical or psychiatric condition? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DAD:** If EMPLOYED, what is their position/employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If DISABLED, for medical or psychiatric condition? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the parent or guardian served in the US military? Yes No

 If YES, number of years and reason of discharge? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cultural Identity (Ethnicity/Religion): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest level of education of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any major changes in the life of your child/teen in the last few years?

 Yes No

 If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child/teen have a history of abuse or neglect or bullying? Yes No

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child/teen ever been arrested or had charges filed against them? Yes No

 If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child/teen ever been cruel to other people or animals? Yes No

 If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any problems in the pregnancy or birth of this child/teen? Yes No

 If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child/teen meet all developmental milestones in a timely manner? (Walking, talking, potty training, etc) Yes No

If NO, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child/teen received any special classes or assistance in school? (Special education classes, tutoring, gifted classes, etc) Yes No

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child/teen have any issues making or keeping friends? Yes No

If YES, when did this start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What grade is your child/teen in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What school do they attend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are typical teacher comments about your child/teen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any problems in school for your child/teen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over the last 2 weeks, how often has your child/teen been bothered by the following problems?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **GAD-7** | Not at all | Several days | More than half the days | Nearly every day |
| 1. Feeling nervous, anxious or on edge
 | 0 | 1 | 2 | 3 |
| 1. Not being able to stop or control worrying
 | 0 | 1 | 2 | 3 |
| 1. Worrying too much about different things
 | 0 | 1 | 2 | 3 |
| 1. Trouble relaxing
 | 0 | 1 | 2 | 3 |
| 1. Being so restless that it is hard to sit still
 | 0 | 1 | 2 | 3 |
| 1. Becoming easily annoyed or irritable
 | 0 | 1 | 2 | 3 |
| 1. Feeling afraid as if something awful might happen
 | 0 | 1 | 2 | 3 |

Please total your score. Total Score: \_\_\_\_\_\_ = \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_\_\_

Please describe, if applicable, the circumstances that can cause or increase anxiety in your child/teen:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mood Disorder Questionnaire**

|  |  |  |
| --- | --- | --- |
| **Has there ever been a period of time when your child was not their usual self and……** | **Yes** | **No** |
| They felt so good or so hyper that you thought they were not their normal self or they were so hyper that it got them into trouble? |  |  |
| They were so irritable that they shouted at people or started fights or arguments? |  |  |
| They seemed to feel more self-confident than usual? |  |  |
| They got much less sleep than usual and seemed like they didn’t really miss it? |  |  |
| They were much more talkative or spoke much faster than usual? |  |  |
| Seemed as though their thoughts were racing or they couldn’t slow their mind down? |  |  |
| They were so easily distracted by things around them that they had trouble concentrating or staying on track? |  |  |
| They had much more energy than usual? |  |  |
| They were much more active or did many more things than usual? |  |  |
| They were much more social or outgoing than usual? |  |  |
| They did things that were unusual for them or that other people might have thought were excessive, foolish or risky? |  |  |
| **Total Number of “Yes” responses** |  |

Has your child/teen abused any of the following substances:

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Alcohol |  |  |
| Marijuana |  |  |
| Prescription Drugs |  |  |
| Other Substances |  |  |

Does your child/teen smoke or vape? Yes No

If other substance abused, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in the household smoke cigarettes? Yes No Former Smoker

How many per day? ½ Pack per day 1 Pack per day Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in the family/household have a history of addiction?

 Yes No Ongoing Past

 If YES, what is the relationship of the person to the child/teen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If YES, person’s drug of choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If YES, last use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If they have an active addiction, what is their longest period of sobriety? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have they experienced drug withdrawals? Yes No

Do they attend AA/NA/12- Step Meetings? Yes No

Has your child/teen been a patient in a psychiatric hospital or in a rehab program for a mental health or a drug/alcohol problem? Yes No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Hospital | City, State | Dates of treatment | Partial Hospital/intensive outpatient or inpatient | Treatment reason |
|  |  |  |  |  |
|  |  |  |  |  |

Has your child/teen ever seen a psychiatrist or counselor in the past? Yes No

|  |  |  |  |
| --- | --- | --- | --- |
| Name of counselor/psychiatrist | City, State | Dates Seen | Treatment reason |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Any prior major medical (non-psychiatric) hospital admissions:

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital Name | City, State | Dates | Reason |
|  |  |  |  |

Major Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, when did menses (1st period) begin in your child/teen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, is teen currently pregnant? Yes No N/A

If applicable, is teen breast-feeding or pumping breast milk for infant feedings? Yes No N/A

If your child/teen generally healthy? Yes No

Please indicate if your child/teen has a history of the following:

|  |  |  |
| --- | --- | --- |
|  | Yes / No | Onset |
| Abnormal changes in weight or changes in strength or exercise tolerance |  |  |
| Frequent headaches or a head injury |  |  |
| Changes in hearing, ringing in ears, bleeding, vertigo |  |  |
| Frequent nose bleeds, colds, obstruction, discharge  |  |  |
| Dental difficulties, gingival bleeding, use of dentures |  |  |
| Difficulty breathing, wheezing, coughing up blood, cough |  |  |
| Chest pains, palpitations, fainting, shortness of breath, irregular heartbeat |  |  |
| Urinary urgency, painful urination, changes in nature of urine |  |  |
| Change in menses, cramping, pelvic pain |  |  |
| Pain in muscles or joints, limitation of range of motion, tingling or numbness |  |  |
| Weakness, tremor, seizures, changes in mental function, problems with muscle coordination |  |  |
| Changes in sleep habits, difficulty sleeping, insomnia |  |  |

Has your child/teen ever severely restricted food intake, or made themselves intentionally throw up or engaged in other behaviors to try to control their weight? Yes No

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Medical History |
| Myself | Mother | Father | Sibling | Please check the following medical history conditions for your child/teen or close family members indicated |
|  |  |  |  | Bipolar |
|  |  |  |  | Depression |
|  |  |  |  | Anxiety |
|  |  |  |  | Addiction |
|  |  |  |  | Attention Deficit Disorder |
|  |  |  |  | Other psychiatric illness, describe: |
|  |  |  |  | Family history of completed suicide |
|  |  |  |  | Heart disease/ Structural cardiac heart defects |
|  |  |  |  | Sudden Cardiac Death (sudden heart attack in 20’s or 30’s) |
|  |  |  |  | Heart arrhythmias |
|  |  |  |  | Seizure Disorder |
|  |  |  |  | High Blood Pressure |
|  |  |  |  | Thyroid Disease |
|  |  |  |  | Kidney Disease |
|  |  |  |  | Liver Disease (Hepatitis / Cirrhosis) |
|  |  |  |  | Sleep Apnea |
|  |  |  |  | Narcolepsy |
|  |  |  |  | Autoimmune disease, if yes specify: |
|  |  |  |  | Diabetes |
|  |  |  |  | Coronary Artery Disease |
|  |  |  |  | Stroke |
|  |  |  |  | Chronic Kidney Disease |
|  |  |  |  | Congestive Heart Failure  |
|  |  |  |  | Asthma or other Respiratory illness |

Does your child/teen have any other chronic medical conditions? Yes No

 If YES, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child/Teen’s Current Height: \_\_\_\_\_\_\_\_ feet \_\_\_\_\_\_\_\_ inches

Child/Teen’s Current Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs

**Medication List**

Please list **ALL** current prescribed and over the counter medication:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Strength | Prescriber | Dates started |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

List any psychiatric medications your child/teen have tried in the past (not listed above)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Strength | Prescriber | Dates used | Why did you stop the medication?  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Is your child/teen allergic to any medications? Yes No Known Drug Allergies

If YES, please list the medication and the reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the parent/legal guardian, give consent to retrieve all medication records from pharmacy and/or prescribers?

 Yes No

**Sleep Questionnaire**

|  |
| --- |
| How likely is your child/teen to doze off or fall asleep in the following situations, in contrast to just feeling tired?  |
| **Situation 0- Least Likely 3- Most Likely** |
| Sitting and reading | 0 | 1 | 2 | 3 |
| Sitting and watching TV or a video | 0 | 1 | 2 | 3 |
| Sitting in a classroom at school during the morning  | 0 | 1 | 2 | 3 |
| Sitting and riding in a car or a bus for about half an hour  | 0 | 1 | 2 | 3 |
| Lying down to rest or nap in the afternoon | 0 | 1 | 2 | 3 |
| Sitting and talking to someone | 0 | 1 | 2 | 3 |
| Sitting quietly by yourself after lunch  | 0 | 1 | 2 | 3 |
| Sitting and eating a meal  | 0 | 1 | 2 | 3 |

Please total your score. Total=\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| 1. Do you feel your child/teen’s work, home, or social life is negatively affected by the above? Yes No |
| 2. Does your child/teen feel tired or sleepy when you need to be awake? Yes No |
| 3. Does your child/teen snore loudly on most nights? Yes No |
| 4. Does your child/teen have morning headaches? Yes No |
| 5. Does anyone in your family snore loudly or have sleep apnea? Yes No |
| 6. Does your child/teen sleep walk? Yes No |
| 7. Does your child/teen have creepy, crawly, legs at night that keep them Yes Noawake on most nights of the week? |
| 8. Does your child/teen have “sleep attacks” during the day while laughing Yes Noor experiencing strong emotions?  |

What is your child/teen’s usual sleep schedule:

 What time do they go to sleep on a typical school day?\_\_\_\_\_\_\_\_\_\_\_

 What time do they awaken on a typical school/work day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long does it take your child/teen to fall asleep on most nights:

Less than 20 minutes 20-40 minutes Greater than 40 minutes

Please describe your child/teen’s average nighttime routine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Drug Screen Policy**

At the initial evaluation and from time to time during treatment, patients may be asked to submit a urine specimen for analysis for drugs. The results of these look to see if in fact the patient is taking medications prescribed and also to verify that the patient is not using other unauthorized substances. For the wellbeing and health of our patients the screening will also help to determine there are no dangerous interactions between multiple drugs.

This fee is normally covered by insurance, but there may be a co-pay or balance owed after the insurance pays. It is the responsibility of the patient to take care of these fees owed. If you do not have insurance or your insurance does not cover it, we will collect $15 as a charge for this urine drug screen test.

By your signature below, you indicate that you have read, understand, and agree with this policy. This document will be scanned into your permanent medical records and you may request a copy of it for your own files.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of parent/legal guardian Date