Ivy Collaborative Healthcare

Child and Adolescent New Patient Information

Name (First, MI, Last, Suffix): _____

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone (main): _____

Patient Demographics:

DOB:(mm/dd/yyyy): _____ Age:_____

Race: _____ Ethnicity: _____ Sexual Orientation _____

Gender Identity _____ Assigned sex at birth: _____ Pronouns: _____

Guarantor Demographics (who is Primary on Insurance)

Guarantor name: _____ DOB:(mm/dd/yyyy): _____

Mobile Phone (main): _____ Consent to leave a message? ☐ Yes ☐ No

SSN:_____ Email:_____

Employer: _____ Patient's relationship to guarantor: _____

Guarantor's Mailing Address: ☐ (check if same as patient)

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance:

Company Name: _____ Phone: _____

Address (may be a PO Box): _____

City: _____ State: _____ Zip: _____

ID#: _____ Group #: _____

Subscriber (Primary on Insurance):_____ Relationship: _____

Secondary Insurance (if applicable): ☐ None

Company Name: _____ Phone: _____

Address (may be a PO Box): _____

City: _____ State: _____ Zip: _____

ID#: _____ Group #: _____

Subscriber (Primary on Insurance):_____ Relationship: _____

Visit Information

Name of person completing this form: _____ **Relationship to patient**: _____

What events or circumstances prompted you to contact us at this time? _____

_____

_____

Please describe what you believe has caused the difficulties the patient is experiencing. _____

_____

_____

What has been done to help these challenges? _____

_____

_____

List any family difficulties or upsetting events (ex. Illness or death of a family member or close relative, moves, financial challenges, marital stress, abuse (emotional/sexual/physical)? _____

_____

_____

What would you like to gain from working with us? What are your goals? _____

_____

_____

_____

List all <u>Current</u> psychiatric and non-psychiatric medications including over the counter, herbal medications and vitamins.

Name of Medication	How many milligrams (mg)?	When is it taken? (am, pm, twice a day, etc.)	Reason for medicine?
1			
2			
3			
4			
5			

Preferred Pharmacy Name: _____ Location: _____

Mail Order Pharmacy: ☐ None _____

Previous Psychiatric/Psychological Treatment

Prior Psychiatric diagnoses: ☐ None _____

Suicide Attempts? ☐ No ☐ Yes (when/what age?)_____

_____

Self-Harm? (eg. Cutting, burning) ☐ No ☐ Yes (how often?)_____

Violent behavior? ☐ No ☐ Yes (when/where?) _____

Has the patient had any suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Has the patient ever engaging in talk therapy before? ☐ Yes ☐ No

Have you ever worked with a Psychiatrist before? ☐ Yes ☐ No

Psychiatrist or Therapists name(s). Please indicate when and how long were you were in treatment?

_____

_____

_____

Any guns or weapons at home? ☐ No ☐ Yes If yes, how/where are they stored?_____

Previous Psychiatric Medication trials:

Medication	Dose	Frequency	Duration of treatment (ex. days, weeks, months, years)	Side Effect(s)
1				
2				
3				
4				
5				

Psychiatric Hospitalizations and/or Residential Treatment:

Dates	Hospital	Reason

Social History:

Family Members at home (spouse, parents, children, siblings and/or other relatives):

1. Name _____ Relationship to the patient:_____
2. Name _____ Relationship to the patient:_____
3. Name _____ Relationship to the patient:_____
4. Name _____ Relationship to the patient:_____
5. Name _____ Relationship to the patient:_____
6. Name _____ Relationship to the patient:_____

Education:

Name of School _____ Current Grade: _____

Has the patient ever skipped a grade or needed to repeat a grade? N/A Skipped Repeated

What grades does the patient typically earn/receive? A's B's C's D's F's

Has the patient been suspended from school in the past? ☐ Yes ☐ No

Occupation: Currently Working? ☐ No ☐ Yes If currently working, where: _____

Has the patient ever been abused: Physically? N/Y Sexually? N/Y Emotionally? N/Y

Did the patient know the person who committed the abuse? ☐ Yes ☐ No

Thank you for completing this form.

Who may we thank for your referral (Physician, Nurse, Teacher, Counselor, Family, Friend): _____

Signature Acknowledgement

Your signature serves as a comprehensive signature acknowledgement for the following forms and policies. Please access the patient portal to review and print your documents or they can be printed for you upon request. You further acknowledge that you have read, understand and accept each policy in its entirety.

- ✓ **HIPPA Form**
- ✓ **Controlled Substance Agreement**
- ✓ **Payment Policy**
- ✓ **Treatment Consent**

Patient/Guardian Signature: _____ Date:_____

Print name: _____