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: ____