DW SIEVERT M.D., INC.

7766 N. Palm Ave., SUITE 107
FRESNO, CA 93711
Ph. 559-435-0800 Fax. 559-435-7720

WELCOME TO OUR PRACTICE

Thank you for scheduling your appointment with our providers. We look forward to meeting you!

GENERAL INFORMATION

Please arrive 30 minutes prior to the first appointment with your paperwork completely filled out (prior to your arrival), along with your insurance card(s) and any other paperwork requested by our office.

Directions: Take Herndon to Palm, turn north on Palm, before you get to the Nees light we are located on your right side. We are located next to Suncrest Bank.

It is our office policy that you provide us with payment in full at the time of the first visit, unless you are part of an HMO/PPO that provides us with a specific co-pay amount which you are required to pay at the time of service. Otherwise, please contact our office in advance of your appointment to be told the exact amount you will need to pay at the time of your first visit. We will bill your insurance and, if they pay for your services, we will apply your initial payment towards your account.

➔ You will need to bring in:
1. Mental Health Intake questionnaire - **FULLY COMPLETED**
2. Return all other forms in this packet, signed and initialed.
3. A **CLEAR** copy of the **FRONT** and **BACK** of all your insurance card(s) 7 days prior to your appointment.

➔ It is your responsibility to contact your insurance company to open your case for pre-authorization for treatment and confirm benefits before your first appointment:
1. Call your insurance company and get a prior authorization for **"Outpatient Mental Health"** services.
2. Ask for the **"Insurance Claim Mailing Address"** to submit your mental health claims.

You may also bring this information into the office before your appointment and we will gladly copy your insurance card(s) for you and help you complete the packet. You may also e-mail your completed packet to **DWSMD@mysecurechart.com.**

OFFICE POLICIES

APPOINTMENTS

Patients are seen only by appointment. Before you first visit, please complete all of the forms which have been sent to you and be sure to bring them with you to your first appointment.

You will not be seen in our office unless all forms are filled out prior to your visit.

This will allow the office staff and the providers to serve you in the most time efficient manner possible. If this information cannot be completed prior to your appointment, please arrive one hour early in order to complete the forms. If they are already complete, **please arrive 15 minutes before your first appointment** so that the staff can prepare your chart.

Upon arrival at the office for any appointment, always check in with the receptionist so that the providers can be informed that you arrived.

PRESCRIPTION REFILL POLICY

During your appointment, your provider will write a prescription with the number of refills he/she feels is needed and safe. With your last refill, ensure you have an appointment with your provider for a medication refill at least two weeks before your medication runs out. At the time of your appointment, your provider will review your medications and write for appropriate refills. Medication refills will not be authorized over the phone or by fax.

Please remind your provider if you require a 90 day prescription and clarify the pharmacy we have on record is correct. Patients are asked to respect the privacy and time concerns of patients who have appointments. In consideration of both patients and providers, patients are reminded not to walk in to the clinic to request a prescription refill. Certain controlled substances may require a monthly appointment.

CANCELLATIONS / MISSED APPOINTMENTS:

When you schedule an appointment, that time is reserved specifically for you. Appointment reminder sheets are printed on your check-out sheet whenever subsequent appointments are scheduled at the office. **It is the patient's responsibility to remember and keep scheduled appointments.** A minimum of 24 hours notice is required for canceling or re-scheduling an appointment.

You will be charged **$100** for missed appointments and appointments which are canceled with less than 24 hours notice.

DISCHARGE:
Three consecutive no shows or three consecutive cancelations will trigger an automatic discharge from our practice unless indicated otherwise by your provider.

FINANCIAL RESPONSIBLITY:
- Co-pays or deductibles are due at time of service.
- A minimum of $20.00 will be collected on all services with a deductible or where a deductible applies. Applicable adjustments will be made once your insurance carrier has paid for services rendered.
- Cash discounts are given only at the time of the appointment when ***paid in full*** at check-in.
- Missed Appointment / Late Cancellation Fees $100.00

PAYMENT:
Co-pays and Deductibles are collected prior to your appointment when you check-in. **If you have no insurance, payment in full is required and must be paid prior to your appointment at the time of check-in.**
Many insurance plans require prior authorization for mental health services. It is the patient's responsibility to obtain the authorization for the first visit. We are happy to bill your Insurance with the information you provide us, however, payment by your insurance company is not guaranteed. If your claim is denied or there is lack of authorization, you are responsible for the billed amount.

CONFIDENTIALITY AND RELEASE OF INFORMATION
Information disclosed within sessions and the written records pertaining to those sessions are confidential and will not be released to anyone without the written consent of the patient or the parent/guardian, in the case of minors and/or dependent adults, except where DW Sievert, M.D., Inc. is mandated by California law to report otherwise confidential information. Circumstances which are required by law to be reported are:

1. Patients who pose an imminent threat of danger to themselves or others.
2. Instances of suspected abuse or neglect of a child (physical, sexual and/or emotional abuse).
3. Instances of suspected abuse or neglect of a dependent adult.

Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from DW Sievert, M.D., Inc. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Providers will use their clinical judgment when revealing such information.

Disclosure of confidential information may be required by your health insurance or workman's compensation carrier, or HMO/PPO/MCO/EAP in order to process your claims. Only the minimum necessary information will be communicated to the carrier. Providers have no knowledge or control over what insurance companies do with the information submitted and assumes no responsibility for any actions which result from a third party misusing or re-releasing such information without his expressed consent.

As a patient, you have the right to review or receive a summary of your records at any time (with notice of 10 or more working days), except in limited legal or emergency circumstances or when DW Sievert, M.D., Inc. assesses that releasing such information might be harmful in any way. In such circumstances DW Sievert, M.D., Inc. may provide the records to a qualified mental health professional of your choice and that individual may then choose to review the information with you if it is deemed clinically appropriate. You will be charged an appropriate fee for any preparation time which is required to comply with an information request.

All other requests to release information regarding your treatment and your condition must be authorized in writing specifically allowing the release of psychiatric records. DW Sievert, M.D., Inc. will provide you with a Release of Information form or you may choose to place your request in writing. There will be no charge for releasing records to other treating medical or mental health professionals. For all other requests to copy records, there will be a minimum charge of $25.00 to cover the expenses of photocopying, postage and handling.

FINANCIAL AGREEMENT & OFFICE BILLING / INSURANCE POLICIES

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.

2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.

3. I understand that if my insurance(s) require a referral from my primary care physician, DW Sievert, M.D., Inc. must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).

4. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.

5. I authorize direct payment by my insurance company(s) to DW Sievert, M.D., Inc.

6. I accept ultimate responsibility for payment for the services that I or my dependent(s) receive, whether or not my insurance(s) cover these services. This includes, but is not limited to fees for: clinical services or treatment, failed appointments and/or appointments not cancelled with 24 hours notice, report/letter writing, time spent in court or talking with attorneys on my behalf or the behalf of my dependent(s), telephone conversations longer than 5 minutes, site visits, reading records, longer sessions, travel time, etc.

7. I understand that I will receive a statement if I have an outstanding balance on my account, and I am to pay any portion that is my responsibility within 15 days of receipt of a statement. A finance charge of 1% per month may be added to my account if payment is overdue.

8. I understand that there will be a $25.00 service fee for any checks returned by my bank due to nonsufficient funds, closed accounts, etc. I agree to accept full responsibility for such fees. The amount of the returned check, plus the service fee, must be paid within 10 days of written notice.

9. I will notify the Office if any problem arises regarding my ability to make timely payments. If my account is overdue (unpaid) and there is no agreement on a payment plan, I understand that this office can use legal means (court, collection agency, etc.) to obtain payment.

10. I am aware of DW Sievert, M.D., Inc.'s office policy requiring 24 hours notice to cancel an appointment. I understand that I may notify the office staff or the answering service of my intention to cancel an appointment. I further acknowledge that I will be charged $100.00 for any appointment which I or my dependent(s) fail to keep without providing 24 hours notice.

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.

_____
Patient Name (Printed)

_____
Responsible Party (Printed) (If patient is a minor or dependent adult)

_____ _____
Signature of Responsible Party Date

DW SIEVERT M.D., INC.

Patient Registration

Are these services Court ordered? ❑ Yes ❑ No

PATIENT INFORMATION ❑ New Patient ❑ Information Update

Patient Name: _____ Social Security #: _____
Date of Birth: _____ Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Other
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____
Primary Contact Phone: _____ Secondary Phone: _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Education Level: _____ Highest Grade Completed: _____
Race: ❑ Asian ❑ Black ❑ Native American ❑ White ❑ More than one race Preferred Language: _____
Ethnicity: ❑ Hispanic ❑ Non-Hispanic
Smoking Status: Current Smoker: ❑ Yes ❑ No History of Smoking: ❑ Yes ❑ No Stop Date: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Referring Physician: _____ Driver's License #: _____

SPOUSE / PARTNER INFORMATION (If relevant)

Spouse/Partner Name: _____
Date of Birth: _____ Sex: ❑ Male ❑ Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____

FINANCIAL RESPONSIBILITY (Must complete if patient/client is under 18 years of age)

Responsible Party: _____ Social Security #: _____
Relationship to Subscriber: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____

INSURANCE INFORMATION (Must complete ALL the information below in order to bill your Insurance)

Primary Insurance: _____ Subscriber Name : _____
Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____
Claim Mailing Address: _____ City: _____ State: _____ Zip: _____
Relationship to Patient: _____
Secondary Insurance: _____ Subscriber Name : _____
Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____
Claim Mailing Address: _____ City: _____ State: _____ Zip: _____
Relationship to Patient:

PHARMACY INFORMATION (PLEASE FILL OUT COMPLETELY WITH CORRECT ADDRESS AND PHONE NUMBER)

Pharmacy Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Cross Street: _____ Pharmacy Phone#: _____
Mail Order Pharmacy Phone #: _____ Pharmacy Fax #: _____

SIGNATURE and DATE

Patient or Responsible Party: _____ Date: _____

DW SIEVERT M.D., INC.

Authorization to Obtain Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of PHI on the above named individual which may contain medical, mental health, or substance abuse history and treatment information.

Name of organization or individual authorized to disclose the information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Are there any restrictions on PHI to be disclosed? ❒ Yes ❒ No

_____No one other than myself may have access to my medical records:

May our office leave a message on your answering machine? ❒ Yes ❒ No

I consent to the use or disclosure of my protected health information by DW SIEVERT M.D., Inc. for the purposes of diagnosis of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of DW SIEVERT M.D., Inc. I understand that diagnosis or treatment of me by DW SIEVERT M.D., Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information (PHI) is used or disclosed to carry out treatment, payment or healthcare operations of the practice. DW SIEVERT M.D., Inc. is not required to agree to the restrictions that I may request. However, if DW SIEVERT M.D., Inc. agrees to restriction that I request, the restriction is binding on DW SIEVERT M.D., Inc. I have the right to revoke this consent, in writing, at any time, except to the extent that DW SIEVERT M.D., Inc. has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This PHI relates to my past, present or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that the "Notice of Privacy Practices" describes how DW SIEVERT M.D., Inc. may disclose and use my protected health information (PHI). I am encouraged to read the "Notice of Privacy Practices" in full.

Signature: _____ Date: _____
(Patient Signature or Authorized Representative and relationship)

Printed Name: _____

DW SIEVERT M.D., INC.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This is a read "friendly" version. A complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Dwight W. Sievert, M.D., Inc.

7766 N. Palm Ave., Suite 107
Fresno, CA 93711
(559) 435-0800 FAX (559) 435-7720

Child/Adolescent Psychological History

Date:_____

Name of person filling out form _____ Relationship to patient _____
Patient Name:_____ Sex:_____ Age:_____ Date of Birth:_____
Social Security #_____ School:_____ Grade:_____ Teacher:_____
Home Address:_____
Home Phone:_____ Parent's Work Phone:_____
Referred By:_____ Reason For Referral:_____
Litigation Pending?_____ Attorney:_____ Phone:_____

History of Present Problem

How long ago did the problem(s) begin: _____

Please describe the problems that you would like help with:

Psychiatric History

Place a check for each symptom that applies.

- ☐ Suicidal thoughts
- ☐ Depression/sadness
- ☐ Recurrent/intrusive thoughts
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Overeating
- ☐ Weight gain
- ☐ Difficulty sleeping
- ☐ Apathy
- ☐ Fatigue
- ☐ Loss of interest in almost all activities
- ☐ Feeling worthless
- ☐ Feelings of hopelessness
- ☐ Poor self esteem
- ☐ Sexual problems
- ☐ Anorexia or Bulimia
- ☐ Unmotivated
- ☐ Dependent
- ☐ Quiet
- ☐ Resists change
- ☐ Wetting bed or clothes
- ☐ Bowel movements in underwear
- ☐ Emotional
- ☐ Immature
- ☐ Is very fidgety
- ☐ Can't remain seated
- ☐ Can't wait his/her turn when playing with others
- ☐ Answers before s/he hears the whole question
- ☐ Rarely follows other's instructions
- ☐ Destroys other people's property
- ☐ Is cruel to animals
- ☐ Starts fights with others
- ☐ Homicidal thoughts
- ☐ Anxiety/nervousness
- ☐ Nightmares
- ☐ Recurrent/intrusive disturbing recollections or dreams
- ☐ Overwhelming need to perform certain behaviors/rituals
- ☐ Excessive fears or phobias
- ☐ Significant concerns with physical problems
- ☐ Poor frustration tolerance
- ☐ Explosive anger
- ☐ Rapid mood changes
- ☐ Euphoria (feel on top of the world)
- ☐ Racing thoughts
- ☐ Decreased need for sleep
- ☐ Aggressive
- ☐ Visual or auditory hallucinations
- ☐ Stomach aches
- ☐ Bizarre behavior
- ☐ Shy and withdrawn
- ☐ Self-mutilates
- ☐ Self-stimulates
- ☐ Exhibits sexually inappropriate behavior
- ☐ Risk-taking
- ☐ Is cruel to other people
- ☐ Swears a lot
- ☐ Steals things without people knowing on several occasions
- ☐ Often runs away from home and stays away overnight
- ☐ Easily lies to others
- ☐ Firesetting
- ☐ Doesn't go to school
- ☐ Breaks into other people's property
- ☐ When fighting, has used a weapon
- ☐ Other unusual behavior: _____

Indicate which stressors the child is experiencing currently (within last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
____	____	Death of family member	____	____	Illness of family member	____	____	Illness of friend
____	____	Personal injury/illness	____	____	Parents separated	____	____	Parents divorced
____	____	Conflicts with family	____	____	Conflicts with friends	____	____	Conflicts at school
____	____	Academic difficulties	____	____	Change in residence	____	____	Legal problems
____	____	Sexual assault	____	____	Incest/sexual abuse	____	____	Physical abuse
____	____	Verbal/emotional abuse	____	____	Other problems: _____			

Is s/he currently receiving therapy?_____ From who?_____
When did s/he start therapy? _____ For what problems(s)? _____
_____
List current psychiatric medications and dosages: _____

Has s/he received therapy in the past?_____ From who? _____
When (Start and finish): _____ For what problem(s)? _____
_____
List past psychiatric medications:_____

Has s/he been hospitalized for psychological problems? _____ When? _____
Where was s/he hospitalized? _____
Has s/he ever attempted suicide?_____ When?_____ How?_____

Substances s/he currently uses (Even if only occasionally or in small amounts):

☐Alcohol ☐Tobacco ☐Marijuana ☐Barbiturates ("Downers") ☐Tranquilizers
☐Amphetamines ("Speed") ☐Crank ☐Crack ☐Cocaine ☐Opiates (Heroine, Opium, Codeine, etc.)
☐Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) ☐PCP ("angel dust") ☐Other: _____

Substances s/he has taken in the past (Even if only occasionally or in small amounts):

☐Alcohol ☐Tobacco ☐Marijuana ☐Barbiturates ("Downers") ☐Tranquilizers
☐Amphetamines ("Speed") ☐Crank ☐Crack ☐Cocaine ☐Opiates (Heroine, Opium, Codeine, etc.)
☐Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) ☐PCP ("angel dust") ☐Other: _____

Has your child had a prior psychological or neuropsychological evaluation? ☐Yes ☐No

Name of psychologist: _____
Address: _____
Phone: _____ Date of and reason for this evaluation: _____
Findings of the evaluation: _____

Birth and Developmental History

Place of Birth: _____ Were parents married at time of birth?_____
Was mother under a doctors care during the pregnancy?_____ Was the child adopted?_____ If so, at what age?_____

Any illnesses during pregnancy:
☐Anemia ☐Toxemia ☐Herpes ☐Measles ☐German measles ☐Bleeding
☐Kidney disease ☐Heart disease ☐Hypertension ☐Abdominal trauma ☐Infection ☐Diabetes

Medications taken during pregnancy:_____
Were drugs or alcohol taken during pregnancy? ☐Yes ☐No If yes, specify:_____
Was there significant emotional stress during pregnancy? ☐Yes ☐No If yes, name stressors: _____

Was the birth: ☐On time Was ☐Premature (By how long _____) ☐Late (By how long _____)
labor: ☐Spontaneous Was the ☐Induced Duration of labor___ (Hours) Cesarean required?_____
presentation: ☐Normal ☐Breach ☐Transverse (Crosswise) ☐Posterior first
Did the baby experience any of these problems: Fetal distress ___ Prolapsed cord ___ Low placenta (Placenta previa) ___ Premature separation of the placenta (Abruptio placenta) ___ Cord wrapped around neck ___
Any other problems that mother or child had: _____
Was general anesthesia used? _____Were forceps used? _____Were there breathing problems?_____
Color at birth: Normal ____ Blue ____ Yellow ____ Was oxygen used (How long)?_____ APGAR Score ____
Birthweight:_____ Length:_____

Check those that apply to the first few weeks after birth:

☐Excessive sleeping ☐Laziness ☐Irritability ☐Excessive crying ☐Stiffness ☐Limpness ☐Tremors
☐Twitching ☐Feeding difficulties ☐Vomiting ☐Jaundice Other_____ Transfusions required?
____ Medication required? (For what)_____ Surgery required?
(For what)_____

Give approximate ages that developmental milestones were achieved:

Head control_____ Rolled over_____ Sat alone_____ Walked____ Run____
Said first word_____ Used sentences_____ Self feeding w/ utensils_____ Toilet trained____
Dress self_____ Tie shoes_____ Color within lines_____

Check any problems that occurred in later development:

☐Hearing ☐Speaking ☐Stuttering ☐Reading ☐Writing ☐Spelling ☐Arithmetic ☐Behavior ☐Hyperactivity
☐Attentional difficulties ☐Seizures ☐Coordination

List family members with developmental or learning problems:_____

Medical History

Please check all the conditions that have been diagnosed.

- ☐ AIDS, ARC or HIV+
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Abscessed ears
- ☐ Arteriosclerosis
- ☐ Bleeding disorder
- ☐ Blood disorder
- ☐ Broken bones
- ☐ Brain disease
- ☐ Cerebral palsy
- ☐ Colds (excessive)
- ☐ Chicken pox
- ☐ Hormone problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Enzyme deficiency
- ☐ Encephalitis
- ☐ Ear Infections
- ☐ Fevers (104 or higher
- ☐ Genetic disorder
- ☐ Head injury/concussion
- ☐ Heart problems
- ☐ Hereditary disorder
- ☐ Headaches
- ☐ Hearing problems
- ☐ Huntington's disease
- ☐ Hypertension
- ☐ Oxygen deprivation
- ☐ Hazardous substance exposure
- ☐ Immune system disease
- ☐ Jaundice
- ☐ Kidney problems
- ☐ Liver disorder
- ☐ Lung disease
- ☐ Lead poisoning
- ☐ Leukemia
- ☐ Metabolic disorder
- ☐ Meningitis
- ☐ Measles
- ☐ Mumps
- ☐ Malnutrition
- ☐ Multiple sclerosis
- ☐ Carbon monoxide poisoning
- ☐ Poisoning
- ☐ Polio
- ☐ Parkinson's Disease
- ☐ Rheumatic Fever
- ☐ Radiation exposure
- ☐ Scarlet fever
- ☐ Senility (Dementia)
- ☐ Stroke or TIA
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Thyroid disease
- ☐ Venereal disease
- ☐ Vision problems
- ☐ Pneumonia
- ☐ Whooping cough
- ☐ Other medical/physical problems_____

Has your child ever been diagnosed with epilepsy or a seizure disorder ☐ Yes ☐ No If yes, check the one you have been diagnosed with.

PARTIAL
- ☐ Simple partial (Jacksonian)
- ☐ Complex partial (Psychomotor)
- ☐ Partial evolving into generalized

GENERALIZED
- ☐ Absence (Petit mal)
- ☐ Myoclonic
- ☐ Clonic
- ☐ Tonic
- ☐ Tonic-clonic (Grand mal)
- ☐ Atonic

☐ UNCLASSIFIED TYPE

List any medications currently being taken (over-the-counter or prescription), and the dosage.

Medication and Dosage

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List any medications your child is ALLERGIC or sensitive to: _____

Past Hospitalizations (When, where and for what):

_____
_____
_____
_____
_____

Outpatient Surgeries (When, where and for what):

_____
_____
_____

Name of family physician:_____
Address:_____
Phone:_____ Date of your last medical check-up:_____

Medical Testing

Check all medical tests that recently have been done and report any abnormal findings:

	Check here if normal	Abnormal findings
☐ Angiography	☐	_____
☐ Blood work	☐	_____
☐ Brain scan	☐	_____
☐ CT scan	☐	_____
☐ EEG	☐	_____
☐ Lumbar puncture or spinal tap	☐	_____
☐ Magnetic Resonance Imaging (MRI)	☐	_____
☐ Neurological office exam	☐	_____
☐ PET scan	☐	_____
☐ Physicians office exam	☐	_____
☐ Skull x-ray	☐	_____
☐ Ultrasound	☐	_____
☐ Other testing: _____	☐	_____

Family History

Father's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____
Mother's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____
Date of parent's marriage _____ Years married ____ Current marital problems? ____ If separated, give date _____
If divorced, date_____ Previous marriages? (Father) _____ (Mother) _____
Subsequent marriages? (Father)_____ (Mother)_____
If divorced, current custody arrangement _____

Please provide information regarding step-parents if parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Names and ages of brothers and sisters (Include step-brothers and step-sisters):
_____
_____
_____

List anyone else who has lived in the home during your child's life: _____

List names of any family members (e.g. Immediate and distant relatives) with any of the following problems:

Alcohol/drug abuse _____
Criminal history _____
Emotional/behavioral problems _____
Medical problems (e.g. Heart disease, Cancer, Seizures) _____
Learning/developmental problems _____

Social History

How long has s/he lived in current home? _____ Apartment or house? _____ How long in this town? _____
How many changes in residence in child's lifetime? _____ Ages moves occurred? _____
What towns has s/he lived in the past?_____ _____

How many friends does your child have in your neighborhood?___ First name of best friend in neighborhood: _____

How often does s/he play with neighborhood friends? _____ Any conflict problems (What type)? _____
What are his/her most frequent play activities? _____
How many friends does s/he have at school? _____ First name of best friend at school: _____
Is your child well liked/accepted at school? _____ Any conflict problems (What type)? _____

Does s/he have a girlfriend/boyfriend? _____ First name: _____ Involved how long? _____
Is this relationship stable? _____ Type of problems (if any): _____
How many girlfriends/boyfriends in the past? ___ Starting at what age: ___ Is s/he currently sexually active? _____
When did s/he first become sexually active? ____ Currently using birth control (What type)? _____
Any aborted pregnancies/miscarriages? ____ Any children outside of marriage? ____ Names/Ages: _____

List clubs and organizations that s/he is involved in: _____
_____
Is your child involved in a church? _____ Denomination: _____ Attend how often? _____
What time/activities do you share with your child? _____
Please describe you last vacation (when & where): _____

Educational History

Current grade (Or highest grade/degree completed): _____ Current school: _____
Past schools attended (List in order): _____
_____
Hardest subject(s): _____ Favorite subject(s): _____
Grades earned in elementary school: _____ Junior High G.P.A _____ High School G.P.A. _____

Grades repeated: _____ Learning problems (what subjects): _____
Special education placement (Type): _____ During which grades: _____
Extracurricular activities (Music, Sports, Clubs, etc.) _____
Expulsions/suspensions/conduct problems (Type of problem and date): _____
Additional schooling or non-academic training: _____

Occupational History

Present employer: _____ Position: _____
Length of employment: _____ Hours worked per week _____ Current responsibilities: _____

List previous employment (Include dates and type of work):
_____
_____
_____
_____
_____
Have you ever been terminated from a job (Please explain): _____
At any time on the job were you ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)?
☐ Yes ☐ No If yes, explain: _____
Have you ever been injured on the job? ☐ Yes ☐ No If yes, explain: _____

Legal History

Present legal problems (Describe): _____
Past arrests (For what?): _____
Convictions (For what?): _____
Time served in juvenile hall, jail or prison (Give dates and locations): _____
_____

Child/Teen General Symptom Checklist

Parents please rate your child or teen on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have the child or teen rate him/herself as well. **For young children it may not be practical to have them fill out the questionnaire.** Use your best judgment and do the best you can.

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Parent	Ch/Tn			
____	____	1. depressed or sad mood		
____	____	2. not as much interest in things that are usually fun		
____	____	3. significant recent weight or appetite changes		
____	____	4. recurrent thoughts of death or suicide		
____	____	5. sleep changes, lack of sleep or marked increase in sleep		
____	____	6. low energy or feelings of tiredness		
____	____	7. feelings of being worthless, helpless, hopeless or guilty		
____	____	8. plays alone or appears socially withdrawn		
____	____	9. cries easily		
____	____	10. negative thinking	MD	5
____	____	11. periods of an elevated, high or irritable mood		
____	____	12. periods of a very high self esteem or big thinking		
____	____	13. periods of decreased need for sleep without feeling tired		
____	____	14. more talkative than usual or feel pressure to keep talking		
____	____	15. fast thoughts or frequent jumping from one subject to another		
____	____	16. easily distracted by irrelevant things		
____	____	17. marked increase in activity level		
____	____	18. cyclic periods of angry, mean or violent behavior	BD	4
____	____	19. periods of time where you feel intensely anxious or nervous		
____	____	20. periods of trouble breathing of feeling smothered		
____	____	21. periods of feeling dizzy, faint or unsteady on your feet		
____	____	22. periods of heart pounding, fast heart rate or chest pain		
____	____	23. periods of trembling, shaking or sweating		
____	____	24. periods of nausea, abdominal upset or choking		
____	____	25. intense fear of dying	PD	19+4
____	____	26. lacks confidence in abilities		
____	____	27. needs lots of reassurance		
____	____	28. needs to be perfect		
____	____	29. seems fearful and anxious		
____	____	30. seems shy or timid		
____	____	31. easily embarrassed		
____	____	32. sensitive to criticism		
____	____	33. bites fingernails or chews clothing	OA	4
____	____	34. persistent refusal to go to school		
____	____	35. excessive fear of interacting with other children or adults		
____	____	36. persistent, excessive fear (heights, closed spaces, specific animals, etc.) please list _____		
____	____	37. excessive anxiety concerning separation from home or from those to whom the child is attached.		

____ ____ 38. recurrent bothersome thoughts, ideas or images which you try to ignore
____ ____ 39. trouble getting "stuck" on certain thoughts, or having the same thought over and over
____ ____ 40. excessive or senseless worrying
____ ____ 41. others complain that you worry too much or get "stuck" on the same thoughts
____ ____ 42. compulsive behaviors that you must do or you feel very anxious, such as excessive hand washing, cleaning, checking locks, or counting or spelling
____ ____ 43. needing to have things done a certain way or you become very upset OC 4

____ ____ 44. recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire etc.), please list _____
____ ____ 45. recurrent distressing dreams of a past upsetting event
____ ____ 46. feelings of reliving a past upsetting event
____ ____ 47. spend effort avoiding thoughts or feelings related to a past trauma
____ ____ 48. feeling that your future is shortened
____ ____ 49. startle easily
____ ____ 50. feel like you're always watching for bad things to happen PTS 4

____ ____ 51. refusal to maintain body weight above a level most people consider healthy
____ ____ 52. intense fear of gaining weight or becoming fat even though underweight
____ ____ 53. feelings of being fat, even though you're underweight AN 2

____ ____ 54. recurrent episodes of eating large amounts of food
____ ____ 55. a feeling of lack of control over eating behavior
____ ____ 56. engage in activities to eliminate excess food, such as self induced vomiting, laxatives, strict dieting or strenuous exercise
____ ____ 57. persistent worry with body shape and weight BN 2

____ ____ 58. involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have motor tics been present?____ How often?_____describe_____
____ ____ 59. involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, swearing). How long have verbal tics been present?____ How often?_____ describe_____
____ ____ 60. repetitive, seemingly driven motor behavior (e.g., hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or bodily orifices, hitting own body) that interferes with normal activities or results in self-inflicted bodily injury that requires medical treatment (or would result in an injury if preventive measures were not used).
____ ____ 61. passage of feces in inappropriate places (e.g., clothing or floor).
____ ____ 62. bed wetting. If present, how often?_____
____ ____ 63. failure to speak in specific social situations (in which there is an expectation for speaking,e.g., at school) despite speaking in other situations.

____ ____ 64. delusional or bizarre thoughts (thoughts you know others would think are false)
____ ____ 65. visual hallucination, seeing objects or images are not really present
____ ____ 66. hearing voices that are not really present
____ ____ 67. odd behaviors
____ ____ 68. poor personal hygiene or grooming
____ ____ 69. inappropriate mood for the situation (i.e., laughing at sad events) 3

____ ____ 70. frequent feelings that someone or something is out to hurt you

---

____ ____ 71. problems with social relatedness before the age of 5, either by failing to respond appropriately to others or becoming indiscriminately attached to others
____ ____ 72. multiple changes in caregivers before the age of 5

____ ____ 73. steals
____ ____ 74. bullies, threatens, or intimidates others
____ ____ 75. initiates physical fights
____ ____ 76. cruel to animals
____ ____ 77. force others into things they do not want to do (sexually or criminally)
____ ____ 78. sets fires
____ ____ 79. destroys property
____ ____ 80. break in to others home, school, car or place of business
____ ____ 81. lies
____ ____ 82. stays out at night despite parental prohibitions
____ ____ 83. runs away overnight
____ ____ 84. cuts school
____ ____ 85. doesn't seem sorry for hurting others CD 4

____ ____ 86. negative, hostile, or defiant behavior
____ ____ 87. loses temper
____ ____ 88. argues with adults
____ ____ 89. actively defies or refuses to comply with adults' requests or rules
____ ____ 90. deliberately annoys people
____ ____ 91. blames others for his or her mistakes or misbehavior
____ ____ 92. touchy or easily annoyed by others
____ ____ 93. angry and resentful
____ ____ 94. spiteful or vindictive ODD 4

____ ____ 95. impairment in communication as manifested by at least one of the following: (Check those that apply)
- ____ delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
- ____ in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- ____ repetitive use of language or odd language
- ____ lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

____ ____ 96. impairment in social interaction, with at least two of the following: (Check those that apply)
- ____ marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- ____ failure to develop peer relationships appropriate to developmental level
- ____ lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- ____ lack of social or emotional reciprocity

____ ____ 97. repetitive patterns of behavior, interests, and activities, as manifested by at least one of following: (Check those that apply)
- ____ preoccupation with an area of that is abnormal either in intensity or focus
- ____ rigid adherence to specific, nonfunctional routines or rituals
- ____ repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- ____ persistent preoccupation with parts of objects

____ ____ 98. stutters

____ ____ 99. feel tired during the day
____ ____ 100. feel cold when others feel fine or they are warm
____ ____ 101. often feel warm when others feel fine or they are cold
____ ____ 102. problems with brittle or dry hair
____ ____ 103. problems with dry skin
____ ____ 104. problems with sweating
____ ____ 105. problems with chronic anxiety or tension Thy 2

____ ____ 106. Has difficulty learning math facts
____ ____ 107. Poor math grades or test scores
____ ____ 108. Has difficulty with abstract concepts and reasoning
____ ____ 109. Has difficulty remembering
____ ____ 110. Makes spelling errors in written assignments
____ ____ 111. Needs words repeated when taking spelling tests
____ ____ 112. Poor spelling grades or test scores
____ ____ 113. Has difficulty reading or spelling phonetically
____ ____ 114. Has difficulty sounding out unknown words
____ ____ 115. Poor reading grades or test scores
____ ____ 116. Avoids reading
____ ____ 117. Reading is slow or choppy
____ ____ 118. Complains about eye strain or fatigue
____ ____ 119. Squints, blinks or rubs eyes when reading
____ ____ 120. Skips words or lines when reading
____ ____ 121. Poor reading comprehension
____ ____ 122. Reverses letters or words
____ ____ 123. Has difficulty hearing
____ ____ 124. Has poor handwriting
____ ____ 125. Has poor coordination
____ ____ 126. Has difficulty writing a paper
____ ____ 127. Makes grammatical errors
____ ____ 128. Has poor vocabulary

Child/Teen Brain System Checklist

Parents please rate your child or teen on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have the child or teen rate him/herself as well. **For young children it may not be practical to have them fill out the questionnaire.** Use your best judgment and do the best you can.

	0 Never	1 Rarely	2 Occasionally	3 Frequently	4 Very Frequently	NA Not Applicable/Not Known

Ch/Tn	Parent				
__	__ 1.	Fails to give close attention to details or makes careless mistakes			
__	__ 2.	Trouble sustaining attention in routine situations (i.e., homework, chores, paperwork)			
__	__ 3.	Trouble listening			
__	__ 4.	Fails to finish things			
__	__ 5.	Poor organization for time or space (such as backpack, room, desk, paperwork)			
__	__ 6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort			
__	__ 7.	Loses things			
__	__ 8.	Easily distracted			
__	__ 9.	Forgetful			
__	__10.	Poor planning skills			
__	__11.	Lack clear goals or forward thinking			
__	__12.	Difficulty expressing feelings			
__	__13.	Difficulty expressing empathy for others			
__	__14.	Excessive daydreaming			
__	__15.	Feeling bored			
__	__16.	Feeling apathetic or unmotivated			
__	__17.	Feeling tired, sluggish or slow moving			
__	__18.	Feeling spacey or "in a fog"			8/6/4
__	__19.	Fidgety, restless or trouble sitting still			
__	__20.	Difficulty remaining seated in situations where remaining seated is expected			
__	__21.	Runs about or climbs excessively in situations in which it is inappropriate			
__	__22.	Difficulty playing quietly			
__	__23.	"On the go" or acts as if "driven by a motor"			
__	__24.	Talks excessively			
__	__25.	Blurts out answers before questions have been completed			
__	__26.	Difficulty awaiting turn			
__	__27.	Interrupts or intrudes on others (e.g., butts into conversations or games)			
__	__28.	Impulsive (saying or doing things without thinking first)		<3	8/6/4
__	__29.	Excessive or senseless worrying			
__	__30.	Upset when things do not go your way			
__	__31.	Upset when things are out of place			
__	__32.	Tendency to be oppositional or argumentative			
__	__33.	Tendency to have repetitive negative thoughts			
__	__34.	Tendency toward compulsive behaviors			
__	__35.	Intense dislike for change			
__	__36.	Tendency to hold grudges			
__	__37.	Trouble shifting attention from subject to subject			
__	__38.	Trouble shifting behavior from task to task			
__	__39.	Difficulties seeing options in situations			

__	__40.	Tendency to hold on to own opinion and not listen to others		
__	__41.	Tendency to get locked into a course of action, whether or not it is good		
__	__42.	Needing to have things done a certain way or you become very upset		
__	__43.	Others complain that you worry too much		
__	__44.	Tend to say no without first thinking about question		
__	__45.	Tendency to predict fear	ACG	10/7/4
__	__46.	Frequent feelings of sadness		
__	__47.	Moodiness		
__	__48.	Negativity		
__	__49.	Low energy		
__	__50.	Irritability		
__	__51.	Decreased interest in others		
__	__52.	Decreased interest in things that are usually fun or pleasurable		
__	__53.	Feelings of hopelessness about the future		
__	__54.	Feelings of helplessness or powerlessness		
__	__55.	Feeling dissatisfied or bored		
__	__56.	Excessive guilt		
__	__57.	Suicidal feelings		
__	__58.	Crying spells		
__	__59.	Lowered interest in things usually considered fun		
__	__60.	Sleep changes (too much or too little)		
__	__61.	Appetite changes (too much or too little)		
__	__62.	Chronic low self-esteem		
__	__63.	Negative sensitivity to smells/odors	DLS	10/7/4
__	__64.	Frequent feelings of nervousness or anxiety		
__	__65.	Panic attacks		
__	__66.	Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)		
__	__67.	Periods of heart pounding, rapid heart rate or chest pain		
__	__68.	Periods of trouble breathing or feeling smothered		
__	__69.	Periods of feeling dizzy, faint or unsteady on your feet		
__	__70.	Periods of nausea or abdominal upset		
__	__71.	Periods of sweating, hot or cold flashes		
__	__72.	Tendency to predict the worst		
__	__73.	Fear of dying or doing something crazy		
__	__74.	Avoid places for fear of having an anxiety attack		
__	__75.	Conflict avoidance		
__	__76.	Excessive fear of being judged or scrutinized by others		
__	__77.	Persistent phobias		
__	__78.	Low motivation		
__	__79.	Excessive motivation		
__	__80.	Tics (motor or vocal)		
__	__81.	Poor handwriting		
__	__82.	Quick startle		
__	__83.	Tendency to freeze in anxiety provoking situations		
__	__84.	Lacks confidence in their abilities		
__	__85.	Seems shy or timid		
__	__86.	Easily embarrassed		
__	__87.	Sensitive to criticism		
__	__88.	Bites fingernails or picks skin	BG	10/7/4

__	__ 89.	Short fuse or periods of extreme irritability		
__	__ 90.	Periods of rage with little provocation		
__	__ 91.	Often misinterprets comments as negative when they are not		
__	__ 92.	Irritability tends to build, then explodes, then recedes, often tired after a rage		
__	__ 93.	Periods of spaciness or confusion		
__	__ 94.	Periods of panic and/or fear for no specific reason		
__	__ 95.	Visual or auditory changes, such as seeing shadows or hearing muffled sounds		
__	__ 96.	Frequent periods of deja vu (feelings of being somewhere you have never been)		
__	__ 97.	Sensitivity or mild paranoia		
__	__ 98.	Headaches or abdominal pain of uncertain origin		
__	__ 99.	History of a head injury or family history of violence or explosiveness		
__	__ 100.	Dark thoughts, may involve suicidal or homicidal thoughts		
__	__ 101.	Periods of forgetfulness or memory problems	TLS	8/6/4

Signature: _____

Date: _____

Parent/Guardian Signature:
(if under age 18) _____ Date: _____

Emergency Contact: _____ Phone # _____

For Office Use Only:

Reviewed by: _____ Date: _____

PHQ-9 & GAD-7

Today's Date: _____ Date of birth: _____/_____/_____

First Name: _____ Last Name: _____

PHQ-9-Patient Health Questionnaire

Over the last 2 weeks, on how many days have you 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 ◯
2. Feeling down, depressed or hopeless	0 ◯	1 ◯	2 ◯	3 ◯
3. Trouble falling or staying asleep, or sleeping too much	0 ◯	1 ◯	2 ◯	3 ◯
4. Feeling tired or having little energy	0 ◯	1 ◯	2 ◯	3 ◯
5. Poor appetite or over eating	0 ◯	1 ◯	2 ◯	3 ◯
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0 ◯	1 ◯	2 ◯	3 ◯
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ◯	1 ◯	2 ◯	3 ◯
8. 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 ◯
9. Thoughts that you would be better off dead, or of hurting yourself	0 ◯	1 ◯	2 ◯	3 ◯
Add the score for each column		+	+	

Total Score (add your column scores)	

If you checked off any problems, how difficulty have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult_____ Very difficult_____ Extremely difficult_____

PHQ-9 & GAD-7

GAD-7
Generalized Anxiety Disorder 7-item scale

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0 ○	1 ○	2 ○	3 ○
2. Not being able to stop or control worrying	0 ○	1 ○	2 ○	3 ○
3. Worrying too much about different things	0 ○	1 ○	2 ○	3 ○
4. Trouble relaxing	0 ○	1 ○	2 ○	3 ○
5. Being so restless that it's hard to sit still	0 ○	1 ○	2 ○	3 ○
6. Becoming easily annoyed or irritable	0 ○	1 ○	2 ○	3 ○
7. Feeling afraid as if something awful might happen	0 ○	1 ○	2 ○	3 ○
Add the score for each column		+	+	

Total Score (add your column scores)	

If you checked off any problems, how difficulty have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult_____ Very difficult_____ Extremely difficult_____

Source: Sptizer, RL, Kroenke K, Williams JBW, Loew B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006; 166:1092-1097

A@663B 10-04-2005