REGISTRATION FORM (PLEASE PRINT)

Please circle one:
George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, ACC III;
Jennifer Wilson, PhD
Affiliates: Ashley Williams, PhD; Tina Nance, PMHNP-BC

Patient's Name ______________________ ___/___/___ ___-___-___
First M.I. Last Date of Birth (mm/dd/yyyy) SSN

Home Address ______________________
Street address Apt. # City State Zip Code

Home phone __________ Work __________ Cell __________

Email Address __________

Sponsor/Primary Insured __________ __________ ___-___-___
First M.I. Last Date of Birth (mm/dd/yyyy) SSN

Full Address if different from patient's __________

Employer __________ Occupation __________

Relationship __________ Home Phone __________ Work __________ Cell __________

If Patient is a child, other parent name: __________ Phone __________

Address, if different __________

Legal Guardian (or custodian) __________ Relationship __________ Type of Custody __________

Emergency contact name & phone __________
(If patient is a child, someone other than the adult regularly bringing the child)

Referred by __________ Address __________ Phone __________

Primary Care Physician __________ Address __________ Phone __________

Appointment reminders

Home email __________ Alternate email __________

Text to # __________ OR Call to # __________

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary insurance

Insurance Company __________ Telephone number __________

Subscriber ID __________ Group # __________ Employer __________

Secondary Insurance: We no longer bill for secondary insurance. If you have a secondary insurance, please let provider know and we will provide a Statement of Service for you to submit to that company.

Copay and Deductible payments are expected at the time of service.

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND I.D.

I acknowledge the above information to be complete and accurate as of this date and agree to update this information whenever changes occur.

______________________________ __________

Signature or Patient (18 years or older) or Authorized Signature or Parent/Guardian/Responsible Party/Witness Date

AUTHORIZATIONS, RELEASES, AND SIGNATURES

(INITIAL EACH BOX AND SIGN AT BOTTOM AFTER READING)

George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, ACC III;
Jennifer Wilson, PhD
Affiliates: Ashley Williams, PhD; Tina Nance, PMHNP-BC

Patient Name:____ Patient Date of Birth:______________

_____1. AUTHORIZATION FOR EVALUATION/TREATMENT

I hereby authorize above provider to evaluate and administer treatment necessary or advisable for the above named patient, and I have legal responsibility to give such authorization.

_____2. RELEASE OF INFORMATION TO HEALTH CARE PROVIDERS

Above provider is authorized to release all or part of the patient's medical record including psychiatric and substance abuse records to HEALTHCARE PROFESSIONALS (i.e. physicians, hospitals, agencies, providers, therapists, etc.) involved in provision of direct or emergent care. Above provider is further authorized to release such information as may be necessary, or required by applicable law (see HIPAA Privacy Notice).

_____3. RELEASE OF INFORMATION FOR INSURANCE CLAIMS

Above provider is authorized to release all or part of the patient's medical record to any person or corporation which is or may be liable for any part of the charges, including but not limited to, hospital or medical service companies, insurers, compensation carriers, government agencies, or collection agencies when necessary. It is understood that a photo copy of this form is a valid authorization for release.

_____4. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of any insurance benefits arising from policies insuring the patient or any party liable to the patient, directly to Above provider. <u>I understand that I am financially responsible for any charges not covered by this assignment.</u>

_____5. FINANCIAL RESPONSIBILITY

In consideration of the services to be rendered to the patient by Above provider, the undersigned guarantees payment of any amount due. I assume financial responsibility for the expenses of the above named patient <u>including</u> fees for missed or inappropriately cancelled appointments, including the first appointment.

_____6. PATIENT INFORMATION SHEET

I acknowledge that I have been given a copy of the New Patient Information Sheet and have read and understand my rights and responsibilities as a patient, parent/guardian, or responsible party as outlined therein.

_____7. HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of a copy of the HIPAA Notice of Privacy Practices. I have read and understood these notices and have had opportunity to ask questions concerning these.

_____8. CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, have received a copy of the foregoing and being the patient, guarantor, or being duly authorized by the patient, do agree and accept these terms.

____

Signature Printed Name Relationship to Patient Date

These authorizations and releases will remain in effect until revoked in writing, or until future date listed here:

Colorado Centers for Neuropsychiatry & Behavioral Care
4760 Flintridge Dr., Suite 250, Colorado Springs, CO 80918
George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, ACC III; Jennifer Wilson, PhD
Affiliates: Ashley Williams, PhD; Tina Nance, PMHNP-BC

PATIENT FINANCIAL RESPONSIBILITIES
(INITIAL EACH BOX AND SIGN AT BOTTOM AFTER READING)

Due to changes in insurance processing, reduction in contracted fee schedules, and increased cost in overhead, the following administrative changes are necessary for our office:

_____1. Each patient will be allowed one “no show” or “late cancellation” exemption per calendar year for follow-up appointments. Intakes (first time appointments) are not eligible for the exemption waiver. A minimum of two working/business days are needed in order to cancel or change an appointment without accruing a charge on your account (Business days are Mon – Fri, 9 a.m. – 5 p.m.). No additional appointments will be scheduled with either your prescriber or your therapist until this is paid.

_____2. Each No show or late cancellation after the first exemption will be billed at $75.00 for any/all follow-up appointments. Any missed appointment for any reason after the first exemption will be billed. If the initial intake appointment is missed, a $150.00 charge will be billed which must be paid prior to scheduling the next intake appointment.

_____3. After three (3) No shows or late cancellations in a calendar year, there will be a consideration of transferring your care and no longer providing services to you.

_____4. The full co-pay or co-insurance is DUE AT THE TIME OF YOUR APPOINTMENT. If it is not paid before leaving the office and a bill must be sent to your home, then you will incur a $10 office administrative fee which will be charged to your account.

_____5. Any unpaid balances after a 90-day billing cycle will incur a $10 office administrative fee which will be charged to your account.

We are sorry to have to make these changes, but financially we must do this if we are to remain in business. If any of these changes cause you undo financial hardship, please discuss this with your provider personally.

Printed Patient Name	Signature	Date
Legal Guardian Printed Name	Signature	Date

New Patient Information Sheet (Rights and Responsibilities)
(Please read carefully as these statements are legally binding concerning your care)

George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, ACC III;
Jennifer Wilson, PhD
Affiliates: Ashley Williams, PhD; Tina Nance, PMHNP-BC
(719) 574-6562 (Main Office) or 719-268-6992 (Dr. Athey/Tina Nance, NP)

1. Your health and well-being are the reason for your therapy. You will be actively involved in your treatment plan and encouraged to ask questions, dialogue and provide feedback to optimize your therapy experience. Prior to each appointment, feel free to write down issues that you would like to discuss. By making the most of your scheduled appointment time we reduce time dealing with medication refill issues, insurance issues, or non-emergency therapeutic issues by phone after the appointments.

2. Please be prepared to keep all of your scheduled appointments in order to ensure quality care. Your concerns and medication refill issues can be most quickly addressed in this manner.

3. Your treatment is confidential. There are limits to your confidentiality if you become in imminent danger to yourself or others and then only minimal information is shared to facilitate the safety of yourself and others. It is in your best interest to authorize the release of information to your primary care doctor and insurance company for continuity of care and for payment.

4. CANCELLATIONS: If it is necessary to cancel an appointment, YOU MUST CALL 48 BUSINESS HOURS IN ADVANCE OF THE SCHEDULED APPOINTMENT TIME. IF YOU DO NOT CALL 48 BUSINESS HOURS AHEAD, YOU WILL BE CHARGED $150.00 FOR AN INITIAL ASSESSMENT AND $75.00 FOR A MISSED APPOINTMENT. No additional appointments will be scheduled until these charges are paid.

5. Any insurance questions can be directed to 719-574-6562. We will help you with your insurance company at your request, either to bill or to obtain approval (authorizations) for your treatment sessions. Please pay for any co-payments or deductibles at the time of service. You should understand that you are personally responsible for the entire bill and filing of insurance is done as a convenience for you. You understand that you are giving permission to submit a claim for insurance and that in doing so you are giving permission to send personal information to the insurance company including, but not limited to, diagnosis and treatment.

6. Please be responsible that your account does not become delinquent. If you have financial concerns, please address these early in treatment with your therapist or with our patient care coordinator. You should understand that if you have an unpaid balance that cannot be worked out with your Provider, then you give permission for information concerning bills, treatment, diagnosis, and personal information necessary for collection to be released to a court, attorney, or collection agency.

7. If you need to contact us urgently you may call 719-574-6562. We are not always available immediately and in the case of a life-threatening emergency where immediate care is needed, call 911 or go to the nearest emergency room. The number one concern is your (or your child's) health and safety. If you do not feel safe, call or get additional help.

8. If you are taking medication, you agree to take medication only as prescribed and not to ingest any alcoholic beverages or illicit drugs. For refills please call at least 3 business days in advance so that the refills may be called, mailed, or faxed into your pharmacy. It greatly facilitates refills if you call the pharmacy requesting a refill and the pharmacy will then contact us with your refill request. Stimulant medications require an office visit and written prescription every 30 days and no mailed, phoned or faxed prescriptions are allowed.

9. Please be mindful of the fact that an initial appointment is 45 minutes to 1 hour and may take more than one appointment for a complete evaluation. Follow-up appointments are either 10-15 minutes for medication management alone, or 20-25 or 40-50 minutes in length for therapy or medication management with some additional evaluation and therapy. Longer times may be needed for certain therapies or in special cases and may require additional fees that may not be paid by your insurance.

10. Requests for letters and reports, extensive review of other records, visits to school or attendance at other meetings, and frequent or extended phone calls will likely not be paid by insurance and the time will be billed directly to you. Reports or extended phone calls are a minimum of $25 and time is billed at $160/hr. Please be courteous to your health care provider as well as to other patients and be on-time and prepared for each appointment.

11. If you are seeking counseling or medication evaluation services for your minor child/children and the parent or legal guardian is divorced, you must provide legal documentation along with the intake packet clarifying the legal guardianship status for minor children.

****Please sign the Authorizations, Releases, and Signatures Form as the authorization of your consent for evaluation and mental health treatment and acknowledgement that you have received, read, and understand these Rights and Responsibilities.
(Rev. 7/17)

Release of Information or Authorization

Please circle one:
George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, ACC III;
Jennifer Wilson, PhD
Affiliates: Ashley Williams, PhD; Tina Nance, PMHNP-BC
4760 Flintridge Drive, Suite 250 Colorado Springs, CO. 80918
(719) 574-6562 (Main Office) **or 719-268-6992** (Dr. Athey/Tina Nance, NP) Fax (719) 570-0386

Name:____ **Birth Date:**__________________
Address:____
Phone:__________________________________ **Social Security Number:**____________________

The purpose of this form is to release Health Care Information to be ____**sent to,** ____**received from, or** ____**two-way communication**, both verbal and written, between above provider, and the following health care / mental health / substance abuse / educational agencies or providers:

Person/Agency **Address** **Phone**

____

____

____

____

For the purpose(s) of (specify): __Continuity of care __Treatment __ Therapy __ Payment or Financial Operations

Special information being requested includes (specify, including dates if applicable)

____

____

- If "treatment", "payment", or "operations" is checked, this form is a "release" of information and if I refuse to sign it, the Provider can withhold treatment, payment, enrollment, or other eligibility benefits.
- Please see the HIPAA Notice of Privacy Practices for this office which was provided to you at registration for your rights concerning release of protected information.
- If this is an authorization the above provider will provide me with a copy if I so request.
- I understand that, unless lined through, information to be released / authorized may include information regarding the following condition(s):
- o Drug Abuse Psychiatric Conditions / Treatment
- o Alcoholism HIV / Auto Immune Deficiency Syndrome (AIDS)
- I understand that by releasing this information to other parties, it may not be protected by the HIPAA regulations.
- I understand that I may revoke this release / authorization at any time by giving written notice to the above provider, except to the extent that action has already been taken to comply with it. Without such revocation, this release / authorization **will expire on / / (date), or if left blank, one year from the date of my signature**, or as of the action or event of ____.

____
Signature of patient **Print Name** **Date**

____
Signature of Parent/Legal Representative **Print Name** **Relationship to Patient** **Date**

(9/16)

Practice of
George Richard Athey, MD, PhD; Scott Gregory, LMFT; Marta McKay, LPC, ACC III;
Jennifer Wilson PhD
Affiliates: Ashley Williams, PhD; Tina Nance, PMHNP-BC

Please read this Notice, ask questions if it is not clear, sign the signature form indicating your understanding of these statements.

HIPPA NOTICE OF PRIVACY PRACTICES

Effective Date (July 1, 2004)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact: 719-574-6562 or 719-268-6992

This notice describes the privacy practices at our office. We are required by law to:
* Maintain the privacy of protected health information
* Give you this notice of our legal duties and privacy practices regarding your health information
* Follow the terms of the notice currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Your provider.

Treatment. We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special

approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law. We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Worker's Compensation. We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your health information request by law enforcement official if

1) there is a court order, subpoena, warrant, summons or similar process;
2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person;
3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement;
4) the information is about a death that may be the result of criminal conduct;
5) the information is relevant to criminal conduct on our premises; and
6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and copy your medical and billing records by written request to your provider in the group, except for restricted mental health information.

Right to Amend. You have the right to request an amendment to your records by written request to Your provider.

Right to an Accounting Of Disclosures. You have a right to an accounting of certain disclosures by written request to Your provider.

Right to Request Restrictions. You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Your provider. We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Your provider. We will accommodate reasonable requests. You give us the right to contact you by phone and leave phone or voicemail messages unless you specifically exclude this right.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Your provider.

Your provider,

4760 Flintridge Drive, Suite 250
Colorado Springs, CO 80918
719-574-6562 (main office)   or   268-6992 (Athey/Nance)

Surprise/Balance Billing Disclosure Form

Surprise Billing - Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado and/or
- You unintentionally received covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what type of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services form an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_FIle_Complaint

If you think you have received a bill for amounts other than your copayments, deductible and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-984-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Dr. George Richard Athey and Tina Nance, PMHNP-BC
Colorado Center for Neuropsychiatric Medicine Child/Adolescent
Initial Assessment Questionnaire

Date:____________

Person Providing Information:________________________________ Relationship to Pt:________________

Patient Full Name:____ Sex___ DOB___/___/___ Age_____

Child's Physician:______________________________ Person making referral:________________________________

FAMILY: List all family living in the home or important others and family elsewhere (use extra sheet if necessary)

FIRST NAME	LAST NAME	BIRTH DATE MM/DD/YY	GENDER M/F	RELATIONSHIP TO PATIENT	WHERE LIVING CITY, ST or HOME

Guardian if other than parent:____

Reason(s) you are bringing your child for an evaluation:
Chief Complaint:
____
____
____
____
____

Problem areas: (check all that apply and explain below)
Behavior Problems___ Legal Problems___ Social Problems___ Emotional Problem___ School Problems___
____
____
____
____
____

History of abuse/neglect (emotional, verbal, physical, sexual):
____
____
Any special cultural issues?
____
Any religious issues?
____
Any sexual issues?
____

Recent Family Stressors:

____
____
____

Past Treatment or Evaluations for these problems:

____
____
____
____

Developmental History:

Any problems during pregnancy?

____
____

Any problems at Birth? ____

Any problems after birth?____

Mother's emotional state:____________________Response to baby:__________________________

Development:

Feeding problems____

Sleeping problems____

Responsiveness____

Social interaction____

Activity level____

Aggressiveness____

_

Motor (age begun): Held up head________ Turned over________ Crawled________ Walked__________

Any problems?____

Abnormal movements?____ Repetitive movements?______ Rocking?____ Head banging?____

Speech/Language: (age begun): Social smiles_________ First words_________ Sentences________

Was child selective who they would talk to?________ Stranger anxiety?_______________

Articulation problems?_______ Stuttering?________ Repeating words or sounds?________

Bowel/Bladder: Toilet Training (age achieved): bladder________ bowel________

Any problems?____

Genital: Curiosity about genital parts_______________ Interest in reproduction________________

Masturbation__________________________

Special problems: Fears or phobias?____

Fantasies/imaginary friends?____

Tantrums?____

Medical History: Current Physician:______________________ Physician's phone___________

Past Physicians:____

Current Height:______ Weight:______

Major Illnesses	Age Begun	Treatment, Hospitalization, or Surgeries
______________	______	______________________
______________	______	______________________
______________	______	______________________

Vision problems:____
Hearing problems:____
Speech problems:____
Motor/coordination problems:_________________________________
Accident prone? Yes___ No___ Seizures_______________ Concussion_______________
Motor Vehicle Accidents or other trauma:________________________________

Allergies/Reactions to Medications or Foods:

____

Has patient ever had: EEG____ EKG____ MRI scan____ CT scan____ Head Xrays____

Past Medications with dosage:

______________ ______ ______________ ______
______________ ______ ______________ ______
______________ ______ ______________ ______

Current Medications with dosage:

______________ ______ ______________ ______

Has patient had problems with alcohol or substance abuse?

____

____

Family Psychiatric History: Has any blood relative had (Parents, grandparents, Uncles, Aunts, Cousins) (circle)

Mental Retardation	Slow development	Learning disabilities	Trouble completing school
Depression	Manic/depressive disorder	Schizophrenia	Anxiety Disorders
Panic attacks	Eating Disorders	Alcoholism	Substance abuse
Dementia	Multiple Personality Disorder	Sexual problems	Pedophilia
Sexual offender	Major legal problems	Personality problems	Obsessive-Compulsive Disorder
Paranoia	Attention Deficit Disorder		

Other_______________ _______________

History of attempted or completed Suicides (Who_____________________________________)

Family Medical/Neurologic History: Has any blood relative had: (circle)

Seizures	Seizure with fever	Tics	Tourettes
Muscle problems	Migraine headaches	Cerebral Palsy	Birth Defects
Strokes	Heart attacks	Arrhythmias	Diabetes
Thyroid problems	Ulcers	Cancer	

Other____

____

Social History:

Live in: Own home___ Rented house___ Apartment___ Trailor___ Other________________

List any non-relatives in the home:________________

____

____

____

Describe any other problems in the home:________________

____

____

____

Is anyone in the family currently involved with any outside agencies? yes___ (check below) no___

Social Services___ Juvenile Services___ Court___ Human Services Center___

Other________________

Current psychological/psychiatric/counselor therapy?________________

____

History of adoption, divorce, separations, or deaths in family:________________

____

Other family issues:________________

____

How are children disciplined in the home?________________

____

Family strengths:________________

____

Please list your **child's strengths**:________________

____

Education: Current School________________ Grade____ Teacher________________

Prior School(s)________________ ________________

Prior School(s)________________ ________________

Regular classes___ LD classes___ ED classes___ Special Ed Services___ Does the child have an IEP?___

Any grades repeated?________________ Is there a 504 Plan?___

Has IQ testing been done?____ Results?________________

How is child doing in school now?________________

Academic problems________________

Behavior problems________________

Peer problems________________