Dial Psychiatry

Adult, Child, and Family Mental Health

New Patient Information Form

(Please fill out and return at or prior to first appointment)

Patient Demographic Information:

Patient Name: ______________________________ Date of Birth: ____________

Address: ____________________ City: ____________ State: _____ Zip: _______

Preferred contact: ____________ home/work/cell ____________ home/work/cell

Email address: ____________________ Appointment reminders: Email or text

Parent's Name (if patient is a minor) ______________________________

Address: ____________________ City: ____________ State: _____ Zip: _______

Occupation: ________________________ Preferred contact: ______________

Parent's Name (if patient is a minor): ______________________________

Address: ____________________ City: ____________ State: _____ Zip: _______

Highest Education: ______________________ Preferred contact: ____________

Referred By: ____

Chief Complaint: What is your primary reason for seeking psychiatric consultation?

____

____

____

History of Presenting Illness:

When did these symptoms begin?

____

____

Did something occur to precipitate them? ___

Have there been symptom-free periods? ___

Past Psychiatric History:

When did treatment first begin?

___

What kind of treatment has occurred?

1. Individual Psychotherapy? If yes, when and with whom?

___

2. Group or Family/Couples Psychotherapy? If yes, when and with whom?

___

Have you (your child) ever been psychiatrically hospitalized? If yes, when, where, and for what reason? ___

___

Have you (your child) ever thought of or attempted to commit suicide? If yes, when, how, and under what circumstances? ___

___

Have you (your child) ever hurt oneself in any way? For example, cutting or burning self. If yes, when, how, and under what circumstances? ___

___

Medical History:

Current and Prior Medical Problems: ___

___

Medical Hospitalizations/Surgeries: ___

Known Drug Allergies: ___

Primary Care Physician: ___ Last physical exam: ___

Address/Phone: ___

Immunizations current? Yes/No

Past Medications:

Name of Medication	Dose Taken	Why Taken	Who Prescribed	Comments (helpfulness / side effects)

Current Medications:

Name of Medication	Dose Taken	Why Taken	Who Prescribed	Comments (helpfulness / side effects)

Please comment on any substance abuse (drugs/alcohol).

What?	When did you start?	How much did you use?	Last use?	What did it do for you?

Please circle any that the patient has had and include dates as best you can:

Head Injury/Loss of Consciousness
Seizures/convulsions
Other neurological problems
Ear, nose or throat problems
Dental problems
Asthma
Chest problems
Stomach or bowel problems/soiling
Urinary or bladder/wetting

Heart Problems
Rheumatic fever/strep infections
Liver/Kidney problems
Skin problems
Joint/limb problems
Hearing/vision problems
Growth/endocrine problems
Gynecological/menstrual problems
Childhood measles/mumps

Family History:

1. Please give the names, ages, and relationships of people living in the home:

____

____

____

2. Who are other immediate family members not living in the home?

____

____

Family Psychiatric History:

Has any family member had any of the following? Please circle and indicate which family member.

Depression	ADHD/ADD
Mania/Bipolar Disorder	Learning Disability
Suicidal thoughts/urges/behaviors	Coordination Problems
Anxiety	Mental Retardation
Panic	Autism/Asperger's Disorder/PDD
Obsessions/Compulsions	Sleep Disorder
Rituals	Drug Use
Movement Disorders	Alcohol Use
Tics	Psychosis
Unusual noises/vocalizations	Legal Problems
Eating Disorder	Psychiatric Hospitalizations

Other: ____

Please elaborate on above as needed: __________________________________

____

Family Medical History:

Please provide information about significant medical issues on the FATHER'S side:

____

____

Please provide information about significant medical issues on the MOTHER'S side:

____

____

Prenatal History:

Was the pregnancy healthy? Yes ______ No ______ Problems: ____________________

Were medications used during the pregnancy? Yes ___ No ___

If yes, what kind? ____________________ How Often? __________________________

Were drugs/alcohol used during the pregnancy? Yes _____ No ___

If yes, what kind? ______________ How Often? ______________

Did the mother smoke during the pregnancy? Yes ___ No ___ If yes how much? _______

Was the pregnancy full term? Yes __ No __

Was delivery normal? Yes ___ No ___ If no, problems? ______________

Any feeding problems? ______________ Gained weight well? ______________

Was there any problem in the first week? ______________

first month? ______________

first year? ______________

Developmental History:

1. Describe yourself/child as an infant:
   - a) active / active but calm / passive / other:
   - b) cuddly / irritable / withdrawn / other:
   - c) cried easily and frequently / reasonable amount / seldom
   - d) soothed easily / difficult to soothe / average
   - e) response to changes: severe / moderate / mild
   - f) response to being held (describe):
   - g) reaction to strangers: friendly / indifferent / fearful
2. Describe current eating habits: ______________ Problems: ______________
3. Describe current sleeping habits: ______________ Problems: ______________
4. Developmental Milestones (**only mark if significantly early or late**):

Motor:	Language:	Adaptive:
rolled front/back (4 mo) _______	smiling (4-6 wks) _______	mouthing (3 mo) _______
sit with support (6 mo) _______	cooing (3 mo) _______	transfers objects (6 mo) _______
sit alone (9-10) _______	babbling (6 mo) _______	picks up raisin (11-12 mo) _______
pull to stand (10 mo) _______	jargon (10-14 mo) _______	scribble (15 mo) _______
crawling (10-12 mo) _______	first word (12 mo) _______	drinks from cup (10 mo) _______
walks alone (10-18 mo) _______	follows 1-step command (15 mo) ___	uses spoon (12-15 mo) _______
running (15-24 mo) _______	2 word combo (22 mo) _______	undresses _______
tricycle (3 yrs) _______	3 word sentence (3 yrs) _______	bowel trained _______
bicycle (5-7 yrs) _______	speech problems _______	bladder trained _______

School:

Repeated Grade? Y/N If yes, which? ______________

Special/resource classes? ______________

Other special services? (speech/OT/PT) ______________

IEP? _______ 504 Plan? _______ Academic grades received: ______________

Evaluations performed:

Date ___________ Type _______________ Reasons_________________________________

Results ____

Date ___________ Type _______________ Reasons _________________________________

Results ____

Relationships with teachers? ___________________ With peers? ______________________

Ability to work independently? good average poor

Organize self? good average poor

Attendance? good average poor

Have you (your child) ever had truancy proceedings? Y/N

Have you (your child) had any other legal proceedings? Y/N If yes, please describe.

____

____

Describe your (your child's) activities, interests, hobbies, skills, strengths:

____

____

Please use the remaining space to describe any other concerns:

____

____

____

Problem Behavior Checklist: Do you/your child have any of the following problems?

	In Past	Occasionally	Often	Very Often
Short Attention Span				
Impulsivity (acts before thinking)				
Won't follow rules/directions				
Irritable, poor frustration tolerance				
Easily riled up				
Picks on others, bullies				
Feels picked on				
Teases others unmercifully				
Deliberately tries to annoy people				
Easily angered, bad temper				
Frequent accidents				
Gets out of control				
Gets violent and aggressive				
Cruel to animals				
Fire Setting				
Steals				
Cries easily				
Gets giddy and silly				
Tiredness/listlessness				
Lack of interest in activities				
Isolates self from others				
Sadness				
Poor appetite				
Problems getting to sleep				
Early morning awakening				
Self-injurious/abusive behaviors				
Excessive sleepiness				
Weight gain/loss				
Worries a lot				
Fear of the dark				
Other specific fears (heights, etc)				
Catastrophic fears				
Reluctance to go to school				
Repeated unwanted thoughts				
Compulsive behaviors				
Rituals (has to repeat same action)				
Hair pulling				
Excessive concerns: body defects				

AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

1. Client's name: ____
   First Name   Middle Name   Last Name

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:

____
Name (client, provider, or other)

5. Information to be released:

☐ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

☐ Other (describe information in detail):

____

6. Purpose of Disclosure: The reason I am authorizing release is:

☐ My request

☐ Other (describe):

____

7. Person(s) Authorized to Make the Disclosure:

____

8. Person(s) Authorized to Receive the Disclosure:

____

9. This Authorization will expire on ___/___/___ or upon the happening of the following event:

____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient:

____

Signature of Personal Representative:

____

Relationship to Patient if Personal Representative:

____

Date of signature: ______________________

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____
Client Signature (Client's Parent/Guardian if under 18)

____
Today's Date

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

____

Client Signature (Client's Parent/Guardian if under 18)

____

Today's Date