Childs Name: ____

PLEASE READ AND INITIAL EACH STATEMENT

_______**CONSENT TO TREATMENT**: I consent to mental health (i.e. psychological/ psychiatric) evaluation and/or treatment by staff from Katie's Way. In doing so, I understand, acknowledge and affirm that such mental health (i.e. psychological/ psychiatric) evaluation and/or treatment services may involve physical evaluation and blood testing.

_______**RECEIPT OF PRIVACY PRACTICES**: We are required by law to provide this notice to you and obtain your acknowledgement of this receipt prior to providing any services to you. I acknowledge receipt of Notice of Privacy Practices.

_______**EMERGENCY RESCHEDULES:** It will be a top priority for Katie's Way staff to see you on time for your appointments. However, due to unexpected clinical emergencies, there may be a time that clinical staff at Katie's Way need to call and delay a clinic appointment or reschedule it for another day.

_______**LATE ARRIVALS:** If you will be **arriving 10 or more minutes late** to an appointment, it is at the discretion of the provider if they can see you that day. We ask that you call and let the front office know if you will be running more than 10-minutes late.

_______**MEDICATION REFILLS:** It is your responsibility to call your pharmacy to request a prescription refill, which may take up to **72 hours** to complete from the time we receive the pharmacy's request. Requests will not be received by the Katie's Way medical staff on weekends or holidays.

_________________________________ Patient/Guardian Signature

_________________ Date

Childs Name: ______________________________

PATIENT INFORMATION

Patient Name ______________________________
First Middle Last

Patient Date of Birth ____________________ Gender (Please check one) ☐ Male ☐ Female

Patient Social Security No. ____________________

Home Address ______________________________
Street City State Zip Code

Legal Guardian Name ______________________________

Home Phone ____________________ Work Phone ____________________

Mobile Phone ____________________ Email Address ____________________

INSURANCE INFORMATION

Primary Insurance Provider ______________________________

Plan Name ____________________ Effective Date ____________________

Policy Number ____________________ Group Number ____________________

Name of Subscriber ______________________________
First Middle Last

Subscriber Date of Birth ____________________ Relationship to Patient ____________________

Subscriber Gender (Please check one) ☐ Male ☐ Female

Subscriber Social Security No. ____________________

Subscriber Address ______________________________
Street City State Zip Code

Subscriber Phone ____________________

PHARMACY INFORMATION

Pharmacy Name ______________________________

Pharmacy Address ______________________________

Pharmacy Phone Number ____________________

Childs Name: ____

PATIENT/ LEGAL GUARDIAN INSTRUCTIONS:
Complete and return this form along with the following:

- ✓ A copy of your insurance card(s), if applicable
- ✓ Copies of your child's Individualized Education Program (IEP), if applicable
- ✓ Copies of any 504 plans or other educational testing records, if applicable

Your Child's/Adolescent's Name: ______________________________

Adolescent's Date of Birth: ______/______/______

Who referred your adolescent to our clinic? ______________________________

What was the reason for referral? ______________________________

____

What is your main concern about your adolescent? ______________________________

What are your adolescent's best qualities? ______________________________

____

What are you hoping Katie's Way can help with the most? ______________________________

____

How does your adolescent feel about coming? ______________________________

____

Has your adolescent been seen by other developmental, behavioral or mental health professionals, such as psychologists, psychiatrists, or counselors?

□ No □ Yes, list and explain.

Name of Professional	Date(s)	Reason/Diagnosis

Childs Name: ____

FAMILY INFORMATION:

Birth Mother: ____ Age: __________

Occupation: ________________________

Home Phone: (____)____-______ Work Phone: (____)____-______ Alternate Phone: (____)____-______

Address:____
Street City State Zip

Birth Father: ____ Age: __________

Occupation: ________________________

Home Phone: (____)____-______ Work Phone: (____)____-______ Alternate Phone: (____)____-______

Address:____
Street City State Zip

If child is not living with birth parents, who does the child live with? (Otherwise, leave blank)

Name: ________________________ ☐ Stepmother ☐ Adoptive Mother ☐ Guardian ☐ Foster Mother

Age: ______ Occupation: ____________________

Home Phone: (____)____-______ Work Phone: (____)____-______ Alternate Phone: (____)____-______

Address: ____
Street City State Zip

Name: ________________________ ☐ Stepfather ☐ Adoptive Father ☐ Guardian ☐ Foster Father

Age: ______ Occupation: ____________________

Home Phone: (____)____-______ Work Phone: (____)____-______ Alternate Phone: (____)____-______

Address: ____
Street City State Zip

(Siblings) Brothers and Sisters

Name	Sex	Age	Living in the Home?	Health or Learning Problems
____________	☐Male ☐Female	______	☐No ☐ Yes	____________
____________	☐Male ☐Female	______	☐No ☐ Yes	____________
____________	☐Male ☐Female	______	☐No ☐ Yes	____________
____________	☐Male ☐Female	______	☐No ☐ Yes	____________

Any mental health history in the immediate or extended family?

____

____

____

Childs Name: ____

ADOLESCENT'S CURRENT HEALTH FUNCTIONING:

SLEEP
What is your adolescent's typical bedtime? ______________ How about typical wake time?____________
Do they sleep in significantly on non-school days?________________________________

Do you have any concerns with your adolescent's sleep (quality of sleep, ability to sleep on his/her own, changes in sleep patterns)? ________________________________
____
____
____

DIET/NUTRITION
Do you have any concerns about your adolescent's diet, eating behavior, or recent changes in appetite/weight? ________________________________
____
____

PHYSICAL ACTIVITY
Does your adolescent get any physical activity or exercise on a daily basis? If so, what kinds of activities?
____
____
____

MEDICAL AND DEVELOPMENTAL HISTORY:

PREGNANCY AND BIRTH HISTORY
How old was the birth mother when your adolescent was born?: ______________years

Did the birth mother have any health problems during the pregnancy?:______________________
____

Were there any complications during labor and delivery?______________________
____

Did your child have any health problems following birth? ______________________
____

Childs Name: ____________________

MEDICAL HISTORY

Does your adolescent have allergies to any medications?____________________

____

Has your adolescent's vision been checked? ☐ No ☐ Yes

Does your adolescent wear glasses/contacts? ☐ No ☐ Yes

Describe any vision problems: ____________________

Has your child's hearing been checked? ☐ No ☐ Yes

Describe any hearing problems:____________________

Serious Illnesses, Injuries, Surgeries, or Hospitalizations (including psychiatric hospitalizations):

Date or Age of Child Reason (Type of Illness/Injury/Surgery/Hospitalization)

____

____

____

____

Are you aware of your adolescent using alcohol or any drugs? ____________________

____

MEDICATIONS:

Current Medications (List names and what for)				
Name of Medications	1.	2.	3.	4.
Dose/Frequency				
Start Date				
Reason for Use				
Prescriber				

Previous Medications (List names and what for)				
Name of Medications	1.	2.	3.	4.
Dose/Frequency				
Start Date				
Reason for Discontinuing				
Prescriber				

Childs Name: ____

Dietary/Herbal Supplements (List names and what for)				
Name of Medications	1.	2.	3.	4.
Dose/Frequency				

GROWTH AND DEVELOPMENT

Motor:
At what age did your child do the following? Sit alone: _________ Crawl: _________ Walk alone: _________

Compared to siblings or friends, was your child awkward or slow to develop motor skills, like running, skipping, climbing, biking, playing ball?: ______________________________
____

Handedness: ☐Right ☐ Left ☐ Both
Has your child had occupational or physical therapy? ______________________________
____

Language:
When did your child- Speak first word: ________ Put 2-3 words together: ________
Does your child have any speech delays or problems, like stuttering or being difficult to understand?
____
____

Was speech/language therapy ever necessary? ______________________________
____

Besides English, any other languages are spoken in the home? ______________________________

SOCIAL FUNCTIONING
Do you have any concerns about your adolescent's social functioning or relationships?
____
____
____

Check all that apply to your child.

☐ Gets along well with other peers
☐ Gets along with adults
☐ Has friends
☐ Has a good sense of humor
☐ Acts aggressively towards others
☐ Seems anxious around others
☐ Problems with peer pressure
☐ Understands social cues
☐ Keep friends

Childs Name: ____

Is your child in any social groups, or social experiences? (sports, drama, church, scouts) ______________
____
____

BEHAVIOR MANAGEMENT

Do you have concerns about your adolescent's behavior? _________________________________
Who ordinarily disciplines your child? ____

How is your adolescent disciplined?
☐ Taking Away Privileges ☐ Sending to Room ☐ Talking or Reasoning
☐ Other: ____________________________

Does it work? ☐ No ☐ Yes
Do adults caring for the adolescent agree on discipline?___________________________________
____

EDUCATIONAL HISTORY

What school does your adolescent attend? ____
Current Grade? ___________________________

School Address:____
Street City State Zip
Teacher's name: __________________________ Counselor's name: _________________________
Principal's name: ___________________________ District: ______________________________

Type of Placement: ☐Regular ☐ Learning Disability ☐ Behavior Disorder ☐Resource Room

Any Educational Diagnosis: ☐ Learning Disability ☐ Behavior Disorder ☐ Intellectual Disability
Date of Last Educational Testing (please send copy): _____/_____/_______
Date of last IEP, if any (please send copy): _____/_____/_______

Childs Name: ______________________________

Any academic problems at school? ______________________________
____

Any behavioral problems at school? ______________________________
____

SUMMARY

Anything else you would really like us to know about your adolescent? ______________________________
____
____
____
____
____

______________________________ Signature of Person Completing This Form

______________________________ Printed Name of Person Completing This Form

______________________________ Relationship to Child

_____/_____/_______ Date

Office Use Only

Reviewed By (signature/title): ______________________________Date: _____/_____/_______ Time: _________hours