KATIE'S WAY

Patient's 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

KATIE'S WAY

Patient's 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 _____

KATIE'S WAY

Patient's Name: _____

**INSTRUCTIONS:** Complete and return this form along with the following:

- ✓ A copy of your insurance card(s), if applicable
- ✓ Copies of any 504 plans or other educational testing records, if applicable
- ✓ A copy of your picture ID.

Date of Birth: _____/_____/_____

Who referred you to our clinic? _____

Reason for referral: _____

What is your main concern? _____

_____

How can Katie's Way help you the most?_____

_____

Have you been seen by other developmental or mental health professionals, such as psychologists, psychiatrists, or counselors?

□ No □ Yes, list and explain.

| Name of Professional | Date(s) | Reason/Diagnosis |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Patient's Name: _____

**CURRENT LIVING SITUATION/FAMILY BACKGROUND:**

Are there other individuals in your place of residence? ☐ No ☐ Yes, please list:

Name: _____ Relation (i.e. Friend, Mother): _____

Age: _____ Occupation: _____

Name: _____ Relation (i.e. Friend, Mother): _____

Age: _____ Occupation: _____

Name: _____ Relation (i.e. Friend, Mother): _____

Age: _____ Occupation: _____

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

<u>If you do not live with or were not raised by your birth parents</u>, other adults that were caregivers? (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

Patient's Name: _____

Brothers and Sisters

| Name | Sex | Age | Living with you? | Health or Learning Problems |
|---|---|---|---|---|
| _____ | ☐Male ☐Female | _____ | ☐No ☐ Yes | _____ |
| _____ | ☐Male ☐Female | _____ | ☐No ☐ Yes | _____ |
| _____ | ☐Male ☐Female | _____ | ☐No ☐ Yes | _____ |

**MEDICAL HISTORY**

Do you have allergies to any medications? _____

_____

**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 | | | | |

| Dietary/Herbal Supplements (List names and what for) | | | | |
|---|---|---|---|---|
| Name of Medications | 1. | 2. | 3. | 4. |
| Dose/Frequency | | | | |
| Start Date | | | | |
| Reason for Use | | | | |

Patient's Name: _____

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

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

_____
_____
_____
_____
_____

Handedness: ☐Right ☐ Left ☐ Both
Have you had occupational or physical therapy? ☐No ☐ Yes, explain: _____
_____
_____

Have you had speech/language therapy? ☐No ☐ Yes, describe: _____
_____

Do you regularly see a primary care physician? If so, who is your provider and approximately when was your last visit? _____

Do you regularly use alcohol or recreational drugs? _____

**CURRENT HEALTH FUNCTIONING:**

**SLEEP**
What is your typical bedtime? _____ How about typical wake time?_____

Do you have any concerns with your sleep? _____
_____
_____
_____

**DIET/NUTRITION**
Do you have any concerns about your diet, eating behavior, or recent changes in appetite/weight? ____
_____
_____
_____

Patient's Name: _____

**PHYSICAL ACTIVITY**

Do you get any physical activity or exercise on a daily basis? If so, what kinds of activities?

_____

_____

_____

**SOCIAL FUNCTIONING/SOCIAL SUPPORT:**

Do you have any concerns about your functioning or relationships?

_____

_____

_____

What do you like to do for fun, or any hobbies? _____

_____

_____

Who would you consider is a source of social support? _____

_____

**EDUCATIONAL/WORK:**

Do you attend any school/college currently?_____

If you are no longer in high school, where did you attend? _____
Did you graduate? _____

Any Educational Diagnosis current/past: ☐ Learning Disability ☐ Behavior Disorder ☐ Intellectual Disability

Any academic problems at school current/past? _____

_____

Any behavioral problems at school current/past? _____

_____

Patient's Name: _____

Do you currently work part-time or full-time? If so, where and what kind of hours? _____

_____

_____

**SUMMARY:**

Anything else that you think is important for us to know about you? _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Patient or Patient's Personal Representative Printed Name of Patient/ Person Completing This Form

_____/_____/_____

Date

Office Use Only

Reviewed By (signature/title): _____Date: _____/_____/_____ Time: _____hours