KATIE'S WAY

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 Name: _____

Child's Date of Birth: _____/_____/_____

Who referred your child to our clinic? _____

What was the reason for the referral?_____

_____

What is <u>your</u> main concern about your child? _____

What are your child's best qualities? _____

_____

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

_____

Has your child been seen by other developmental, behavioral or mental health professionals, such as psychologists, psychiatrists, or counselors?
□ No □ Yes, list and explain.

<u>Name of Professional</u>	<u>Date(s)</u>	<u>Reason/Diagnosis</u>

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	_____

Childs Name: _____

Any mental health history in the immediate or extended family?_____

_____

_____

CHILD'S CURRENT FUNCTIONING:

SLEEP

What is your child's typical bedtime? _____ What is your child's typical wake time? _____

Does your child have an established bedtime routine?_____

_____

Do you have any concerns with your child'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 child's diet, eating behavior, or recent changes in appetite/weight? _____

_____

_____

PHYSICAL ACTIVITY

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

_____

_____

_____

TOILETING

Is your child toilet trained? ☐No ☐ Yes, since what age?: _____

Does your child have problems with bedwetting, daytime urine accidents or bowel movement soiling?

_____

_____

_____

Childs Name: _____

MEDICAL AND DEVELOPMENTAL HISTORY:

PREGNANCY AND BIRTH HISTORY

How old was the birth mother when your child 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? _____

_____

MEDICAL HISTORY

Does your child have allergies to any medications?_____

_____

Has your child's vision been checked? ☐ No ☐ Yes Does your child wear glasses? ☐ 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 (Illness/Injury/Surgery/Hospitalization)

_____

_____

_____

MEDICATIONS:

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

Childs Name: _____

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				

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?

_____

_____

Does your child have any oral motor problems, like late drooling, poor sucking, poor chewing?

_____

Was speech/language therapy ever necessary? _____

_____

Childs Name: _____

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

SOCIAL FUNCTIONING

Do you have any concerns about your child's social functioning or relationships?

_____

_____

Check all that apply to your child.

□ Engages in pretend play	□ Gets along well with other children	□ Has a good sense of humor
□ Gets along with adults	□ Acts aggressively towards others	□ Understands social cues
□ Has friends	□ Seems anxious around others	□ Feels uncomfortable or needs support
□ Keep friends	□ Understands gestures (i.e. pointing)	□ Has problems with peer pressure

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

_____

_____

BEHAVIOR MANAGEMENT

Do you have concerns about your child's behavior? _____

Who ordinarily disciplines your child? _____

How is your child disciplined?

☐Spanking ☐ Taking Away Privileges ☐ Sending to Room ☐Time-Out ☐ Talking or Reasoning

☐ Other: _____

Does it work? ☐ No ☐ Yes

Do adults caring for the child agree on discipline?_____

_____

EDUCATIONAL HISTORY

What school does your child attend? _____

Current Grade? _____

School Address:_____

Street City State Zip

Teacher's name: _____ Counselor's name: _____

Principal's name: _____ District: _____

KATIE'S WAY

Childs Name: _____

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): _____/_____/_____

Any academic problems at school? _____
_____

Any behavioral problems at school? _____
_____

SUMMARY:

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

_____ _____
Signature of Person Completing This Form Printed Name of Person Completing This Form

_____ _____/_____/_____
Relationship to Child Date

Office Use Only

Childs Name: _____

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