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.

_____**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:** We ask that you call and let the front office know if you are running late to your appointment. If you are more than 10 minutes late for an appointment, you may need to reschedule.

_____ _____

Patient Signature Date

Patient's Name: _____

PATIENT INFORMATION

Patient Legal Name _____
First Middle Last

Patient Preferred Name _____

Patient Date of Birth _____ Gender _____

Billing Address _____
Street City State Zip Code

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

INSURANCE INFORMATION

Primary Insurance Provider _____Effective Date _____

Policy Number _____ Group Number _____

Name of Subscriber _____
First Middle Last

Subscriber Date of Birth _____ Relationship to Patient _____

Subscriber Gender _____ Subscriber Social Security No. (Tricare only) _____

Subscriber Address _____
Street City State Zip Code

PHARMACY INFORMATION

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____

Patient's Name: _____

INSTRUCTIONS: Complete and return this form along with the following:
- ✓ A copy of your insurance card(s), if applicable
- ✓ A copy of your picture ID.

Who referred you to our clinic? _____

Who is your primary care doctor? _____

Do you have internal metal in your head or neck? If yes, please explain _____
_____

Have you ever experienced a seizure? Have you been diagnosed with a seizure disorder? If yes, please explain _____
_____
_____

Have you ever had a stroke and/or suffered from a traumatic brain injury? If yes, please explain _____
_____
_____

Do you have bipolar disorder? If yes, do you believe this is an accurate diagnosis? Please provide details on when you were diagnosed and how you were diagnosed _____
_____
_____

Have you been seen by other developmental or mental health professionals?

☐ 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 Psychiatric 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