CRUZ CLINIC and
INTEGRATIVE PSYCHOLOGY

CONSENT TO SERVICES

Patient:_____ Date of Birth:_____

(Please initial to verify understanding)
___ I acknowledge that I have received Cruz Clinic's pamphlet, "Important Information for Patients," in which is described the policies and procedures of Cruz Clinic/Integrative Psychology regarding confidentiality of patient records, emergencies, fee payment requirements, canceled and missed appointments, termination and discharge from treatment, and my rights and responsibilities as a recipient of services.

___I understand that my records, or the records of my dependent, at Cruz Clinic are confidential. These records can be released only as allowed by law under the statutes of the State of Michigan and Federal guidelines, or as allowed by my signature on a release form, with the exceptions written below and in other patient information I have received.

____I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Cruz Clinic (HIPPA) pertaining to my right to privacy and the confidentiality of my protected health information. I understand that upon my request, a copy will be provided to me. I further understand that at any time I may contact the Cruz Clinic/Integrative Psychology Administrator in reference to any concern or question I may have regarding the notice or my rights.

___I understand that the services I, or my dependent, will receive at Cruz Clinic/Integrative Psychology is based on currently accepted practice in the fields of mental health and/or substance abuse treatment. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent. I have been provided with the name and credentials of the clinician who will provide services to me, or my dependent. I understand that all providers are either fully licensed or under the supervision of a fully licensed professional.

___Also, I understand that in order for Cruz Clinic/Integrative Psychology to provide care to me or my dependent, I may be asked to consult with a psychiatrist when this is considered necessary by a clinical staff member. I too may ask to consult with a psychiatrist on staff at Cruz Clinic/Integrative Psychology, if I consider this necessary. Further, I may request that I be referred to another organization for services.

___If services are paid either in part or in full for by a third-party payor such as an insurance company, I understand that the funding source or its agent has the right to examine my records at any time. I hereby authorize the examination of my or my dependent's patient records sources as required for reimbursement and/or clarification of services. I also understand that it may be necessary to release information regarding me, or my dependent, to a Case Manager or insurance verifier from my third-party payor in order for Cruz Clinic to obtain authorization to provide services. I give permission for this release. I also give my permission for Cruz Clinic/Integrative Psychology to release information acquired to process billing claims for services provided to me, or my dependent by the third-party payor reimbursing for these services.

___I understand that fees for services are to be paid at the time of the appointment, unless other arrangements have been made. If my third-party payor does not cover any fees or any portion of fees for the services I, or my dependent have received, I accept responsibility for them. If maximum third-party benefits have been reached, I understand that I am responsible for any fees for services subsequently rendered.

___I understand that it is my responsibility to know my insurance policy benefits. I realize that Cruz Clinic/Integrative Psychology has contacted my insurance company to receive my benefit information, yet sometimes the insurance companies do not give clinics accurate information. Payment is subject to the terms of your insurance policy and can only be determined at the time the claims are processed. Therefore, I realize it may be in my best interest to contact my insurance company myself to verify this information. If Cruz Clinic was quoted incorrect information, resulting in lesser benefit coverage, I understand that I am responsible for the difference. Many clients have found it helpful to ask the following question to my carrier:

Is out-patient mental health a covered benefit?
If covered, are there a certain number of visits allotted and or any parameters regarding the duration of therapy allowed?
Will therapy charges be applied to my deductible?
Are there any co-pays that I will be responsible for?
Do I need pre-authorization?

___I understand that I will be charged for missed appointments and late cancellations with less than 24 hours notice. I am aware that because third-party payors, such as insurance companies, will not pay for missed appointments or late

(Please continue on reverse side)

cancellations, any appointment that is missed or canceled without my giving 24 hours notice will be billed directly to me. I understand that I may be billed for these appointments at Cruz Clinic/Integrative Psychology's usual and customary fee. Payment for a missed or late canceled appointment is due within two weeks of the appointment. If treatment or diagnostic evaluation is terminated by my choice or because of violation of program rules, I agree to pay all outstanding fees existing at the time of termination. Cruz Clinic/Integrative Psychology utilizes an automated system which makes reminder calls the day prior to your appointment. I understand that this automated call is strictly a courtesy call, and I further understand that I am still responsible for a No Show/Late Cancel fee if I do not receive this call.

___ Yes, I would like to be included in this reminder call service at the following number _____.
___ No, I would prefer not to get a reminder call.

___I agree to inform Cruz Clinic/Integrative Psychology of any changes in my health insurance benefits and to assign insurance benefits to Cruz Clinic/Integrative Psychology. I understand and hereby agree that accounts more than 90 days delinquent, excluding those where payment is made directly to Cruz Clinic by a third-payor (e.g., and insurance company), may be subject to collection action.

___If I have been referred to Cruz Clinic/Integrative Psychology by a court, agency, Employee Assistance Program, physician, attorney, hospital, or another mental health or substance abuse treatment practitioner or program, Cruz Clinic/Integrative Psychology may want to acknowledge the referral by another professional. In order for this to occur, my consent is necessary. I hereby give consent to this limited release of information. Further, unless specified herein or by statute, the release of any further information to anyone required my written permission.

___I recognize that if I, or my dependent, have been ordered by a court to seek services at Cruz Clinic/Integrative Psychology the court will require one or more reports. My separate, written consent is required for this to occur. I understand that Cruz Clinic/Integrative Psychology shall not be obligated to send or release a copy or original of any report or any clinical records concerning me or my dependent to anyone until the balance on my or my dependent's account is paid in full.

___I understand and accept that it may be necessary for Cruz Clinic/Integrative Psychology to reach me by mail or by telephone during, or after, my or my dependent's treatment with Cruz Clinic for confirming or scheduling appointments, billing and payment issues, completing forms, conducting surveys and any necessary follow-up.

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services at Cruz Clinic/Integrative Psychology for myself, or my dependent. I recognize that I may refuse any aspect of treatment. I also accept that such a refusal may result in termination of services by Cruz Clinic/Integrative Psychology. If termination of services does occur, I understand that I have the right of appeal. Further, I have read, understand and accept what is written in this "Consent To Services" and the "Important Information for Patients" pamphlet. I also understand that I may request a copy of this "Consent To Services" form.

_____		_____
Signature of Patient	Date	Witness
_____		_____
Signature of Parent/Guardian	Date	Witness

Patient Name _____
Patient I.D. _____

CRUZ CLINIC
Psychiatric & Psychological Care

Missed Appointment Policy

_____ _____

Patient Name (Please Print) Patient Date of Birth (mm/dd/yyyy)

We strive to create as many appointments as possible for our providers so that we can provide all the services needed by our patients. We need the help of our patients to make our system work. We know and understand how busy everyone's lives are and we know plans change. We would like the courtesy of a call if an appointment cannot be kept.

It is our policy that any scheduled appointment be canceled with at least 24 hours notice to the appointment time, except in case of an unforeseen emergency.

If an appointment is canceled, we will do our best to give our patient the next available appointment time for the type of visit required.

If you fail to keep an appointment or cancel on time, there will be a charge of **$75**. Three missed appointments may cause dismissal from our practice.

Please understand this policy will not affect those patients that keep their appointments. In an office with many missed appointments, we are trying to accommodate those patients that need to be seen in our office. We look forward to your anticipated understanding and cooperation.

_____ _____

Patient Signature Date

_____ _____

Legal Guardian Signature Date

_____ _____

Witness Signature Date

Cruz Clinic
Integrative Psychology of Ann Arbor

Release of Information

Patient Name _____ Date of Birth _____

The following individuals may contact Cruz Clinic for the following reasons:

NAME	PHONE
_____	_____
_____	_____

Please check all that apply

____ Call to schedule/cancel/change an appointment

____ Inquire about or inform the clinic about patient's insurance/or patient liability

____ Other _____

_____

_____

This authorization will not expire unless requested by patient.

_____ _____
Patient Signature Date

_____ _____
Witness/Cruz Clinic Employee Date

Cruz Clinic
17177 N Laurel Park Dr, Ste 131
Livonia, MI 48152
Ph: (734) 462-3210 Fax: (734) 462-1024

PAYMENT INFORMATION SHEET – INSURANCE

Date _____

Patient Name _____ DOB _____

On _____ (date) _____ (staff member at Cruz Clinic) contacted your insurance carrier _____ at _____ (phone number) and spoke with _____ (representative providing benefits).

We were advised that your coverage for outpatient mental health services is as follows:

Deductible _____ Copay _____
Max visits per year _____ Max visits lifetime _____
Authorization needed? ____ Yes _____ No
If yes, after _____ (number) visits
If yes, who is required to get this authorization? _____

Based on these benefits your insurance should pay _____
_____

However, please be advised that this is not a guarantee of payment from the insurance company. Please also be aware that your contract is between you and your insurance provider and therefore we can not guarantee this information is accurate. Please contact your insurance company for more details.

_____ _____
Patient Name Signature of Responsible Party

_____ _____
Date Printed Name of Responsible Party

_____
Cruz Clinic Witness

_____ (Please initial) I understand that it is my responsibility to know my insurance policy benefits. I realize that Cruz Clinic has contacted my insurance company to receive my benefit information, and I understand that occasionally insurance companies do not provide accurate information. Therefore, I know it is in my best interest to contact my insurance company myself to verify this information. If Cruz Clinic was quoted incorrect information that results in lesser benefit coverage, I understand that I am responsible for the difference.

Please advise if you would like us to bill your insurance for services rendered.

_____ (Please initial) Yes, please bill my insurance company for services rendered
OR
_____ (Please initial) No, I prefer to pay cash for these services

Cruz Clinic/Integrative Psychology - Coordination of Care

FOR YOUR INFORMATION ONLY - NOT A REQUEST FOR MEDICAL RECORDS

Patient Name: _____ Date of birth: _____

Behavioral Health Provider/Primary Care Physician Communication Form

Patient Consent to Exchange Information (to be completed by patient)

I, _____, **authorize / do not authorize** (CIRCLE ONE)
Cruz Clinic to send this coordination of care form to my primary care physician.

Primary Care Doctor Name _____
Primary Care Doctor Address _____
Primary Care Doctor Phone _____
Primary Care Doctor FAX _____

_____Patients please initial if you prefer no coordination of care and received "Be Your Own Health Manager" information sheet.

To exchange information regarding my mental health/substance abuse treatment and medical healthcare coverage for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care or substance care and or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for the course of this treatment. I understand that I may revoke this authorization at any time by written notice to the above behavioral health provider. I also understand that it is my responsibility to notify my behavioral health provider if I choose to change my Primary Care Physician. I also understand that most health care insurance (under the new health care act) require coordination of care with your PCP prior to paying for services rendered.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent/ Guardian (If patient is a minor) Date

_____ _____
Signature of Witness Date

Provider Information (To be completed by Behavioral Health Provider)

(Provider Name) _____ at Cruz Clinic
17177 N. Laurel Park Drive, Ste 131, Livonia, MI. 48152 Phone 734-462-3210 Fax 734-462-1024
DSM V Diagnosis code & name:_____

Symptoms:_____
Treatment Type _____ Frequency _____ Length of TX_____
Medication (s) Prescribed: _____
___ screening tools attached (check here)
___ psychosocial assessment attached (check here)
Comments: _____

For Urgent or emergency situation, please call the primary care physicians In addition to sending form

Conclusion of mental health/ Substance treatment
_____ Date of last session _____ treatment completed? Yes _____ No_____
_____ Notification of prescription or change in medications (see comments)
_____Summary of care attached (check here)
_____ Comments: _____

_____ _____ _____
Provider's Signature Credentials (MD, PA ,NP, or Therapist) Date

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICAIN, RETAINING THE ORGINAL IN THE PATIENT CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATIONN THAT THE FAX WAS SENT.
DATE SENT _____ SENT BY INTIALS_____ FAX OR MAIL

Please File in Patient's Chart

Cruz Clinic/Integrative Psychology
Credit Card Authorization Form

_____ _____/_____/_____
Patient Name Patient Date of Birth

□ Visa □ MasterCard □ Discover □ American Express

_____
Cardholder Name

_____
Cardholder Address

_____
City State Zip

_____
Credit Card Number

_____
Expiration Date Security Code

I AUTHORIZE CRUZ CLINIC TO CHARGE MY CREDIT CARD FOR PAYMENT/S TO BE PROCESSED:

□ AT EACH TIME OF SERVICE □ TOTAL BALANCE ON LAST DAY OF MONTH

□ PER PAYMENT AGREEMENT $_____

PLEASE READ AND INTIAL BELOW:

_____HAVING READ THIS FORM, MY SIGNATURE BELOW ACKNOWLEDGES THAT I VOLUNTARILY GIVE MY AUTHORATION AND CONSENT TO PROVIDING THE REQUESTED INFORMATION FOR MY CREDIT CARD TO BE CHARGED ACCORDINGLY FOR THE CONDITIONS LISTED ON THIS FORM.

_____I UNDERSTAND THAT THIS FORM IS VALID UNTIL_____ (DATE/YEAR) UNLESS I CANCEL THROUGH WRITTEN NOTICE TO CRUZ CLINIC.

_____OTHER THEN THE CONDITIONS MENTIONED IN THIS FORM, UNDER NO CIRCUMSTANCES WILL CRUZ CLINIC CHARGE YOUR CREDIT CARD FOR ANYTHING OTHER THEN WHAT IS LISTED ON THIS FORM.
IN CONJUNCTION WITH HIPAA REGULATIONS, ALL CREDIT CARD INFORMATION WILL BE CONFIDENTIALLY KEPT AND ONLY AUTHORIZED STAFF WILL BE ABLE TO ACCESS THIS INFORMATION.

_____ _____/_____/_____
Patient signature or authorized person Date

_____ _____/_____/_____
Witness signature Date

RECIEPTS CAN BE MAIL TO: □ ADDRESS IN ACCOUNT ☐ THE CARDHOLDER'S ADDRESS

N:forms/ patient forms/ Credit card auth form

Cruz Clinic
Integrative Psychology of Ann Arbor
TELEMEDICINE SERVICES CONSENT FORM

Name: _____ DOB: _____

Informed Consent for Telemedicine Services

•I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

•I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.

•I understand that the laws that protect privacy and the confidentiality of medical information including (HIPAA) also apply to telemedicine.

•I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

•I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without effecting my right to future care or treatment.

•I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Signature of Client/Patient _____ Date _____

Printed Name _____

Phone # _____

E-mail Address _____

Witness _____ Date _____

PATIENT NAME: _____ DATE: _____

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ9 total score:			

Q6 CORE10	I made plans to end my life in the last 2 weeks	NO	YES

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score:			

Cruz Clinic

Child & Adolescent Psychosocial Questionnaire / 2020

(Ages 1-17)

In order to better serve you, Cruz Clinic would like you to **FULLY** complete this questionnaire and return it to the receptionist as soon as it is complete. Please ensure that no question is left blank. This information is kept strictly **confidential** as required by State and Federal guidelines.

Today's Date: _____

Client Name: _____SSN _____ - ____ - _____
Last First MI

Parent/Guardian Name: _____SSN _____-_____-_____
Last First MI

Date of Birth: _____Age: ____ Male ____ Female _____ Other Gender Identification _____

Place of Birth:_____ Primary language:_____

Telephone: (_____) _____ ( ) Home - OK to leave a message YES / NO

Telephone: (_____) _____ ( ) Cell - OK to leave a message YES / NO

Telephone: (_____) _____ ( ) Work - OK to leave a message YES / NO

Telephone: (_____) _____ ( ) Other - OK to leave a message YES / NO

Please explain "Other" Phone: _____

Primary Care Physician: _____Phone: _____

Why have you decided to come into treatment now?

_____

_____

_____

What would you like to accomplish by coming to the Cruz Clinic? (*criteria for discharge*)

_____

_____

Did anyone refer you to Cruz Clinic? ( ) YES ( ) NO If YES, please tell us who referred you:

_____

_____

In Case of Emergency, Contact:

Name:_____Relationship:_____
Address: _____
Home Phone:_____
Work Phone:_____

Risk Assessment & Protective Factors:

Please indicate whether this child is **experiencing** any of the following: ( ) None
( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) physical violence
Please explain:

_____

_____

Please indicate whether your child has a **history** of any of the following: ( ) None
( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) physical violence
Please explain:

_____
_____

Parents please complete 1 to 5

In the past 3 months did your child:

1	Think he/she would be better off dead or wish he/she were dead?	NO	YES
2	Want to harm himself/herself?	NO	YES
3	Think about suicide?	NO	YES
4	Have a suicide plan?	NO	YES
5	Ever make a suicide attempt?	NO	YES

Child/Adolescent please complete 6 to 13

6	I feel happy with my family	NO	YES
7.	I feel happy in school	NO	YES
8.	Sometimes I feel like crying	NO	YES
9.	I have friends	NO	YES
10.	I am sleeping well	NO	YES
11.	I have some problems/concerns/worries	NO	YES
12.	I feel nobody loves/likes me	NO	YES
13.	My family would be happier if I didn't live there	NO	YES

If your child had any thoughts of hurting themselves, what factors would prevent them from acting on these thoughts? Please check all that apply:

____ religion ____ family ____ pet(s) ____ the people they are close to ____ their friends

____belief that things will get better ____belief that suicide is wrong _____ other (please explain)
_____

Does your child has friends/family they can talk to: ( ) YES ( ) NO

Name three things that are very important to your child (such as friends, family, spirituality, pets)

1._____
2._____
3._____

Do you believe your child has conflict resolution skills and non-violent dispute resolution skills?
___YES ___NO

Residence Situation:

( ) lives with both parents ( ) joint custody arrangement ( ) lives with mother
( ) lives with father ( ) lives with grandparents ( ) other_____

Family Social History:

Name of child's mother: _____Level of Education: _____
Age of Mother: _____If deceased, age at death _____

Name of child's father: _____Level of Education: _____
Age of father _____If deceased, age at death _____

Biological parents are: ( ) married ( ) separated ( ) divorced ( ) other:_____
If deceased, age at death _____

Are both parents aware that child is coming to Cruz Clinic?
( )YES ( ) NO, If NO, please explain:

_____

_____

How would you describe your child's relationships with your family/siblings?
( ) Excellent ( ) Good ( ) Fair ( ) Poor

Family Composition: (number of siblings, parents) - please include names

_____

_____

_____

If any sibling or parent is deceased indicate name and age of death:

_____

How would you describe the relationship between your child and his/her family?

Mother ( ) good ( ) fair ( ) poor issue? _____
Father ( ) good ( ) fair ( ) poor issue? _____
Step-Parent ( ) good ( ) fair ( )poor issue? _____
Sibling ( ) good ( ) fair ( ) poor issue? _____
Sibling ( ) good ( ) fair ( ) poor issue? _____
Sibling ( ) good ( ) fair ( ) poor issue? _____
Other ( ) good ( ) fair ( ) poor issue? _____

Custody issues we should be aware of: _____

_____

_____

Has a court made any custody decisions for this child? ( ) YES ( ) NO
If YES, please explain, and please be aware that Cruz Clinic requires a copy of the court papers:

_____

_____

Family History:

Please indicate **any family history** of the following:

( ) Substance Abuse: indicate who: _____
( ) Mental Illness: indicate who: _____
( ) Suicide: indicate who: _____
( ) Autism: indicate who: _____
( ) Developmental Disability: indicate who: _____
( ) ADD/ADHD: indicate who: _____

Social History:

Please indicate if you have the following concerns regarding your child:
( ) Peer Relationships ( ) Gang Involvement ( ) Relationship with Authority
( ) Social Support Networks ( ) Hobbies/Interest ( ) Relationship with your other children
( ) Other: _____
If any concerns, please explain: _____

Leisure Time

How does your child spend his/her leisure time?
( ) Alone ( ) Mostly Alone ( ) with others ( ) About equal, ½ alone, ½ with others

Please list your child's hobbies and leisure interests, activities, talents,
_____
_____

Religion ( ) NONE, or fill in: _____
How important is your child's Religious/Spiritual Beliefs:
( ) very important ( ) somewhat important ( ) not important
Would you like to talk to your therapist about your child's religious/spiritual beliefs? ( ) YES ( ) NO

Race ( ) Caucasian ( ) African-American ( ) Native American ( ) Asian-American
( ) Other: _____

Ethnicity ( ) Hispanic ( ) Asian ( ) Other
Would you like to talk to your therapist about any racial/cultural issues? ( ) YES ( ) NO

Sexual Orientation (optional): ( ) Heterosexual ( )Lesbian ( )Gay ( )Questioning
( ) N/A ( ) Other: _____

Gender Identity (optional): ( )Male ( )Female ( )Transgender
( ) Self identification: _____
Would you like to talk to your therapist about gender or sexual orientation identity? ( ) YES ( ) NO

Behavioral Health Treatment History:

Has your child ever seen a behavioral health care provider before? ( ) YES ( ) NO

If YES, inpatient or outpatient? _____
If YES, for Inpatient, Name of Facility:_____
Address:_____
Length of Stay:_____ Number of admissions:_____

If YES for Outpatient, Name of Facility:_____
Address:_____
Name of Therapist:_____
Type of therapist were they? ( ) Psychiatrist ( ) Psychologist ( ) Social Worker ( ) Counselor
( ) Other: _____

When did your child see therapist and for what reason?
_____
_____
_____

Current General Health Status:

Please describe your child's current general health:

( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor ( ) Very Poor

Please check all of the following physical conditions that apply to you now, or in the past.

___Thyroid Problems	_____ Diabetes	_____ Seizures
___Attention Problems	_____ Mental Problems	_____ High Blood Pressure
___Ulcers	_____ Low Blood Sugar	_____ Trouble sleeping
___Colitis	_____ Other	

Please describe current health status:

_____
_____
_____
_____

Have you been exposed to any communicable diseases in the past 3 months? ( ) YES ( ) NO
If YES, please explain:_____

Pain Status: Is your child feeling any physical pain at this time? ( ) YES ( ) NO
If YES, please explain: _____
Make a **circle** around the intensity level of your pain: **Mild** 1 2 3 4 5 6 7 8 9 10 **Extreme**

Medical:

Do you feel your child needs a physical exam? ( ) YES ( ) NO
When was the last time your child had a physical exam? _____
If it has been more than 12 months since your child's previous physical exam, he/she will need to see a primary care doctor.

If it has been more than 12 months since my child's last visit:
( ) I will schedule an appointment with my pediatrician/primary care doctor.
( ) I would like to be referred to a pediatrician/primary care doctor.
( ) I refuse to see a pediatrician/primary care doctor.

Has your child suffered from any childhood illnesses/disorders, disabilities/handicaps, operations, and/or hospitalizations (please include dates and ages)
( ) YES ( ) NO If YES, please explain and include dates and ages: _____
_____
_____
_____
Have you had any serious accidents/injuries? ( ) YES ( ) NO If YES, please explain
_____

Head Injuries: ( )None ( ) Yes, without loss of consciousness ( ) Yes, with loss of consciousness
Please explain: _____

Convulsions: ( ) YES ( ) NO If YES… ( ) without fever ( ) with fever
Please explain: _____
_____
Any Disabilities/Handicaps: ( ) YES ( ) NO if YES, please explain _____
_____

Do out have any **non-food** allergies? ( ) YES ( ) NO
If YES please list allergies and allergic responses: _____
_____

Does your child have difficulty sleeping? ( ) YES ( ) NO If YES, Please explain:
_____
_____

Dental Screening:

Does your child have any dental concerns (cavities, broken teeth, etc.) ( ) YES ( ) NO

If yes, please explain: _____

Nutritional Screening:

Has your child ( ) gained weight or ( ) lost weight in the last 30-60 days? ( ) YES ( ) NO
If YES, how much and why? _____
_____
_____

Do you believe your child is at a: ( ) low nutritional risk ( ) medium nutritional risk
( ) high nutritional risk

Does your child have any diet or nutritional concerns that may be an indication of an eating problem such as binging, inducing vomiting, extreme dieting, etc? ( ) YES ( ) NO
If YES, please explain:_____
_____
_____

Does your child have any **food** allergies? ( ) YES ( ) NO
If YES, please list which food and allergic response: _____
_____

Allergies to Medications: ( ) NONE

Medication _____ Type of allergic reaction _____

Medication _____ Type of allergic reaction _____

Medication _____ Type of allergic reaction _____

If your child has additional allergies please check here ( ) and continue on reverse.

Medications:

Does your child currently take any medications: ( ) YES ( ) NO If YES, please list all the medications your child is **currently** taking or have taken in the **last year** (prescription and over-the-counter):

Name of Medication	**Dosage**	**How taken**	**When started?**	**Why are you taking?**	**Prescribing doctor**

(If your child is taking additional medications, please check here _____ and continue on reverse)

Who has been prescribing the medications listed above?
Name:_____
Address: _____
Telephone: _____

What medications do you know your child must continue to take? _____

What supplements is your child currently taking?

Name of Supplement	**How often?**	**When started?**	**Why taking supplement?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(If your child takes additional supplements, please check here _____ and continue on reverse)

Substance Use:

Does your child use Nicotine? YES / NO
If YES, ( ) Cigarettes/Cigars/Pipe ( ) Chewing tobacco ( ) e-cigarettes
Amount per day: _____ How long have they used? _____
Any related health issues? ( ) YES ( ) NO if YES, please explain: _____
_____

Does your child use Alcohol? ( ) YES ( ) NO, if YES….
How often does your child use? _____ How long has he/she used? _____
How much does your child usually drink?
_____

Any related health issues? ( ) YES ( ) NO if YES, please explain: _____
_____
If any Recovery, Longest length of sobriety: _____

Do your child use any Illegal Drugs? ( ) YES ( ) NO
If YES, what drug (s) does your child use? _____

How often does your child use? _____
How much does your child use? _____
When was the last time your child used? _____

Abuse:

Has your child ever experienced any?
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse ( ) Abandonment/Neglect ( ) NONE
If YES, by whom:
_____
Length/Duration of abuse:
_____

Was abuse reported to the authorities: ( ) YES ( ) NO Please explain:
_____
_____

Has your child ever physically, emotionally, or sexually abused anyone? ( ) YES ( ) NO
If YES, please explain:
_____
_____
_____

Was it reported to the authorities: ( ) YES ( ) NO Please explain:_____

Has your child ever witnessed abuse? ( ) YES ( ) NO If YES, please check off:
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse

Strengths /Weaknesses:

What are your child's main strengths and abilities?

_____
_____

What are your child's main weaknesses?

_____
_____

Finances:

Do your family currently have financial problems? ( ) YES ( ) NO If YES, please explain:

_____
_____

Legal History:

Is your child currently facing any pending charges/ convictions? ( ) YES ( ) NO
If YES, please explain:

_____

Has your child ever been arrested or spent time in jail? ( ) YES ( ) NO If YES, please explain:

_____

Does your child currently have a probation officer? ( ) YES ( ) NO If YES…
Name of probation officer:_____Phone Number: _____

Developmental History:

Duration of Pregnancy: _____

Smoking during pregnancy ( ) YES ( ) NO
If YES, number of cigarettes daily: _____

Alcohol during pregnancy ( ) YES ( ) NO
If YES, amount and type:

_____

Drugs during pregnancy ( ) YES ( ) NO
If YES, please explain:_____
_____
_____

Medications during pregnancy ( ) YES ( ) NO
If YES, please explain:_____
_____
_____

Complications during pregnancy? ( ) YES ( ) NO
What type? _____

Delivery

Was the labor and delivery of your child normal? ( ) YES ( ) NO
If NO, Please explain:

_____
_____
Birth Weight_____lbs.
Infant days in the Hospital: _____
APGAR (if known) _____

Milestones:

Please indicate and describe if you child has had any problems with **motor skills**, **language**, or **social attachment**: If yes, please specify which area and what happened:

_____
_____
_____
_____

Education:

What grade is your child currently in?_____

Child Attended:
( ) Infant day care ( ) pre-school ( ) kindergarten

Official School Classifications
( ) LD or ADHD ( ) EI ( ) DHI ( ) ASD
( ) Visually Impaired ( ) Hearing Impaired ( ) Other
If other, please explain: _____

Type of Placement:
( ) regular classes ( ) special education ( ) honors (T&G) ( ) home study

Please indicate if you have any concerns in the following areas:
( ) Adjustments
( ) Behavioral Problems
( ) Repeated grades
( ) Suspensions/Expulsions
( ) Performance/Achievements
( ) Attitude towards school
( ) Learning issues

Did your child have any learning issues? ( ) YES ( ) NO If YES, please explain:

_____
_____
Name of School:_____
Address:_____
Telephone No.:_____
Principal's Name: _____
School Social Worker: _____

Developmental Perspective:

Parents/Guardian Section:

	Below age expectation	At expected age level	Above age expectation
Physical			
Emotional			

Cognitive			
Educational			
Nutritional			
Socialization			

Concerns:

_____

_____

I have completed these questions to the best of my knowledge and I am aware that I can discuss any concerns with my clinician.

_____ _____

Signature of Parent/Guardian Date

PARENTS/GUARDIANS STOP HERE

- -

- -

Developmental Perspective continued:
This portion for clinician use:

Clinician

	Below age expectation	At expected age level	Above age expectation
Physical			
Emotional			
Cognitive			
Educational			
Nutritional			
Socialization			

Concerns:

_____

_____

(For the clinician only) I have reviewed and addressed all issues cited on this form with the client and/or guardian.

_____ _____

Signature of Clinician Date
MD/PA/Therapist/Nurse Practitioner

Client Name: _____
DOB: _____

PLEASE CHECK ALL MEDICATIONS THAT YOU RECALL TAKING AT ANY TIME IN THE PAST

Antidepressants

- ☐ Adapin/Sinequan (doxepin 3 & 6mg)
- ☐ Anafranil (clomipramine)
- ☐ Aplenzin
- ☐ Brintellix/Trintellix (vortioxetine)
- ☐ Buspar (buspirone)
- ☐ Celexa (citalopram)
- ☐ Cymbalta (duloxetine)
- ☐ Effexor/XR (venlafaxine)
- ☐ Elavil (amitriptyline)
- ☐ Fetzima (levomilnacipran)
- ☐ Lexapro (escitalopram)
- ☐ Luvox/CR (fluvoxamine)
- ☐ Norpramin (desipramine)
- ☐ Pamelor (nortriptyline)
- ☐ Paxil/CR (paroxetine)
- ☐ Pristiq (desvenlafaxine)
- ☐ Prozac (fluoxetine)
- ☐ Remeron (mirtazapine)
- ☐ Symbyax (fluoxetine/olanzapine)
- ☐ Trofranil (imipramine)
- ☐ Viibryd (vilazodone)
- ☐ Welbutrin/SR/XL (bupropion)
- ☐ Zoloft (sertraline)

Psychotropics

- ☐ Abilify (aripiprazole)
- ☐ Clozaril (clozapine)
- ☐ Fanapt (iloperidone)
- ☐ Geodon (ziprasidone)
- ☐ Haldol (haloperidol)
- ☐ Invega (paliperidone)
- ☐ Latuda (lurasidone)
- ☐ Rexulti (brexpiprazole)
- ☐ Risperdal (risperidone)
- ☐ Saphris (asenapine)
- ☐ Seroquel/XR (quetiapine)
- ☐ Thorazine (chlorpromazine)
- ☐ Triavil (Elavil/Trilafon)
- ☐ Trilafon (perphenazine)
- ☐ Vraylar (cariprazine)
- ☐ Zyprexa/Zydis (olanzapine)

Mood Stabilizers/Antiepileptics

- ☐ Depakote/ER (valproate)
- ☐ Dilantin (phenytoin)
- ☐ Keppra (levetiracetam)
- ☐ Lamictal (lamotrigine)
- ☐ Lyrica (lamotrigine)
- ☐ Neurontin/Horizant (gabapentin)
- ☐ Tegretol (carbamazepine)
- ☐ Topamax/Trokendi (topiramate)
- ☐ Trileptal (oxcarbazepine)

- ☐ **Lithium (Eskalith/Lithobid)**

Antihistamines

- ☐ Benadryl (diphenhydramine)
- ☐ Periactin (cyproheptadine)
- ☐ Vistaril/Atarax (hydroxyzine)

Beta Blocker

- ☐ Inderal (propranolol)

Alcohol Dependence

- ☐ Anabuse (disulfiram)
- ☐ Campral (acamprosate)
- ☐ Revia/Vivitrol (naltrexone)

Sedative-Hypnotics and Sleep Aid

- ☐ Ambien/CR (zolpidem)
- ☐ Belsomra (suvorexant)
- ☐ Dalmane (flurazepam)
- ☐ Halcion (triazolam)
- ☐ Intermezzo/Edular/ZolpiMist Spray (Zolpidem)
- ☐ Lunesta (eszopiclone)
- ☐ Rozerem (remelteon)
- ☐ Restoril (temazepam)
- ☐ Silenor (doxepin 3 & 6 mg)
- ☐ Sonata (Zaleplon)

Anxiolytics

- ☐ Ativan (lorazepam)
- ☐ Klonopin (clonazepam)
- ☐ Librium (chloridiazepoxide)
- ☐ Valium (diazepam)
- ☐ Xanax/XR (alprazolam)
- ☐ Trazodone

Stimulants

- ☐ Adderall/XR (mixed amphetamine salts)
- ☐ Aptensio XR (methylphenidate)
- ☐ Concerta (methyphenidate ER)
- ☐ Daytrana Patch (methyphenidate)
- ☐ Dextroamphetamine tablets (immediate release)
- ☐ Dexadrine Spansule/XR (dextroamphetamine)
- ☐ Evekeo (amphetamine salts)
- ☐ Focalin/XR (dexmethylphenidate)
- ☐ Metadate CD (methylphenidate)
- ☐ Quillivant (liquid methyphenidate)
- ☐ Ritalin/SR/LA (methylphenidate)
- ☐ Vyvanse (lisdexamphetamine)
- ☐ Zenzedi (dextroamphetamine sulfate)

Dopamine Agonists

- ☐ Mirapex (pramipexole)

Alpha 1A Antagonist

- ☐ Minipress (prazosin)

Alpha 2A Agonist

- ☐ Catapres (clonidine)
- ☐ Catapres TTS (clonidine patch)
- ☐ Kapvay (clonidine extended release)
- ☐ Intuniv (guanfacine extended release)
- ☐ Tenex (guanfacine)

Wake Promoting Agents

- ☐ Provigil (modafinil)

Supplements

- ☐ Axona (caprylidene)
- ☐ Cerefolin NAC or N-acetylcysteine
- ☐ Deplin/Enlyte/Enbrace/Bellevue S8/MethylPro
- ☐ Melatonin
- ☐ Sam-e
- ☐ St. John's Wort

IF PREVIOUSLY TAKEN, WHAT WAS THE REASON FOR DISCONTUNING MEDICATION?

PLEASE EXPLAIN ON FOLLOWING PAGE. ⟶

MEDICATIONS DISCONTINUED	REASON FOR DISCONTINUING