LiveOak Psychiatric and Family Practice PLLC

(210)-441-6024 | 41100 Northwest Loop 410 Suite 700 Castle Hills, TX 78213 United States.

Children Psychiatric Intake and Annual Health Questionnaire

Patient Name:_____ Date:_____

Medicaid ID:_____ DOB:_____ Age:_____ M F

Parent/ Guardian Name:_____ Phone:_____

Address:_____

Pharmacy:_____

Case Manager:_____ Phone:_____ email:_____

CPS CW_____ County_____ Phone:_____

CPS CW email : _____

Has the Patient had Psychological Testing? Yes No
Details if Known :

Is the patient currently receiving psychotherapy/counseling? Yes No
(If yes please specify the name of the therapist, frequency, and response to treatment)

_____

Is the patient currently having visits or other contact with biological parents or other family members?
Yes No (If yes please describe the nature of the contact and the child's response)

What is the current CPS Plan for the patient and family?

_____

When was the child placed in your home? When and why was the child placed in CPS custody?
(Please include what you know about the child's exposure to neglect, abuse, and /or other trauma)

_____

Describe the current living situation (number of children 1n the home, please specify whether biological,

_____

adopted, or foster children, other adults living in home)

_____

_____

Describe the child's interests hobbies and talents:

_____

Educational History:

Current Grade in School _____

Typical Grades/Academic Performance: _____

Educational Classification Mainstream Alternative Special Education Emotionally Disturbed

Learning disorders/ delays Speech Spelling Reading Arithmetic Written Language

Any behavioral problems in school? Yes No (describe)_____

Any alternative school history? Yes No

Any grades skipped or repeated? (describe)

_____

Child Medical History:

Hospitalizations:_____

Surgeries: _____

Other Medical Problems: : _____

Abuse History : Physical : _____

Emotional: _____

Sexual: _____

Current/Pending Abuse Issues _____

Head Injury : _____

Seizure : Yes No Date Diagnosed:_____Treatment: _____

EEG done/date:_____Any loss of consciousness? _____

Sleep Problems: _____

Developmental:

Prenatal Problems Premature Jaundice Low Birth weight Other _____

Postnatal Problems: _____

Drug use during pregnancy: Alcohol Cocaine Marijuana Other Drugs _____

Delivery: Normal C-Section Gestational Diabetes Hypertension Eclampsia

Milestones: Sat up at_____Talked at:_____Walked at _____

2-3 word sentences at _____

Does the child have any handicapping conditions (not previously discussed)? Yes No (describe)

_____

Medical conditions in family	Brother	Sister	Mom	Dad	Grandparent	Other'
High Blood Pressure						
High Cholesterol						
Diabetes						
Sickle cell						
Anemia						
Sudden death before age 40						
Early death by heart attack before age 50						
Asth ma						
Lung Cancer						
Glaucoma						
Narrow angle						
Other						

Family Psychiatric History

Family History of Schizophrenia _____ Family History of thought disorder_____

Family History Bipolar Disorder _____ Family History of ADHD _____

Family History of suicide: _____

Other:_____

What is the main problem your child is experiencing currently (Please be specific) :

_____

_____

What interventions have you tried with your child?

_____

_____

Has the patient had any previous psychiatric evaluations? Yes No (if yes details)

_____

Any H1story of Psychiatric Hospitalization?

_____

Residential Treatment (RTC) Placement

_____

Other Psychiatric Treatment

_____

Current dedications Patient is taking: Please include Dosage(mg) and times
INDICATE NONE OR N/A IF NOT ON ANY MEDICATIONS

Medication Name and Dose	Complete Instruction	Reason for Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is the guardian the Medical Consenter? Yes No - if no who is medical Consenter

_____

Are current medications being given as prescribed? Yes No Please Explain : _____

_____

Please describe any side effects your child may have or may currently be experiencing:

Rash Fever Dizziness Stomach Aches

Other: _____

List previous medications and reasons discontinued: _____

_____

Is your child allergic to any medications? _____

Is your child sexually active? Yes, how long_____ No Unknown

History of sexually transmitted diseases? Yes, what types? _____ No Unknown

Behavior Checklist

On the items below, please check all that apply and provide a brief explanation of your observations.

Sleep/Appetite/Hygiene/Health Trouble Sleeping Nightmares/sleep terrors Sleeps too much Low energy/fatigued Poor appetite Overeats Poor grooming/hygiene Bedwetting/toileting accidents Complains frequently about physical symptoms/illness For all checked items, please describe what has been observed or reported.	*Depression/Anxiety* Withdrawn/prefers to be alone Cries frequently Down, depressed, discouraged Lacks confidence/self-esteem Suicidal thoughts or actions Frightened, worried Specific phobias (e.g. fear of spiders, heights) Shy, timid, slow to warm up to people Dependent, clingy, afraid to separate For all checked items, please describe what has been observed or reported
Conduct Problems Breaking house rules Oppositional/argumentative History of arrest/conviction Drug/alcohol use Skipping school Fire setting Lying Stealing Runaway behavior Sexual acting-out/sexualized preoccupations Gang involvement Apathetic (acts as if he/she doesn't care) For all checked items, please describe what has been observed or reported.	*Aggression* Angers easily Uses foul language Yells, screams Hits, kicks, bites Temper tantrums Violent threats, homicidal thoughts Self-injurious acts (e.g. cutting, head banging) Destroying property Taunting, teasing, bullying Cruelty to Animals Instigates, incites others to become aggressive For all checked items, please describe what has been observed or reported.

Attention/Concentration/Judgment Distractible Trouble sitting still Impulsive (acts without thinking first) Accident prone (always getting hurt) Poor judgment Limited problem solving skills Trouble grasping new information Confused, disoriented For all checked items, please describe what has been observed or reported.	*Arypical Thinking/Behavior* Hallucinations (sees/hears things that are not there) Delusions (Bizarre, Irrational beliefs) Rapid speech Flightiness (jumps from subject to subject) Grandiose (overestimates capabilities/skills, full of him/herself) Poor social skills Parentified (tries to act too grown-up, takes care of siblings, etc.) Compulsions (rituals, odd, repetitive habits) Speech problems/tics/tremors Guarded, suspicious, aloof. cautious For all checked items, please describe what has been observed or reported.

Client Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of services, LiveOak Psychiatric and Family Practice creates and maintains health records and other information describing, among other things, my mental health history, symptoms, evaluations and test results, diagnoses, and treatment recommendations.

I have been provided with a Notice of Privacy Practices that provides a more complete description *of* the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about he for the purpose of treatment recommendations, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral, or in an electronic format, are confidential and cannot be disclosed for reasons outside of treatment recommendations, payment, or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment recommendation, payment, or health care operations, be restricted. I also understand that Charles H Sargent, MD, PA and I must agree: to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions, in writing, on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Cancellation Policy

*We **ask** that patient.s arrive in a timely manner, which **insures** that yo**u** will meet with one of our **clinicians** and that **other** patients are not **inconvenienced.** **If you** **do** riot arrive **at the specific time of** your **appointment, it** may be necessary ta **reschedule your** visit. **If you must** cancel or reschedule an appointment, 48 hours **advance** notice is required. After two **no-shows or** late cancellations, **LiveOak Psychiatric and Family Practice** may request **that you** seek **service from a different provider.***

Patient's Name	Patient/Parent Guardian Sip•nature
Referring Agency (Name of Case Manager, Case Worker, or Physician)	Patient/ Parent/Guardian Mailing Address
Today's Date	Patient/Parent Guardian Telephone Number/Contact Number