Calhoun Consultants



NEW PATIENT PACKET

(12 and under)

Welcome to Calhoun Consultants.

Calhoun Consultants provides the highest quality of mental health care. Our goal is to assist with alleviating emotional pain and suffering for individuals, families and communities. Our plan for treatment is to improve each individual's quality of life.

We feel that your emotional health is a priority! Our plan is to provide services that are individualized for each and every client. Our clinicians will work with you to provide services that are comfortable for each individual while meeting their personal needs. It is important to us that you recognize improvement and obtain results in improving your quality of life.

Our team of clinicians is professional and well trained with scientific knowledge of useful treatment techniques. Such techniques can be used to assist individuals to cope with stressful situation in the home, work, school and community. Within treatment, we use traditional and complementary approaches with the highest level of clinical and ethical standards.

As a new patient, there are several things we will be asking for:

- Please fill out all forms completely.
- We will need a copy of your driver's license. (If you are writing checks for services rendered, we need this on file.)
- A copy of your current insurance card.
- Please verify that your physician/therapist is a member of your insurance plan. You can do that by calling your insurance company.

Depending on whether you are here for medical or mental health reasons, your benefits might be different. Find out if you are required to pre-certify your visits. It might mean the difference in how, or if, your insurance company pays.

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Website: https://calhounconsultants.com

NEW PATIENT INFORMATION SHEET (12 and under)

Personal Information (must be filled out completely)

Doctor you are seeing today _____ Today's Date _____
Patient Name _____
Home Address _____
Street City State Zip

E-Mail Address _____
Home Telephone _____ Work Telephone _____
Cell Telephone _____ Other Telephone _____
Patient Date of Birth _____ Patient Social Security Number _____
Driver's License # of the Responsible Party _____
Employer _____
Employer's Address _____
Street City State Zip

Employer's Phone _____ Extension _____
Spouse's Name _____ Spouse Work phone _____
Referral Source (i.e.: Doctor, phone book, etc) _____
Referral Address _____
Street City State Zip
Referral Phone Number _____
Reason for coming to _____
_____
Family Physician _____ Telephone Number _____
Whom may we contact in an emergency? _____
Telephone number _____ Relationship _____

Insurance Information

PRIMARY Insurance _____
Group Number _____ Policy Number _____
Address _____
Street City State Zip

Insurance Telephone Number _____ Effective Date _____
Insured's Name _____ Insured's Date of Birth _____
Insured's Social Security Number _____
Employer's Name _____

Please note: Calhoun Consultants will only bill to secondary insurance if it is related to Medicare.

SECONDARY Insurance _____
Group Number _____ Policy Number _____
Address _____
Street City State Zip

Insurance Telephone Number _____ Effective Date _____
Insured's Name _____ Insured's Date of Birth _____
Insured's Social Security Number _____
Employer's Name _____

PATIENT INFORMATION

NOTE: ALL MENTAL HEALTH INFORMATION IS PRIVILEGDED AND HIGHLY CONFIDENTIAL. The information you share is **STRICTLY BETWEEN YOU AND YOUR DOCTOR OR THERAPIST!** No information will ever be released without your written permission!

INSTRUCTIONS:
Please fill out this form completely. If you are the parent/guardian of the patient, please ask the patient any questions that he/she is able to answer according to his/her age. Otherwise, answer the questions below to the best of your knowledge of the patient. The answers to these questions are very important in allowing us to care for the patient. Some of these questions we ask may seem silly or that they don't apply to you. Regardless, answer all questions to the best of your ability.

Name: _____ Age: _____ Sex: ☐ Male ☐ Female Date: _____

Name of Individual Completing this form for the patient listed above: _____

Relation to Patient: _____

What are the child's current problems that you are here for?

1. _____
2. _____
3. _____
4. _____
5. _____

PAST PSYCHIATRIC HISTORY

Have your child ever seen a psychiatrist, psychologist or therapist in the past? ☐ Yes ☐ No If yes, who?

Was your child ever prescribed a medication to help your mood, anxiety, or thinking? ☐ Yes ☐ No If yes, what medications?

Which medications were helpful?

Has your child ever had a bad reaction to medication? ☐ Yes ☐ No If yes, which ones?

Has your child ever been hospitalized in a psychiatric facility? ☐ Yes ☐ No If yes, where and when?

Has your child ever tried to take his/her life? ☐ Yes ☐ No If yes, when and what did you attempt to do?

Has your child ever tried to hurt him/herself? ☐ Yes ☐ No

If *yes*, how did he/she try to hurt him/herself? _____

When? _____ How Often? _____

Who is your child's primary care physician? _____

*** In the event that you request we contact your child's physician to coordinate his/her care, please give us his/her general doctor's phone number. _____

*** Please make sure to sign an CC Release of Information Form**

Does your child have any medical problems? ☐ Yes ☐ No If yes, please list them:

1. _____

2. _____

3. _____

4. _____

5. _____

Has your child had any surgeries? ☐ Yes ☐ No If yes, please list them with dates:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all medications with dosage that your child currently takes:

1. _____ 5. _____ 8. _____

2. _____ 6. _____ 9. _____

3. _____ 7. _____ 10. _____

4. _____

Does your child have any allergies or sensitivities to medications? ☐ Yes ☐ No If yes, please list:

Has your child ever been hospitalized other than for the above surgeries?

Has your child ever seriously hit your head or lost consciousness?

PAST SUBSTANCE ABUSE HISTORY

Does your child use alcohol? ☐ Yes ☐ No If yes, please answer the following questions:

What type of alcohol do he/she drink? _____

How long has he/she been drinking and how much? _____

Does your child use street drugs? ☐ Yes ☐ No If yes, please answer the following questions:

What different drugs does he/she use? (for each drug, please list how many days per week, and how many uses per day)

1. _____
2. _____
3. _____
4. _____

Does your child smoke cigarettes? ☐ Yes ☐ No If yes, how many packs per day? _____

How many years has he/she smoked? _____

FAMILY HISTORY

Does anyone in your child's family have any psychiatric problems? ☐ Yes ☐ No

If *yes*, who and what type of psychiatric problems & what relation is this person to him/her?

Does anyone in your child's family have any serious medical problems? ☐ Yes ☐ No

If *yes*, who and what type of medical problems & what relation is this person to him/her?

Does anyone in your child's family have a serious drug and/or alcohol problem? ☐ Yes ☐ No

If *yes*, who and what type of drug or alcohol problem & what relation is this person to him/her?

SOCIAL/DEVELOPMENTAL HISTORY

At what (approximate) age did your child:

Crawl? _____ Walk? _____ Talk? _____Toilet Train? _____

Was your child born with any developmental delays? ☐ Yes ☐ No

*If yes, please list any diagnosis that your child has been given since birth:

Does your child live with his/her biological parent(s)? ☐ Yes ☐ No

(Please list if your child lives with only one parent- Mother or Father) _____

*If No, who does your child live with and who is his/her legal guardian? _____

Has your child or his/her family been under a lot of stress lately? ☐ Yes ☐ No If *yes*, please list what events have been stressful:

Has your child suffered from physical, emotional, or sexual abuse? ☐ Yes ☐ No If *yes*, please explain:

Has your child ever been in trouble with the law? ☐ Yes ☐ No ☐ NA If *yes*, please explain:

Is there anything we did not ask that you feel is important or we should know?

GOALS

Many times people come to feel better or to manage a crisis. In addition, however, life enhancement is also something we may be able to help you with. For example: overcoming past painful events, improving self-esteem or self-understanding, losing weight, quitting smoking, improving your marriage, not worrying as much, improving self-confidence, dealing with sexual problems, changing the way you parent your children, etc.

What additional goals do you have that you would like to accomplish?

REVIEW OF SYMPTOMS

THE FOLLOWING IS A LIST OF SYMPTOMS THAT MAY OCCUR AS THE RESULT OF HIGH LEVELS OF STRESS OR BRAIN CHEMISTRY PROBLEMS. PLEASE CIRCLE YES OR NO TO THE FOLLOWING SYMPTOMS.

	YES	NO		YES	NO
Sad, blue or blah feelings	☐	☐	Thoughts of not wanting to go on	☐	☐
Low energy	☐	☐	Thoughts of ending his/her life	☐	☐
Difficulty with concentration	☐	☐	Plans to follow through on taking his/her life	☐	☐
Low motivation	☐	☐	Change in sexual interest	☐	☐
Difficulty with memory	☐	☐	Feeling nervous	☐	☐
Change in appetite	☐	☐	Difficulty controlling the worry	☐	☐
Low self-esteem	☐	☐	Low pep during the day	☐	☐
Sense of hopelessness	☐	☐	Muscle tension in upper back and neck	☐	☐
Sense of loss of control	☐	☐	Changes in mood for no reason	☐	☐
Waking up at night	☐	☐			
Sleeping too much	☐	☐			
Worrying a lot	☐	☐			

PLEASE ANSWER THE FOLLOWING TO WHETHER YOU HAD A SUDDEN ONSET OF ANY OF THE FOLLOWING SYMPTOMS:

	YES	NO
Onset of nervousness for no expected reason	☐	☐
Pounding heart or chest pains	☐	☐
Shortness of breath	☐	☐
Dizziness or unsteadiness	☐	☐
Upset stomach when nervous	☐	☐
Feelings of going out of his/her mind	☐	☐
Feelings of impending doom	☐	☐
Feelings like he/she might die	☐	☐
Feelings like he/she is out of his/her body	☐	☐
Feelings like things are not real	☐	☐

SOMETIMES UNDER UNUSUAL STRESS, INDIVIDUALS MIGHT HAVE THOUGHTS THAT THEY ORDINARILY MIGHT NOT HAVE HAD. HAVE YOU EVER:

	YES	NO
Seriously hurt someone else	☐	☐
Heard a voice when no one was there	☐	☐
Thought others might be out to hurt him/her	☐	☐
Thought something which he/she were not sure was true or not	☐	☐
Noticed a change in yhis/her personality	☐	☐
Had weakness or numbness in any part of his/her body	☐	☐
Had new onset of headaches	☐	☐
Felt like he/she had to do something over and over again for no reason	☐	☐
Had a thought in his/her mind which could not get out of his/her head	☐	☐
Does your child have any problems with his/her relationships?	☐	☐
Does your child have any fears that interfere with his/her life?	☐	☐

REVIEW OF SYMPTOMS (CONTINUED)

Please check the frequency which best answers the following questions about your child:	Never	Occasionally	Often	Very Often
Does your child fail to give attention to details or make careless mistakes?	☐	☐	☐	☐
Does your child have difficulty paying attention to tasks or activities?	☐	☐	☐	☐
Does your child seem not to listen when directly spoken to?	☐	☐	☐	☐
Does your child have difficulty following instructions and fail to finish assignments?	☐	☐	☐	☐
Does your child have difficulty organizing assignments and activities?	☐	☐	☐	☐
Does your child avoid doing tasks requiring mental effort (i.e., homework)?	☐	☐	☐	☐
Does your child lose things necessary for assignments?	☐	☐	☐	☐
Is your child easily distracted?	☐	☐	☐	☐
Is your child forgetful in daily activities?	☐	☐	☐	☐
Does your child fidget or squirm in his/her seat?	☐	☐	☐	☐
Does your child have difficulty remaining seated?	☐	☐	☐	☐
Does your child run or climb on things when asked not to?	☐	☐	☐	☐
Does your child have difficulty playing quietly?	☐	☐	☐	☐
Does your child talk excessively?	☐	☐	☐	☐
Does your child blurt out answers to questions before they have been completed?	☐	☐	☐	☐
Does your child have difficulty awaiting his/her turn?	☐	☐	☐	☐
Does your child interrupt people or interrupt other children's work?	☐	☐	☐	☐
Does your child lose his/her temper?	☐	☐	☐	☐
Does your child argue with adults?	☐	☐	☐	☐
Does your child refuse to do what you tell him/her to do?	☐	☐	☐	☐
Does your child do things that he/she knows will annoy others?	☐	☐	☐	☐
Does your child blame others for his/her own misbehavior?	☐	☐	☐	☐
Is your child easily annoyed by others?	☐	☐	☐	☐
Is your child angry and resentful?	☐	☐	☐	☐
Does your child take his/her anger out on others?	☐	☐	☐	☐
Is your child truant from school?	☐	☐	☐	☐
Does your child lie to avoid responsibility?	☐	☐	☐	☐
Does your child intimidate, bully or threaten others?	☐	☐	☐	☐
Does your child start physical fights?	☐	☐	☐	☐
Has your child stolen items?	☐	☐	☐	☐
Has your child deliberately destroyed the property of others?	☐	☐	☐	☐
Has your child used physical force to steal items?	☐	☐	☐	☐
Has your child used a weapon when fighting?	☐	☐	☐	☐
Does your child show excessive fear (heights, insects, storms, etc.)?	☐	☐	☐	☐
Does your child have trouble getting worrisome thoughts out of his/her mind?	☐	☐	☐	☐
Does your child feel compelled to perform ritualistic habits (checking locks, washing hands, etc.)?	☐	☐	☐	☐
Has your child experienced a traumatizing event and continues to let it bother him/her?	☐	☐	☐	☐
Does your child have unusual movements (twitching, blinking, etc.)?	☐	☐	☐	☐

REVIEW OF SYMPTOMS (CONTINUED)

Please check the frequency which best answers the following questions about your child:	**Never**	**Occasionally**	**Often**	**Very Often**
Does your child have an unusual way of relating to others (odd gestures, avoiding eye contact, etc.)?	☐	☐	☐	☐
Does your child have problems playing or relating well with other children?	☐	☐	☐	☐
Is your child uninterested in making friends?	☐	☐	☐	☐
Does your child have no interest in the feelings of other people?	☐	☐	☐	☐
Has your child had a significant language development problem?	☐	☐	☐	☐
Does your child struggle to make conversation that is socially appropriate?	☐	☐	☐	☐
Does your child talk in a strange way (uses odd words or phrases, repeats what others say, etc.)?	☐	☐	☐	☐
Is your child unable to use his/her imagination when playing?	☐	☐	☐	☐
Does your child show excessive preoccupation with a certain topic?	☐	☐	☐	☐
Does your child become very upset when he/she experiences a change in his/her routine or environment?	☐	☐	☐	☐
Does your child make strange repetitive motions?	☐	☐	☐	☐
Does your child have a strange preoccupation for parts of objects?	☐	☐	☐	☐
Is your child abnormally shy?	☐	☐	☐	☐
Is your child unusually shy with his/her peers?	☐	☐	☐	☐
Is your child generally outgoing and friendly with familiar adults?	☐	☐	☐	☐
Does your child avoid or withdraw from social situations in which he/she feels uncomfortable?	☐	☐	☐	☐