



**Child/Teen New Patient Paperwork**

Full Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: Female Male

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Gender: Male Female Non-Binary Transgender MTF Transgender FTM

Preferred Pronouns: She/Her/Hers He/Him/His They/Their/Theirs Other

Preferred Pharmacy- Please provide the pharmacy name AND address

\_\_\_\_\_

Release of Information (ROI)- Please list below individuals with whom your provider can discuss your care or release your psychiatric medical records. If you do not want anyone to discuss your medical records, please write "N/A".

Name	Relationship

	Name	DOB	Contact Number	Can give consent to treatment? (Y/N)
Parent/Guardian 1				
Parent/Guardian 2				

Guarantor Name: \_\_\_\_\_

Guarantor's Relationship to Child: \_\_\_\_\_

What service are you looking to schedule?

- Medication Management (where medication can be prescribed)
- Talk Therapy (No medication prescribed)
- Hospital Discharge
- Other: \_\_\_\_\_

Reason for appointment? \_\_\_\_\_

Circle which symptoms you are currently experiencing.

Sleep Difficulty	Anxiety	Stress	Bipolar Symptoms	Depression
Withdrawal from Substance Abuse	PTSD	ADHD		Panic Attacks

Has your child/teen ever seen a psychiatrist or counselor in the past? If yes, please provide the name of the psychiatrist, dates seen, treatment reason, and reason for seeking care elsewhere.

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Has your child/teen ever been a patient in a psychiatric hospital or in a rehab program within the past year for a drug/alcohol problem? If yes, please give the name of the facility, location, dates seen, type of program, and treatment reason.

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### Office Policies- Initial and sign

- There is a new patient no-show fee of \$100. This will be required before our staff is able to reschedule an initial appointment. \_\_\_\_\_
- There is a new patient same-day cancellation fee of \$100 that will be required before the initial appointment can be rescheduled. \_\_\_\_\_
- There is an existing patient no-show fee of \$50 for medication management and \$100 for talk therapy. \_\_\_\_\_
- There is an existing patient same-day cancellation fee of \$25 for medication management and \$50 for talk therapy. \_\_\_\_\_
- A urine drug screening is required for ALL medication management new patients and can be requested at any time at a follow-up visit at the discretion of your provider. The cost of this screening is \$15. \_\_\_\_\_
- Patients with 3 or more missed/cancelled appointments may be considered for possible termination from our practice. \_\_\_\_\_
- Patient responsibility is due at the time of service. \_\_\_\_\_
- Any medication refill requests will be considered on a case-to-case basis and must be approved by your provider. If approved without an appointment, there is a \$25 refill fee. \_\_\_\_\_
- All insurance, address, phone number, and pharmacy changes need to be updated with our office. \_\_\_\_\_
- Any disability cases will NOT be filled out at an initial evaluation. \_\_\_\_\_

### Financial Policies and Benefits Assignment

I authorize Georgia Psychiatry and Sleep to furnish information as necessary to my insurance carrier regarding my illness and treatment, and I assign to Georgia Psychiatry and Sleep all insurance payments for medical services rendered. I understand that I am responsible for providing all necessary information to the office or submitting charges to the insurance company for payment. If I fail to provide this information, I accept the financial responsibility of payment for services rendered. This office has a cancellation policy that requires 24-hour advance notification. I understand that if I cancel with less than 24-hour notice, a charge will be made for the time reserved. This charge is not covered by insurance and is not payable from any insurance company.

### Consent to Treatment with Psychotropic Medications

The indications for the medication(s) that are a part of my treatment plan have been discussed with me. I understand that, on occasion, some psychotropic medications may be used for psychiatric conditions or symptoms, despite a lack of FDA approval for these uses. I accept this and accept the advantages and disadvantages of this treatment. Based on the information provided, I agree to comply with the instructions provided by my physician. If I have further questions or concerns about the medication(s) or treatment, I understand that I should contact the prescribing physician as soon as possible.

### Drug Screen Policy

At the initial evaluation and from time to time during treatment, patients may be asked to submit a urine specimen for analysis for drugs. The results of these look to see if in fact the patient is taking medications prescribed and also to verify that the patient is not using other unauthorized substances. For the wellbeing and health of our patients, the screening will also help to determine there are no dangerous

interactions between multiple drugs. The fee is normally covered by insurance, but there may be a copay or balance owed after the insurance pays. It is the responsibility of the patient to take care of these fees owed. If you do not have insurance or your insurance does not cover it, we will collect \$15 as a charge for this urine drug screen test. By your signature below, you indicate that you have read, understand, and agree with this policy. This document will be scanned into your permanent medical records and you may request a copy of it for your own files.

Consent to Treatment with Telemedicine

By signing this form, you agree that you have read, understand, and agree with these terms if scheduled for a telemedicine appointment. By signing below, I acknowledge the following:

I am aware of the provider that I am scheduled to have my telemedicine appointment with.

I have been able to ask questions about telemedicine sessions with GPS staff.

I am aware that I can reach out to the office if I have any questions.

I understand that no guarantees have been made about the success or outcome, and I agree to take part in a telemedicine appointment.

I understand that the telemedicine consultation will be similar to a routine medical office visit.

I understand that this is an option on a temporary basis due to the COVID-19 Pandemic.

I give consent to retrieve and release records to care providers within my treatment circle. \_\_\_\_\_

I have received and read the full office policies, financial policy, and patients' rights and responsibilities documents. This is a separate series of documents that further outlines our full office policies. A copy of these forms has been emailed to you and can be provided on request.

Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

Scales/Questionnaires- Please get your child's input in answering the following scales (if developmentally appropriate)

**PHQ 9**- Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not At All (0)	Several Days (1)	More than half of the days (2)	Nearly every day (3)
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people have noticed? Or the opposite- being so fidgety/restless that you have been moving around more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

Total Score (Add up your answers): \_\_\_\_\_

If your child checked off any of the above problems, how difficult have these problems made it for your child to do school work/activities, or get along with other people?

Not difficult at all                      Somewhat difficult                      Very difficult                      Extremely difficult

In the past year, has your child/teen felt depressed or sad most days, even if they felt okay sometimes?

Yes                      No

Has there been a time in the past month when your child/teen had serious thoughts about ending their life?

Yes                      No

Has your child/teen ever, in their whole life, tried to kill themselves or made a suicide attempt?

Yes                      No

### **ADHD**

	Never (0)	Occasionally (1)	Often (2)	Very often (3)
Doesn't give close attention to details or makes careless mistakes in school/work	0	1	2	3
Has difficulty sustaining attention in tasks/play activities	0	1	2	3
Does not seem to listen when spoken to directly	0	1	2	3
Does not follow through on instructions and fails to finish schoolwork/chores (not due to oppositional behavior or failure to understand)	0	1	2	3
Has difficulty organizing tasks and activities	0	1	2	3
Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3

Loses things necessary for tasks/activities such as toys, books, assignments, etc.	0	1	2	3
Is often easily distracted	0	1	2	3
Is often forgetful in daily activities	0	1	2	3
Fidgets with hands or feet, squirms in seat	0	1	2	3
Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
Runs about or climbs excessively in inappropriate situations	0	1	2	3
Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
Often "on the go" or often acts as if driven by a motor	0	1	2	3
Talks excessively	0	1	2	3
Blurts out answers before questions are completed	0	1	2	3
Has difficulty waiting their turn	0	1	2	3
Interrupts/intrudes on others	0	1	2	3

**GAD 7-** Over the last 2 weeks, how often has your child/teen been bothered by the following problems?

	Not at all (0)	Several days (1)	More than half of the days (2)	Nearly every day (3)
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful may happen	0	1	2	3

Please describe, if applicable, the circumstances that can cause or increase anxiety in your child/teen:

**MDQ-** Has there ever been a time when your child was not their usual self and...

	Yes	No
Felt so good that you thought they were not their normal self or they were so hyper that it got them in trouble?		
Was so irritable that they shouted at people or started fights/arguments?		
Seemed to feel more self-confident than usual?		
Got much less sleep than usual and seemed like they didn't really miss it?		
Was so much more talkative or spoke much faster than usual?		
Seemed as though their thoughts were racing or they couldn't slow their mind down?		



Was so easily distracted by things around them that they had trouble concentrating or staying on track?		
Had much more energy than usual?		
Was much more active or did many more things than usual?		
Was much more social or outgoing than usual?		
Did things that were unusual for them or that other people might've thought were excessive, foolish, or risky?		

**ESS-** How likely is your child/teen to doze off or fall asleep in the following situations, in contrast to just feeling tired?

	Least likely (0)	Somewhat likely (1)	Likely (2)	Most likely (3)
Sitting and reading	0	1	2	3
Sitting and watching TV or a video	0	1	2	3
Sitting in a classroom at school during the morning	0	1	2	3
Sitting and riding in a car/bus for about half an hour	0	1	2	3
Lying down to rest/nap in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly by yourself after lunch	0	1	2	3
Sitting and eating a meal	0	1	2	3

**Sleep Routine**

	Yes	No
Do you feel like your child's school/home/social life is negatively affected by their sleep habits?		
Does your child feel tired or sleepy when they need to be awake?		
Does your child snore loudly on most nights?		
Does your child have morning headaches?		
Does anyone in your family snore loudly or have sleep apnea?		
Does your child sleepwalk?		
Does your child have creepy, crawly legs at night that keep them awake most nights of the week?		
Does your child have "sleep attacks" during the day while laughing or experiencing strong emotions?		

What is your child/teen's typical sleep schedule on a school/work day?

\_\_\_\_:\_\_\_\_ AM/PM to \_\_\_\_:\_\_\_\_ AM/PM

How long does it take for your child/teen to fall asleep most nights?

Less than 20 minutes

20-40 minutes

More than 40 minutes

Please describe your child/teen's average nighttime routine.

Is your child generally healthy?

Yes

No

**ROS**

	Yes	No
Changes in weight or changes in strength/exercise tolerance		
Headaches, vertigo, head injury		
Changes in hearing, ringing in ears, bleeding in ears, vertigo		
Nose bleeds, colds, obstruction, discharge		
Dental difficulties, gingival bleeding, use of dentures		
Chest pain, palpitations, fainting, shortness of breath, irregular heartbeat		
Change in appetite, abdominal pains, bowel habit changes		
Urinary urgency, painful urination, change in nature of urine		
Change in menses, cramping, pelvic pain		
Pain in muscles/joints, limitation of range of motion, tingling or numbness		
Weakness, tremors, seizures, change in mental function, problems with muscle coordination		
Changes in sleep habits, difficulty sleeping, insomnia		

Has your child/teen been more irritable than usual?

Yes                  No

Has your child/teen been isolating from friends/family?

Yes                  No

Have your child/teen's grades dropped from their baseline?

Yes                  No

Does your child/teen have behaviors that are of concern? If yes, please explain:

Does your child/teen have access to any weapons in their home(s)? If yes, please explain:

Does your child/teen live with both biological parents? If not, please explain:

If parents are separated/divorced, how often does the child/teen see the other parent?

Who currently lives in the home with your child/teen? List all household members and ages.

Current marital status of parent/legal guardian? \_\_\_\_\_

Number of parent/legal guardian prior marriages? \_\_\_\_\_

Number of parent's/legal guardian's children? \_\_\_\_\_

Parent/Guardian #1 Highest level of education? \_\_\_\_\_

Parent/Guardian #2 Highest level of education? \_\_\_\_\_

Parent/Guardian #1 Employment status? \_\_\_\_\_

Parent/Guardian # 1 Employer/Position? \_\_\_\_\_

Parent/Guardian #2 Employment status? \_\_\_\_\_

Parent/Guardian #2 Employer/Position? \_\_\_\_\_

Has either parent/guardian served in the US military? If yes, please specify how many years of service and the reason for discharge.

\_\_\_\_\_

Have there been any major changes in the life of your child/teen in the last few years? If yes, please explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child/teen have a history of abuse, neglect, or bullying? If yes, please explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child/teen ever been arrested or had charges filed against them? If yes, please explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child/teen ever been cruel to other people or animals? If yes, please explain.

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Were there any problems in the pregnancy/birth of this child/teen? If yes, please explain.

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Did your child/teen meet all developmental milestones in a timely manner? (Walking, talking, potty training, etc.) If not, please explain.

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Has your child/teen received any special classes or assistance in school? (special education classes, tutoring, gifted classes, etc.) If yes, please explain.

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Does your child have any issues making or keeping friends? If yes, when did this start?

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What school does your child/teen attend? \_\_\_\_\_

What grade are they in? \_\_\_\_\_

Are there any problems in school for your child/teen?

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What are the typical teacher comments about your child/teen?

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Has your child/teen abused any of the following substances?

	Yes	No
Alcohol		
Marijuana		
Opiates		
Cocaine		
Meth		
Kratom		

If other substance abused, please specify: \_\_\_\_\_

Does anyone in the family/household have a history of addiction?

Yes          No          Ongoing          Past

If yes, please specify the member's relationship to the child/teen, drug of choice, family member's last use, and longest period of sobriety.

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If yes, has this family member ever experienced withdrawals?

Yes          No

Does your child/teen smoke or vape?

Yes          No

Does anyone in the household smoke cigarettes?

Yes          No          Former Smoker

Any major medical (non-psychiatric) hospital admissions? If yes, please provide the hospital name, location, dates seen, and reason.

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If applicable, when did your child/teen's first menses/period begin? \_\_\_\_\_

If applicable, is your teen currently pregnant?      Yes              No

If applicable, is your teen breastfeeding or pumping breast milk for infant feedings?

Yes              No

Has your child/teen ever severely restricted food intake or made themselves intentionally throw up or engaged in other behaviors to control their weight? If yes, please explain.

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Does your child/teen have any other chronic medical conditions?

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Child/Teen's current height: \_\_\_\_\_, \_\_\_\_\_

Child/Teen's current weight: \_\_\_\_\_



**Family History**

	Self	Mother	Father	Sibling
Bipolar disorder				
Depression				
Anxiety				
Addiction				
ADHD				
Schizophrenia				
Family history of completed suicide				
Heart disease/structural heart defects				
Sudden cardiac death (sudden heart attack in 20s/30s)				
Heart arrhythmias				
Seizures				
High blood pressure				
Thyroid disease				
Kidney disease				
Liver disease (Hepatitis/Cirrhosis)				
Sleep apnea				
Narcolepsy				
Autoimmune disease				
Diabetes				
Coronary Artery Disease				
Congestive heart failure				
Stroke				

Please list ALL current medications your child/teen is taking (prescriptions and over-the-counter).

Please provide the medication name, dosage, frequency, and date started.

Please list any psychiatric medications your child/teen has tried in the past (not listed above). Please provide the medication name, dosage, prescriber, dates taken, and the reason for stopping.

Is your child allergic to any medications? If yes, please list below.

Yes

No

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Parent/Guardian Signature: \_\_\_\_\_

Today's date: \_\_\_\_\_