*LAGUNA BEHAVIORAL*

28281 Crown Valley Parkway, Suite 140
Laguna Niguel, CA 92677

Phone: (949) 367-1200
Fax: (949) 367-1300

# NEW PATIENT INFORMATION – CHILD/ADOLESCENT

**To be completed by the patient (or parent/guardian if patient is younger than 18 years of age)**

## CLIENT INFORMATION

Patient's Name:_____ Today's Date:_____

Other Names: _____

Date of Birth:_____ Age: _____

Address: _____
Street Apartment City State ZIP

E-mail Address: _____

PHONE NUMBER (S) Home (_____)_____ Work (_____)_____
May we call you/leave a message ...at home ( ) yes ( ) no ...at work ( ) yes ( ) no
on your cell: (_____)_____ ( ) yes ( ) no

Marital status: ( ) single ( ) separated ( ) divorced ( ) widowed ( ) living together ( ) married

Employer/School: _____ Occupation:_____

Primary Care Physician: _____ Phone Number: _(_____)_____

WHO REFERRED YOU TO US?
( ) Friend ( ) Health Plan/EAP ( ) Family Member ( ) Medical Doctor ( ) Web/Other

## RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION

Responsible Person/Spouse's:_____ Today's Date:_____

Other Names: _____

Date of Birth:_____ Age: _____

Address: _____
Street Apartment City State ZIP

E-mail Address: _____

PHONE NUMBER (S) Home (_____)_____ Work (_____)_____
May we call you/leave a message ...at home ( ) yes ( ) no ...at work ( ) yes ( ) no
on your cell: (_____)_____ ( ) yes ( ) no

Marital status: ( ) single ( ) separated ( ) divorced ( ) widowed ( ) living together ( ) married

Employer/School: _____ Occupation:_____

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Primary Care Physician: _____ Phone Number: _(_____)_____

**INSURANCE INFORMATION**

Health plan/ insurance_____ Policy ID #_____

Subscriber name_____ Subscriber social security_____

Employer_____

**PERSON TO BE CONTACTED IN CASE OF AN EMERGENCY**

Name_____ Home phone number (_____)_____

Relationship_____ Work phone number (_____)_____

Address if different from above:

_____

## CHILD/ADOLESCENT DEVELOPMENT

Pregnancy and Birth: Full Term Yes _____ No _____ C-Section Yes _____ No _____

Complications or problems during pregnancy and/or birth: _____

_____

Developmental Milestones (Ages): Sat-Up _____ Crawled _____ Walked _____ Talked _____
Toilet Trained _____

Describe delays or complications in any of these areas: _____

_____

Describe any illnesses and/or surgeries or other medical conditions: _____

_____

Traumas: Yes _____ No _____ If Yes, describe: _____

Day Care: Yes _____ No _____ If Yes, describe: _____

Pre-School: Yes _____ No _____ If Yes, describe: _____

1st – 5th Grade: Current Grade: _____ School: _____

Grades: _____

Describe behavior: _____

Type of classes: (i.e. special ed., GATE, AP, etc.)

_____

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Comments:

_____

9th Grade and up : Current Grade: _____ School: _____

Describe Behavior:

_____

Type of classes: (i.e. special ed., GATE, AP, etc.)

_____

Comments:

_____

Social Development: Clubs:

_____

Sports: _____

Hobbies: _____

Family Life: (i.e. include age and dates: adopted, parents divorced, significant losses/deaths; blended family, moves, etc.)

_____

Describe Family Relationships:

_____

_____

Describe Peer Relationships:

_____

_____

Describe Problems:

_____

**PRESENTING PROBLEM (S):**
Please describe your reasons for seeking counseling:

_____

_____

Was there an event that made these issues or problems surface? **YES** **NO**
If yes please describe:

_____

_____

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**Please indicate which of the following issues or problems are you currently experiencing and would like to work on in treatment. You may choose more than one.**

| | | |
|---|---|---|
| _____Depression | _____Lack of friends | _____Marriage/relationship problems |
| _____Anxiety/Panic | _____Loneliness | _____Sexuality/sexual issue |
| _____Controlling stress | _____Problems coping | _____Family conflict |
| _____Loss of loved one | _____Abuse/victimization | _____Behavioral problems |
| _____Problems at school | _____Financial problems | _____Eliminating a drug/alcohol habit |
| _____Problems at work | _____Legal matters | _____Police/Probation Involvement |
| _____Suicidal Thoughts | _____Irritability | _____Racing Thoughts |
| _____Paranoid Thoughts | _____Homicidal Thoughts | _____Increased/Decreased Appetite |
| _____Insomnia/Oversleep | _____Headaches | _____Rages/Aggression |
| _____Crying | _____Withdrawal | _____Communication Issues |
| _____Unable to Concentrate | _____Discipline Issues | _____Flashbacks |
| _____Spending Sprees | _____Hallucinations (Hearing/Seeing Things) | |
| _____Eliminating another habit (overspending, overeating, gambling, etc.) | | |

_____Other: _____
(Please indicate)

If you have any medical problems, please describe them below:

_____

_____

## Psychiatric History:

Have you seen a psychiatrist or therapist in the past? **YES NO**
**Please list below**

_____

Have you ever been diagnosed with a psychiatric or mental health disorder? **YES NO**

| | | | |
|---|---|---|---|
| Depression | **Y N** | Schizophrenia | **Y N** |
| Bipolar Disorder | **Y N** | Schizoaffective | **Y N** |
| Anxiety | **Y N** | Psychosis | **Y N** |
| Panic Attacks | **Y N** | Attention Deficit/Hyperactivity Disorder | **Y N** |
| Social Anxiety | **Y N** | Learning Disorder | **Y N** |
| Post traumatic | **Y N** | | |
| Stress Disorder | **Y N** | Dementia | **Y N** |
| Anorexia | **Y N** | Pathological Gambling | **Y N** |
| Bulimia | **Y N** | Alcohol or drug abuse | **Y N** |
| Addictions of any kind | **Y N** | | |

**Have you ever been hospitalized for mental health treatment? YES NO**
***If you indicated yes, please explain:***

_____

_____

_____

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**Please circle the psychiatric medication that you have taken in the past:**

Buspar – buspirone
Celexa – citalopram
Cymbalta – duloxetine
Effexor – venlafaxine
Lexapro – escitalopram
Luvox – fluvoxamine

Pristiq – Desvenlafaxine
Paxil – paroxetine
Prozac – fluoxetine
Remeron – mirtazapine
Wellbutrin – buproprion
Zoloft – sertraline
Elavil – amitriptyline
Pamelor – nortriptyline

Ambien – zolpidem
Lunesta – eszopiclone
Rozerem – ramelteon
Desyrel – trazadone

Valium – diazepam
Xanax – alprazolam
Ativan – lorazepam
Klonopin – clonazepam

Vyvanse - Lisdexamfetamine
Ritalin - Methylphenidate
Adderall - Amphetamine
or Dextroamphetamine

Depakote – divalproex
Lithium – eskalith
Tegretol – carbamazepine
Lamictal – lamotrigine

Abilify – aripiprazole
Clozaril – clozapine
Geodon – ziprasidone
Risperdal – risperidone
Seroquel – quetiapine
Zyprexa – olanzapine
Haldol – haloporaldol
Trilafon – perphenazine

Please list any additional psychiatric medication that you have taken in the past:

_____

**Family Psychiatric History and Medical History**

Have any of your family members suffered from any of the above listed psychiatric disorders? Please explain:

_____
_____

Current or Chronic Illnesses:

_____
_____

Please list current medications and doses including over the counter medications and herbs and vitamins:

_____
_____

Allergies and reaction:

_____

Please list any additional information that you think I should know or that you would like to discuss at today's visit.

What are your goals for psychiatric treatment?

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## OFFICE POLICIES AND AGREEMENT FOR GENERAL MENTAL HEALTH SERVICES

### CONFIDENTIALITY

It is understood that all information between client and psychiatrist(s) and/or therapist(s) is held strictly confidential, and the psychiatrist(s) and/or therapist(s) will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State laws;
2. The client presents an imminent danger to self,
3. The client presents an imminent danger to others;
4. Child/elder abuse/neglect is suspected;
5. If a judge determines that our discussions are not confidential, a judge may request specific information,
6. As requested by a court-appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the psychiatrist (s) and/or therapist (s) is required by law to inform potential victims and legal authorities so that protective measures can be taken. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family.

### CONSENT FOR TREATMENT

I authorize and request that my psychiatrist(s) and/or therapist(s) at Laguna Behavioral/Adel Eldahmy, MD Inc. carry out psychiatric evaluations, psychological exams, treatments, and/or diagnostic procedures during the course of my care as a patient.

### RELEASE OF INFORMATION

I authorize the release of information for claims, certification/case management, and other purposes related to the benefits of my health plan.

### NOTICE OF PRIVACY PRACTICES

A notice of privacy practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA), describing how information about you may be used and disclosed and how you can get access to this information is provided to you. Please review it carefully. By signing below, you agree to the following: I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

**I understand and agree to all of the above information.**

_____
**Patient's Name (printed)**

_____ _____
**Signature of Legal Guardian (and relationship to Patient)** **Date**

_____ _____
**Signature of Legal Guardian (and relationship to Patient)** **Date**

***All legal parties must agree and sign consent for any and all treatment.**

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**FINANCIAL TERMS**

The fees for all services are negotiated between Laguna Behavioral/Adel Eldahmy, MD Inc. and your insurance carrier or managed care company. In general, you will not be asked to pay more than your co-pay/deductible as set in your insurance plan and explained in your insurance plan manual. In some cases you may request additional services not covered by your insurance plan.

*At the time of service, if we are not able to verify and get full information regarding the patient's insurance, he/she is responsible for the full contracted rate and will be given a receipt to submit to his/her insurance.
*With certain selected insurance companies the patient will be responsible for the full contracted rate and will be given a receipt to submit to his/her insurance.

**Document copy services/medical record processing fees will be charged at $30.00 per request and the patient will be responsible for $35.00 charge per returned check.**

**All fees are to be paid at the time of service.**

Certain health insurance plans have pre-arranged contracted fee arrangements that are different than the amounts quoted. Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for the visit and your provider will be paid directly by the carrier. **The patient will be responsible for any deductibles and co-payments at the time of service**. If you are not eligible at the time of services are rendered, you are responsible for payment or if your insurance carrier does not authorize the services, you are responsible for payment of the quoted fees or the rate negotiated with your insurance carrier, whichever applies.

**REPORT WRITING**
**If required to write reports there is a minimum charge of $50.00 for 1 page or less. Each additional page will be an extra $50.00.**

**LITIGATION CHARGES**
**If I am required to attend a deposition, hearing or other legal proceeding you will be billed at $300.00/hour for my time, which includes preparation and travel time, as well as the time I spend at the legal proceeding.**

**CANCELLATION/MISSED APPOINTMENTS**
**Scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24 hours notice, the patient will be billed $50.00. This charge cannot be billed to your insurance plan.**

**Please sign to indicate that you have carefully read and agree to the above conditions.**

_____
**Print Patient Name**

_____ _____
**Signature of Person Financially Responsible** **Date**