Right Track Medical Group

Child and Adolescent Patient Registration

Completed by: _____

How did you hear about us?: _____

Child's Name: _____

Sex: ☐ M ☐ F

Age: _____

Date of Birth: _____

Preferred name to be called: _____

Social Security Number: _____

Ethnicity: _____

Adopted/Custody: Yes ☐ No ☐ Explain: _____

Parent's or Guardian's Name: _____

Relationship to Child: _____

Home Address: _____

_____

Home phone: _____

Work phone: _____

Cell phone: _____

Who does Child live with:

☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Parents are:

Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed ☐ Cohabitating ____

If divorced, what are the custody arrangements?

_____

(*Please bring copy of custody agreement for the chart)*

Please give other parent's name, address and phone number:

Name:

_____

Address:

_____

Cell phone: _____

Work phone: _____

Name of Physician: _____

Phone: _____

Pharmacy Name: _____

Phone: _____

Insurance Company: _____

Phone: _____

ID# _____

Group number _____

Subscriber's Name: _____

Child's relationship to Subscriber: _____

Subscriber's Date of Birth: _____

Employer: _____

Subscriber's Address:

_____

_____

Emergency Contact:

Name	Relationship	Phone

HOUSEHOLD MEMBERS

Name	Age	Relationship	Occupation/Grade

FAMILY MEMBERS NOT LIVING IN HOUSEHOLD (e.g., stepchildren, adult children, etc.)

Name	Age	Relationship	Occupation/Grade

AREAS OF CONCERN (check all that apply):

Personal/Social Adjustment:

☐ Unduly sad

☐ Overly anxious

☐ Overly aggressive

Family Adjustment:

☐ Parent-child problems

☐ Marital conflict/Co-parenting problems

☐ Sibling conflict

☐ Temper Tantrums

☐ Withdrawn or shy

☐ Disturbing habits or mannerisms

☐ Strange or bizarre behavior

☐ Problems in peer relationships

☐ Drug or alcohol problems

☐ Problems with the law

☐ Hams self or others (suicidal or homicidal)

☐ Domestic violence

☐ Abuse

☐ Other (please specify):

☐ Recent family changes

☐ Neighborhood difficulties

☐ Mother experiencing difficulties

☐ Father experiencing difficulties

☐ Sibling experiencing difficulties

☐ Drug or alcohol problems in family

☐ History of trauma or loss

☐ Hyperactivity

☐ Other (Please specify):

_____

_____

_____

<u>School Adjustment:</u>

☐ Academic problems

☐ Difficulty with peers

☐ Difficulty with authority

☐ Attendance problems or reluctance to go to school

☐ Grooming

☐ Language or speech

<u>Physical/Developmental Factors:</u>

☐ Eating

☐ Sleeping

☐ Toileting

☐ Behavior problems

☐ Learning disabilities

☐ Perceptual/visual functions ☐ Attentional problems

☐ Motor coordination problems ☐ Other (please specify):

_____

_____

_____

PAST PSYCHIATRIC HISTORY: CHECK THOSE THAT APPLY

Outpatient psychotherapy: ☐ yes ___ no

Family therapy: ___yes ___no

If yes, how long: _____

Individual therapy: ☐yes ☐no

If yes, how long: _____

Group Therapy: ___yes ___no

If yes, How long: _____

Inpatient (Hospital or Residential): ☐yes ___no

If yes, where and when? _____

Past suicidal ideations? ☐yes ☐no

Plan? ☐yes ___no

Number of attempts and dates:

_____

_____

Current suicidal ideations? ___yes ___no

Plan? ___yes ___no

Most recent attempt date: _____

Method: _____

Previous diagnosis:

_____

_____

MEDICAL HISTORY:

Any significant or relevant medical problems (e.g. allergies, asthma, accidents & dates, surgery & dates, abuse & dates):

_____

_____

_____

_____

Chronic condition or disability:

_____

Medications of any kind child is currently taking:

Medication	Dosage	Frequency	Purpose

Has child had an allergic reaction or other problems with medications? ___yes ___no

If yes, which drugs, and briefly explain:

_____

_____

_____

HABITS (LIST AMOUNTS AND FREQUENCY):

Alcohol or Drugs: _____

Caffeine: _____

Vitamins: _____

Herbal Supplements: _____

Exercise (amount/type/frequency): _____

Sleep: _____

Eating: _____

Other: _____

FAMILY OF ORIGIN HISTORY

Please list below family member(s) who have (or had) emotional problems, depression, anxiety, psychiatric illness, drug or alcohol abuse, attention difficulties, learning disabilities, autism, developmental delays or cognitive disabilities, abuse, neglect, suicide attempts, etc.

Family Member Relationship to Child	Problem	On-going	Resolved

DEVELOPMENTAL FACTORS

A. Prenatal History

1. Mother's health during pregnancy was: ☐ Good ☐ Fair ☐ Poor
2. Age of mother at child's birth? ☐ Under 20 ☐ 20-24 ☐ 25-29 ☐ 30-34 ☐ 35-39 ☐ 40-44 ☐ Over 44
3. Did mother use any alcohol or substances during pregnancy? ☐ yes ☐ no
4. Did mother smoke during pregnancy? ☐ yes ☐ no
5. Did mother use coffee/caffeine during pregnancy? ☐ yes ☐ no
6. Did mother have toxemia or eclampsia? ☐ yes ☐ no
7. Was there Rh factor incompatibility? ☐ yes ☐ no

8. Child born on schedule? ☐ yes ☐ no

   If early, how premature _____

9. Duration of labor? _____

10. Fetal distress during labor? ___yes ___no

11. Was delivery: ___Normal ☐ Breech ☐ Caesarian ☐ Forceps ___Suction ☐ Induced

12. Child's birth weight? _____

    APAR Score (if known) _____

13. Were there complications following birth? ☐ yes ☐ no

    If yes, what were they?

    _____

    _____

    _____

    _____

    _____

    _____

    _____

B. Postnatal Period/ Infancy/ Toddler

1. Feeding problems: ☐ yes ☐ no
2. Colic? ___yes ___no
3. Sleep pattern difficulties? ___yes ___no

4. Problems with responsiveness(alertness)? ___yes ___no
5. Were there health or congenital problems during infancy? ___yes ___no
6. How was it to care for this child? ___Very easy ___Easy ___Average ___Difficult ___Very difficult
7. How did the child behave with other people? ___More sociable than average ___Average sociability ___More unsociable than average
8. When the child wanted something, how insistent was he/she? ___Very insistent ___somewhat insistent ___Average ___Not very insistent ___Not at all insistent
9. Rate the activity level of the child: ___Very active ___Active ___Average ___Less active ___Not active

C. Developmental Milestones

1. Age child sat up: ___3-6 months ___7-12 months ___Over 12 months
2. Age child crawled: ___6-12 months ___12-18 months ___Over 18 months
3. Age child walked alone: ___Under 1 ___1-2 years ___2-3 years
4. Age child spoke single words other than "mama or dada"?

   ___9-13 months ___14-18 months ___19-24 months ___25-36 months ___37-48 months
5. Age child strung two or more words together:

   ___9-13 months ___14-18 months ___19-24 months ___25-36 months ___37-48 months

6. Age toilet trained? Bladder controlled _____

   Bowel controlled _____

7. How long did toilet training take from onset to completion? _____

   (months)

SCHOOL HISTORY

Current grade level: _____

Current School: _____

Has Child been held back in any grade: ___yes ___no

Has Child failed any grade: ___yes___no

Has Child ever been evaluated? _____ School Study Team (SST)? _____ Individualized

Educational Program (IEP)? ___

What was the outcome of the evaluation? Accommodations?

_____

_____

_____

_____

_____

Learning disabilities class _____

Dates: _____

Behavioral/emotional disorders class_____

Dates: _____

Resource Room: _____

Dates: _____

Speech & Language therapy _____

Dates: _____

Suspended, expelled, retained: _____

Dates: _____

Other evaluations: Psychological, Educational, Speech, Occupational Therapy:

Type of evaluation	Name and number of evaluator	Date of Exam	Outcome

Signature of Parent or Guardian filling forms out

_____

Date _____

OFFICE USE ONLY:

Reviewed by Signature _____

Date _____

Consent to Discuss Treatment

Patient Name: _____

Date of Birth: _____

First _____ MI _____ Last _____

Check one:

☐ **I authorize Right Track Medical Group to discuss my child's treatment with the following individuals I have listed below:** [Please Print]

Name: _____

Relationship: _____

☐ **I do not authorize discussion of my child's treatment with any other individuals.**

Name: _____

Relationship: _____

Parent/Guardian Signature: _____

Date: _____

RightTrack MEDICAL GROUP

CONSENT TO TREAT MINOR

We require the consent of a parent or legal guardian to provide care for patients under the age of 18. ***PLEASE NOTE we do not see patients under the age of 18 years old for appointments without an adult accompanying them and strongly encourage a parent or legal guardian to attend all appointments.*** *Please sign the first authorization below to allow us to care for your child. If you would like us to care for your child, if the child comes in alone or brought in by another person, please sign the second authorization below as well.*

Patient's Name:_____

Date of Birth:_____

1. Authorization to treat a minor patient when accompanied by a parent or legal guardian.

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, psychological assessment and/or psychiatric care from the professional staff associated with or employed by Right Track Medical Group.

Printed Name of parent/guardian:

_____

Signature of parent/guardian:

_____

Date: _____

2. Advance authorization to treat a minor patient when not accompanied by a parent or legal guardian.

I am the parent or legal guardian of the patient named above. If the patient comes into the clinic alone or is brought in by any other person/persons listed below, I give advance authorization and consent for the minor to seek counseling, psychotherapy, psychological assessment and/or psychiatric care from the professional staff associated with or employed with Right Track Medical Group.

Approve to bring child to appointments	Relationship to child

This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

(Parent/Legal Guardian, Print)

_____

(Parent/Legal Guardian, Signature)

(Date)

Right Track Medical Group

Consent and Acknowledgment Form

Welcome to Right Track Medical Group. This document contains important information about our services and business policies. We can discuss any questions you have when you sign them or at any time in the future.

Patient Name: _____

DOB_____

Consent for Mental Health Services. I voluntarily consent for care encompassing diagnostic procedures and treatment by my physician/nurse practitioner, therapist, his/her assistant, designees or consultants, as may be necessary in the judgement of my physician/nurse practitioner. I also understand that I will be billed direct for those services provided. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of treatments or examinations in this clinic. I understand that my medical record may be maintained on a computer-based system and is available to persons involved in my care.

Patient or Responsible Party Initials_____

Authorization to Release. I hereby authorize Right Track Medical Group and any provider caring for me to release or disclose to insurance companies and / or outpatient benefit programs and their designees all information from my medical record pertaining to my medical treatment as needed to process insurance claims.

Patient or Responsible Party Initials_____

Communication: I hereby authorize Right Track Medical Group to communicate with me via voice mail in the event I cannot be reached directly. The phone number on which a voice mail may be left is _____.

Patient or Responsible Party Initials_____

Release from Responsibility. If I should leave the clinic against medical advice or prior to treatment being completed, I hereby relieve said physicians/ nurse practitioner, therapists and the clinic of all liability for my action.

Patient or Responsible Party Initials_____