

The New Mind: Whole Person Psychological Care

Janiel L. Henry, Psy.D.

PSY 28724

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(909) 603-9300, (909) 603-9301 FAX

New Patient Registration—Child/Adolescent

Welcome, and thank you for the opportunity to collaborate together for the mental, physical, spiritual, and social health of your child/adolescent. If you will take a few moments and provide information about him/her and your current concerns, it will help us focus treatment most effectively. Developmental, medical, and family history is important because physical issues can often affect psychological issues. Please feel free to bring any questions to the attention of Dr. Henry.

Name _____ Birthdate _____ Today's Date _____

Address _____ City, State, Zip _____

Home Phone (OK to call?) _____ Cell Phone _____ E-mail _____

Gender: ___ Female ___ Male School Attending _____ Grade _____

Biological Mother's Name _____ Birthdate _____ SS# _____

Address _____ City, State, Zip _____

Home Phone (OK to call?) _____ Driver's License _____ SS# _____

Work Phone (OK to call?) _____ Cell Phone _____ E-mail _____

Biological Father's Name _____ Birthdate _____ SS# _____

Address _____ City, State, Zip _____

Home Phone (OK to call?) _____ Driver's License _____ SS# _____

Work Phone (OK to call?) _____ Cell Phone _____ E-mail _____

Parents Divorced? ___ Yes ___ No Legal Custody ___ Joint ___ Sole *If custody is joint legal, permission must be obtained from the other parent before treatment can proceed.*

Emergency Contact _____
Name Relationship to Patient Phone

Primary Care Physician _____ Physician's Phone _____

Other Persons in Household (Relationship to Patient):

How were you referred to Dr. Henry? _____

May we acknowledge contact? ___ Yes ___ No

Primary Insurance Plan _____ Payor/Health Plan _____

Policy/Group # _____ Psychiatric/Mental Health Plan _____

Insured Party _____ Insured Party SS# _____

Insured Party Birthdate _____ Patient's Relationship to Insured:
_____ Self _____ Spouse _____ Dependent

Employer _____

What concerns about your child/adolescent have prompted you to see Dr. Henry at this time?

What events or circumstances made these concerns surface? _____

Please rate any problems or concerns about your child/adolescent according to their severity (rate 1-5):

NO PROBLEM MILD PROBLEM MODERATE PROBLEM SEVERE PROBLEM EXTREME PROBLEM
1 2 3 4 5

_____ Depressed Mood _____ Lack of Friends _____ Bedwetting/soiling

_____ Anxiety _____ Loneliness _____ Sexuality/Sexual Issues

_____ Stress _____ Coping Difficulties _____ Family Conflict

_____ Loss of a Loved One _____ Abuse/Victimization _____ Behavioral Problems

_____ School Difficulties _____ Nightmares/Night Terrors _____ Drug/Alcohol Use

_____ Work Difficulties _____ Legal Matters _____ Illegal activities

_____ Fighting _____ Arguing _____ Truancy

_____ Anger _____ Attention/Concentration _____ Memory

_____ Unusual Experiences _____
_____ (Describe)

_____ Other _____
_____ (Please specify)

Current Medications: _____
(Name and Dosage) _____

Last Physical Exam? _____
Date Doctor

Significant Findings? _____

Blood Test Results? _____
(include date)

Medical Conditions _____
Currently Being _____
Treated: _____

Does your child/adolescent experience any of the following? (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Double or Poor Vision | <input type="checkbox"/> Excessive Thirst/Dry Mouth | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Indigestion, Gas Heartburn | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Diarrhea or Constipation | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Vomiting/Vomiting Blood | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Change in Appetite/Eating Habits | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Sleep Difficulties | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Coughing or Wheezing | <input type="checkbox"/> Difficulties with Memory, Attention, or Concentration | |
| <input type="checkbox"/> Chest Paine | <input type="checkbox"/> Weakness or Lack of Energy | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Heart Palpitations or Irregularities | <input type="checkbox"/> Lumps Anywhere in Body |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Weight Gain or Loss _____ | |

(Number of pounds over what period of time)

Describe what you know of your child's/adolescent's use of drugs or alcohol:

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>Last Use</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child/adolescent ever been in trouble with the law because of using alcohol or illegal substances?

What mental health or substance abuse treatment has your child/adolescent received previously?

Please respond to the following lifestyle questions for your child/adolescent:

	Current Frequency	Highest Frequency	Last Use/Occasion
Caffeinated drinks	_____	_____	_____
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Exercise and Sports	_____	_____	_____
Work	_____	_____	_____
Dating	_____	_____	_____
Religious Services	_____	_____	_____

Please answer the following questions about your child's/adolescent's development:

Any difficulties with the pregnancy? _____ Full term? _____ Birthweight? _____

At what age did s/he walk? _____ Talk? _____

Behavioral or emotional difficulties at preschool? _____

Any unusual fears? _____

History of molestation or abuse? _____

Typical hours of sleep? _____

Attitude toward school? _____ Grades? _____

Special education (subjects)? _____

Problems with homework? _____

Suspensions or expulsions? _____

Activities at school? _____

What kind of serious medical illness has been in your family? _____

What kind of mental health issues have been in your family? _____

What kind of substance use problems have been in your family? _____

Policies and Agreements

Please read each item carefully and sign below. A copy of this agreement will be provided to you. Dr. Henry will discuss with you any questions or concerns you may have.

TREATMENT APPROACH

Dr. Henry will be working closely with you to identify clearly areas on which your treatment will focus, as well as goals of treatment and modes of treatment (e. g., individual therapy, family therapy). Alleviating distress and making progress toward optimal mental, physical, spiritual, and social functioning, are my highest concerns. If you are involving your health plan, a case manager may be collaborating with us and making certification decisions. Your active involvement in your treatment, including “homework” assignments, will be essential for the best outcome of treatment.

CONFIDENTIALITY

All information disclosed by you to Dr. Henry will be held in strictest confidence, unless court-ordered to release it, or:

- You authorize a release of information with your signature. *Parents/guardians sign releases for a child/adolescent.*
- You present a danger of physical harm to yourself or others.
- There is a reasonable suspicion of child exploitation, abuse, or neglect, or dependent adult abuse or neglect.

To protect others, law enforcement and potential victims may need to be contacted, according to the requirements of the law.

FINANCIAL TERMS

You (parents/guardians) will be responsible for the financial obligations of treatment. This will mean making payment for each session at the time of service (unless other arrangements are made), or fulfilling the applicable deductible amount and making co-payments. Co-payments must be made at the time of each session. If you are not eligible for benefits or your insurance company should not pay for any reason, you are responsible for full payment of services. Unpaid accounts may be sent to a collection agency, and a 40% service charge will be added to the balance assigned to the collection agency. INITIAL _____

CANCELLED OR MISSED APPOINTMENTS

This practice relies upon your responsibility for arriving at your appointments at the designated times. Of course, schedule changes and emergencies are inevitably a part of life. When making changes to appointments, please allow at least **24 hours notice**. Notification within less than 24 hours or not showing for an appointment will result in a **\$70 fee**, which must be paid prior to your next appointment. Health plans do not cover charges for late cancellations or missed appointments. INITIAL _____

EMERGENCY PROCEDURES

You may contact Dr. Henry outside of session at 909-603-9300, and leave a message at any time. Every effort will be made to respond to non-urgent messages the same day. If it is an urgent matter, you may contact Dr. Henry on her mobile phone: 510-329-6442. Any life-threatening emergency should be addressed by calling 911, or by going immediately to the nearest hospital emergency room.

RELEASE OF INFORMATION TO YOUR HEALTH PLAN

If I am involving my health plan in my treatment, I authorize Dr. Henry to release information regarding my care to my health plan for the payment of claims, certification and case management decisions, and other purposes related to the administration of my benefits.

CONSENT FOR TREATMENT

I authorize and request Dr. Henry to carry out the assessments, diagnostic procedures, and treatments necessary during the course of treatment for my child/adolescent. I understand that the purpose of any facet of treatment will be explained to me and will be subject to my agreement. I also understand that the process of psychotherapy, while designed to facilitate recovery to optimal mental, physical, spiritual, and social functioning, may be challenging and difficult at times.

APPEALS AND GRIEVANCES

I acknowledge my right to request reconsideration in the event certification for my care is denied. To appeal, I understand I would request an appeal through Dr. Henry, and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to Dr. Henry at any time to register a complaint about any aspect of my care. And at any time, if I am not satisfied with the response I receive from an appeal or grievance, I may submit the complaint directly to my health plan.

I have read, understand, and agree to all of the above information.

Patient (or Parent/Guardian)—PRINTED, then SIGNED

Date

Policies and Agreements—YOUR COPY

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I, _____, authorize my insurance company,
_____, to send payment automatically to
Janiel L. Henry, Psy.D., 114 N. Indian Hill Blvd., Suite B, Claremont, CA 91711.

Signed _____ Date _____