The New Mind: Whole Person Psychological Care

Rachel M. Day, M.A., AMFT

Registration #95271
114 N. Indian Hill Blvd., Suite B
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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 Rachel Day.

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 Rachel Day?_____

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 Rachel Day 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 1 MILD PROBLEM 2 MODERATE PROBLEM 3 SEVERE PROBLEM 4 EXTREME PROBLEM 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)

_____Double or Poor Vision	_____Excessive Thirst/Dry Mouth	_____Difficulty Hearing
_____Indigestion, Gas Heartburn	_____Fainting	_____Stomach Pain
_____Blackouts	_____Diarrhea or Constipation	_____Convulsions
_____Vomiting/Vomiting Blood	_____Blood in Stool	_____Paralysis
_____Dizziness	_____Change in Appetite/Eating Habits	_____Headaches
_____Sleep Difficulties	_____Thyroid Problems	_____Sexual Difficulties
_____Coughing or Wheezing	_____Difficulties with Memory, Attention, or Concentration	
_____Chest Paine	_____Weakness or Lack of Energy	_____Shortness of Breath
_____Joint Pain	_____Heart Palpitations or Irregularities	_____Lumps Anywhere in Body
_____Swelling	_____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:

Substance	Amount	Frequency	Last Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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. Rachel Day will discuss with you any questions or concerns you may have.

TREATMENT APPROACH

Rachel Day 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 Rachel Day 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 Rachel Day 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 Rachel Day on her mobile phone: 909-276-0503. 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 Rachel Day to release information regarding my care to my health plan for the payment of claims, certification and case management decisions, and other purposed related to the administration of my benefits.

CONSENT FOR TREATMENT

I authorize and request Rachel Day 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 Rachel Day, and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to Rachel Day or her supervisor, Dr. Dennis Wallstrom, 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 form 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

Rachel M. Day, M.A., AMFT, 114 N. Indian Hill Blvd., Suite B, Claremont, CA 91711.

Signed_____ Date_____