Jamestown Psychiatric, P.C.

237 Delaware Avenue
Olean, New York 14760
(716) 790-8847

1465 Foote Avenue Ext.
Jamestown, New York 14701
Phone 716) 526-4041 Fax (716) 526-4161

20 Gillis Avenue
Ridgway, PA 15853
info@psychwebmd.com

CHILD NEW CLIENT INTAKE FORM

Jamestown Psychiatric, PC would like to thank you for choosing our services. We look forward to a productive relationship with you by providing the best quality mental health care to meet your individual needs. Our first new patient appointment may be scheduled out between 2-3 weeks. If at any time you feel you cannot wait until then, or you have thoughts of self-harm or of harming someone else, please go directly to the nearest hospital and a counselor there will assess you for further help. Please complete this Child New Client Intake Form to the best of your ability so that we understand your child better.

DATE COMPLETED: _____

OFFICE LOCATION REQUESTED: _____ JAMESTOWN _____ OLEAN _____ RIDGWAY

DEMOGRAPHICS:

NAME: _____

HOW DO YOU WANT TO BE ADDRESSED : _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ MOBILE PHONE: _____

WORK PHONE: _____ EMAIL ADDRESS: _____

SEX: _____ HEIGHT: _____ WEIGHT: _____

ETHNICITY: _____ PREFERRED LANGUAGE: _____

PREFERRED METHOD OF CONTACT: _____ HOME PHONE _____ MOBILE PHONE_____ EMAIL

NOT APPROVED METHOD OF CONTACT: _____TEXTS _____ VOICE MESSAGES _____ EMAILS

NAME OF RESPONSIBLE PARENT: _____ PHONE: _____

NAME OF OTHER PARENT: _____ PHONE: _____

EMERGENCY CONTACT'S NAME: _____ PHONE: _____

NAME: _____

CONCERNS:

WHAT ARE YOUR PRIMARY CONCERNS?

_____

_____

_____

WHEN DID THE CONCERN START, WAS THERE A CERTAIN CIRCUMSTANCE THAT STARTED THIS, HAS THE PROBLEM CHANGED IN FREQUENCY OR INTENSITY SINCE ONSET, DO YOU HAVE ANY TRIGGERS?

_____

_____

_____

WHAT ARE YOUR EXPECTATIONS FROM YOUR CARE HERE?

_____

_____

_____

FINANCIAL INFORMATION -

GUARANTOR'S NAME (Person responsible for payments): _____

PATIENT'S RELATIONSHIP TO GUARANTOR: _____

GUARANTOR'S DATE OF BIRTH: _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY INSURANCE: _____

INSURANCE ID #: _____ INSURANCE GROUP #: _____

INSURANCE FOR MENTAL HEALTH **PHARMACY** BENEFITS IF DIFFERENT FROM MEDICAL INSURANCE:

PHARMACY INSURANCE NAME: _____ PHONE: _____

INSURANCE ID #: _____

DO YOUR PHARMACY VISITS REQUIRE A PRIOR AUTHORIZATION? _____ AUTHORIZATION #: _____

DATES APPROVED: _____

NAME: _____

MENTAL HEALTH AND SUBSTANCE USE HISTORY:

PAST HISTORY OF MENTAL HEALTH DIAGNOSES:

PAST MENTAL HEALTH PROVIDERS, FACILITIES AND LOCATIONS:

COUNSELOR'S NAME -

PHONE: FAX:

DOES YOUR CHILD HAVE A HISTORY OF ATTEMPTED SUICIDE ATTEMPTS: DETAILS

DOES YOUR CHILD HAVE A SUBSTANCE USE HISTORY (ALCOHOL USE, DRUG USE,NICOTINE USE): DETAILS

WOULD YOU LIKE TO RECEIVE SMOKING CESSATION INFORMATION?

WOULD YOU LIKE A REFERRAL FOR SUBSTANCE TREATMENT?

MEDICAL HEALTH HISTORY:

PRIMARY CARE DOCTOR:

PHONE: FAX:

PAST HISTORY OF MEDICAL DIAGNOSES:

PAST MAJOR EVENTS OR HOSPITALIZATIONS:

DOES YOUR CHILD HAVE ANY KNOWN DRUG, FOOD OR ENVIRONMENTAL ALLERGIES: (ALLERGEN'S NAME AND REACTION):

NAME:

MEDICATION HISTORY:

CURRENT MEDICATIONS:

LIST BELOW THE NAMES OF ALL CURRENT MEDICATIONS (PRESCRIBED, OVER THE COUNTER, HERBALS, VITAMINS, RECREATIONAL) INCLUDING STRENGTH (DOSE), TIMES TAKEN EACH DAY, DATE STARTED, AND THE PRESCRIBING PROVIDER'S NAME: (USE EXTRA PAPER IF NEEDED)

_____

_____

_____

PAST MENTAL HEALTH MEDICATIONS :

LIST BELOW THE NAMES OF ALL PAST MENTAL HEALTH MEDICATIONS (PRESCRIBED, OVER THE COUNTER, HERBALS, VITAMINS, RECREATIONAL) INCLUDING STRENGTH (DOSE), TIMES TAKEN EACH DAY, DATE STARTED, DATE ENDED, THE REASON FOR ENDING IT AND THE PRESCRIBING PROVIDER'S NAME: (USE EXTRA PAPER IF NEEDED)

_____

_____

_____

PREFERRED PHARMACY TO USE: _____ PHONE #: _____

ADDRESS: _____

SAFETY CHECK:

DO YOU FEEL SAFE IN YOUR HOME ENVIRONMENT? _____

DO YOU HAVE ACCESS TO GUNS OR OTHER WEAPONS? _____

DO YOU WEAR YOUR SEAT BELT, USE AN AGE-APPROPRIATE CAR SEAT, AND YOUR BICYCLE HELMENT? (IF NO, GIVE DETAILS) _____

DO YOU HAVE A GOOD SUPPORT SYSTEM? (I.E. FAMILY, FRIENDS)
_____ ARE YOU HAVING DIFFICULTIES IN SCHOOL?
_____

_____

_____

FAMILY MENTAL HISTORY:

FAMILY'S MENTAL HEALTH HISTORY:

_____

_____

FAMILY'S HISTORY OF ATTEMPTED OR COMPLETED SUICIDE ATTEMPTS:

_____

_____

NAME: _____

JAMESTOWN
Psychiatric PC
305 East Fairmount Avenue, Lakewood NY 14750
P: (716) 526-4041
F: (716) 526-4161
info@psychwebmd.com
jamestown.psychwebmd.com

	have you been bothered by the following problems?	ENot at all	Rare < 2days	Several Days	More than half the days	Nearly every day	SCORE IN THIS COLUMN
I	1. Complains of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2. Said he/she was worried about his/hers health?	0	1	2	3	4	
II.	3. Had problems sleeping- that is trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5. Had less fun doing things that he/she used to enjoy?	0	1	2	3	4	
	6. Seemed sad or depressed for several hours?	0	1	2	3	4	
V.	7. Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8. Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9. Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10. Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11. Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12. Not been able to stop worrying?	0	1	2	3	4	
	13. Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14. Said that he/she heard voices – when there was no one there- speaking about him//her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15. Said that he/she had a vision when he/she was completely awake, that is saw something that no one else could see?	0	1	2	3	4	
X.	16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17. Said that he/she felt the need to check on certain things over and over again, like whether the door was locked?	0	1	2	3	4	
	18. Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
XI.	20. Uses alcoholic beverages, smokes cigarettes, cigars, or a pipe, or uses snuff or chewing tobacco?	0	1	2	3	4	
	21. Uses marijuana, cocaine, crack, club drugs, hallucinogens, heroin, inhalants or solvents like glue or methamphetamine?	0	1	2	3	4	
	22. Uses any medications without a doctor's prescription, I.E. stimulants, sedatives, tranquillizers or steroids?	0	1	2	3	4	
	23. Has he/she talked about, attempted to kill himself/herself, or someone else?	Yes	No	Don't Know			

THIS SECTION MUST BE COMPLETED & SIGNED:

CONSENT OF CO

CLIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

RE: Communication Policy & Contract -

For Jamestown Psychiatric, P.C. to be able to assure that both parents / guardians are aware of appointments and treatment plans, we must have an understanding in agreement with both parents / guardians. Both parents / guardians should attend all appointments. All communication should be done during a scheduled appointment. The parents / guardians will communicate via email to Jamestown Psychiatric, P.C. with a copy sent (C.C.) to the opposite parent / guardian regarding any appointment requests to discuss concerns and questions. If no appropriate appointment is available, then both parents / guardians will be notified by email and other arrangements will be made. This email communication will produce a written copy for the child's chart and will notify the opposite parent / guardian of any correspondence.

Jamestown Psychiatric, P.C. email address to use: info@psychwebmd.com

If a telephone call is required then: Jamestown Psychiatric, P.C. will address the communication with the 'agreed upon #1 court appointed parent / guardian" ONLY and that court appointed person will notify the other parent / guardian within 24 hours.

MUTALLY AGREED UPON:

#1 PARENT / GUARDIAN'S NAME: _____

RELATIONSHIP: _____

PHONE: _____ EMAIL: _____

*The communication will then be shared within 24 hours with the other parent / guardian by the 'agreed upon #1 parent / guardian'.

#2 PARENT'S / GUARDIAN'S NAME: _____

RELATIONSHIP: _____

PHONE: _____ EMAIL: _____

SIGNATURES: In an emergency, attempts to both parents / guardians will be made via both phone and email. DATE: _____

Agreed: (#1 parent / guardian) Signature: _____

Agreed: (#2 parent /guardian) Signature: _____

Witness Signature: _____

NAME: _____

CONSENT OF CONTRACT - THIS SECTION MUST BE COMPLETED & SIGNED:

I (printed name) _____ by placing my signature at the bottom of this contract, I have attested that the information I have provided is correct to the best of my knowledge. Jamestown Psychiatric, P.C. has offered to provide me with a complete copy of their office and HIPAA policy handouts in which I agree to abide with and understand that failure to comply may result in the dismissal from this practice. They may leave messages of discretion at the provided contact information re: appointments and call back instructions via text, email, and voice messaging. My emergency contact person may receive information on my behalf. Jamestown Psychiatric, P.C. may receive information from pharmacies regarding my medication history. Jamestown Psychiatric, P.C. may submit claims to my insurance carrier to receive payments for services rendered. I understand that any non-covered claims and any balance is totally my responsibility and will be paid in a timely manner. I consent to the credit card use for No show appointments charge of my new patient appointment will my credit card will be billed at the time of the missed appointment. Payments may be made via my credit card for balance due only at my request via phone, e-mail or in person unless indicated below.

PLEASE SIGN BELOW INDICATING YOU ARE AWARE OF OUR POLICIES.

I. OFFICE POLICIES: (See Handout given along with your intake form also available from staff)

II. NOTICE OF HEALTH INFORMATION PRIVACY PLAN ACT: (See Handout given along with your intake form also available from staff)

III. CONSENT TO TEXT, EMAIL AND VOICE MESSAGING

IV. CONSENT TO ALLOW PHARMACIES TO PROVIDE YOUR PHARMACEUTICAL HISTORY

V. CONSENT TO ALLOW JAMESTOWN PSYCHIATRIC, P.C. TO SUBMIT INFORMATION TO YOUR INSURANCE FOR BILLING

X Date: _____

X Signature of Responsible Party for the Client: _____

NAME: _____

CONSENT FOR CREDIT CARD USE - THIS SECTION MUST BE COMPLETED & SIGNED:

INFORMATION TO BE COMPLETED BY CREDIT CARD HOLDER: The undersigned agrees and authorizes Jamestown Psychiatric, P.C.to use my credit card for the new client no show appointment fee if applicable at the time of the missed appointment.

CLIENT'S NAME: _____

CREDIT CARD HOLDER'S AUTHORIZED NAME: _____
(AS IT APPEARS ON THE CREDIT CARD)

ACCOUNT NUMBER ON CARD: _____

EXPIRATION DATE: _____ CVV: _____ BILLING ZIP CODE: _____

I, AS THE AUTHORIZED CREDIT CARD HOLDER, _____
(INSERT NAME)

authorize Jamestown Psychiatric, P.C. to process the above credit card for the new client No-Show fee. I understand this authorization will remain in effect until the completion of the New Client Appointment. I understand that this credit card will only be used for _____ 's
(INSERT CLIENT'S NAME)

account for the new client no show fee when applicable. I understand that I may also revoke this consent by submitting a written request to Jamestown Psychiatric, P.C.'s office at any future date without question.

X Date: _____

X Signature of Credit Card Holder: : _____