Rudolph Bolling Psychiatry, PC

Patient Information Form (May be faxed to (844)270-4926)

This THREE PAGE form must be completed and returned BEFORE an appointment is given.

For Medicaid recipients, a referral/ EPSDT is REQUIRED.

Date completing this form: ___________________________

PATIENT DEMOGRAPHICS

Child's Name *as it appears on Insurance card*: ______________________________________

Date of Birth: __________________ Age: ______________ Sex: Male/ Female

Social Security Number: ______________________________

Race: [ ] Black [ ] Caucasian [ ] Hispanic [ ] Biracial [ ] Other _____________

Address: ____

City: _________________________ State: ______________ Zip Code: _____________

GUARDIAN INFORMATION

Guardian name: _________________________________ Phone number: _________________

Are you biological parent?: Yes/ No. **If not, please be sure to provide proof of guardianship.**

Is child adopted?: Yes/ No. If yes, does child know he or she is adopted?: Yes/ No

Is child in foster care? Yes/ No. If yes, what is the agency? _____________________________

PRIMARY PHYSICIAN INFORMATION

Name of primary doctor the child ***sees***: ______________________________

Primary doctor's phone number: ______________________ Fax number: __________________

When was child last seen by PCP? ____________________________

Name of doctor ***Medicaid lists as primary physician***, if different: _________________________

INSURANCE INFORMATION

Company: [ ] Medicaid [ ] AllKids [ ] Blue Cross [ ] Other: ______________________

ID & Group/ Medicaid Number: ____

****If you have Medicaid, a referral/ current EPSDT IS REQUIRED EVERY YEAR*. Ask your PCP for details.***

Please list any other medical insurance here: ______________________________________

MENTAL HEALTH CONCERNS AND HISTORY

1. Regarding your child, which of these are you concerned about?
   [ ] ADHD: Hyperactivity/ Inattention [ ] Academics [ ] Depression
   [ ] Behavior Problems [ ] Anxiety [ ] Other: ____________________
2. What is your primary goal for this appointment? ________________________________
3. Are you interested in trying medications for your child? Yes/ No. If no, please explain your concerns. ____
4. Has your child ever been hospitalized for MENTAL HEALTH reasons? Yes/ No. If yes, please explain: ____
5. Has your child ever used drugs? Yes/ No. If so, please list. _______________________
6. Has your child ever been given a mental health **DIAGONSIS**? Yes/ No. If yes, please list it/ them. ____
7. Has your child ever seen a therapist or psychiatrist? Yes/ No. If so, what was the name of the provider and/ or the clinic, and why did the child see them?

Name	Clinic	Reason
______________________	______________________	_________________
______________________	______________________	_________________

8. Please list any MENTAL HEALTH medications the child **CURRENTLY** takes.

Medication	Strength	How often
________________________	_______________	_______________
________________________	_______________	_______________
________________________	_______________	_______________
________________________	_______________	_______________

9. Please list any MENTAL HEALTH medications your child has taken in the **PAST**.

Medication & highest strength	Date stopped & Why was it discontinued
________________________	________________________________
________________________	________________________________
________________________	________________________________

PAST MEDICAL HISTORY

10. Was your child full-term (at least 37 weeks gestational age)? Yes/ No. If no, how many weeks was the baby at birth? _________ What was the birth weight? _______________
11. Did the baby spend any time in the NICU (Neonatal Intensive Care Unit)? Yes/ No
12. Was the baby intubated (breathing machine)? Yes/ No. If so, for how long? __________
13. What was mother's age at the time of birth? ______________
14. How many PREVIOUS times had mom been pregnant? ______________
15. Did mom use any substances (i.e. medications, cigarettes, street drugs, alcohol) during pregnancy? Yes/ No. If so, please list. ____
16. Was the baby born vaginally or via C-section? Vaginal/ C-section
17. Were there any complications with the pregnancy or delivery? Yes/ No. If so, please explain (i.e. gestational diabetes, high blood pressure, etc.). ________________________
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18. Were there any concerns with speech, gross, or fine motor development? Yes/ No
19. Has the child ever been in speech, physical, or occupational therapy? Yes/ No. (Circle which apply.)
20. Please list the child's medical diagnoses (i.e. asthma, eczema). _____________________
21. Has the child had any surgeries? Yes/ No. ______________________________________
____
22. Besides the primary doctor, does the child see any other doctors? ___________________
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CURRENT MEDICATIONS AND ALLERGIES

23. Besides the mental health medications already listed, does the child take any other medications? If so, please list: ____
____
24. Please list any allergies to medications or other allergens: ________________________

FAMILY MEDICAL AND MENTAL HEALTH HISTORY

Please list any medical disorders, mental health issues, and substance abuse problems that run in the family and list who has them. ____
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____
____

Patient Name ____ Date of Birth _____________

SOCIAL HISTORY

Please list all persons who live with the child:

Relation to patient	Name	Age
____________________	______________________________________	___________
____________________	______________________________________	___________
____________________	______________________________________	___________
____________________	______________________________________	___________
____________________	______________________________________	___________
____________________	______________________________________	___________

Are both biological parents involved? Yes/ No. If no, please explain.

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Please list guardians' professions/ employer and job:

____________________ ____

____________________ ____

____________________ ____

____________________ ____

What school does the child attend? ______________________________________

What grade is the child in school? ________________

Has s/he ever repeated a grade? Yes/ No. If yes, which grade(s)? ________________________

Does the child have an IEP or 504? Yes/ No. If so, for what subjects/ reasons? _______________

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What grades does the child usually make on report cards? ______________________

Has the child ever been suspended? ___________ How many times this school year? _________

Please use the space below to explain anything else that you want Dr. Rudolph Bolling and her staff to know. (You may list the number of the question you are referencing.)

Thank you!

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