Sunshine Psychiatry
... because we care!

CHILD/ADOLESCENT REGISTRATION FORM

Please answer the following questions to the best of your abilities. These questions are to help the practitioner with the evaluation process. This information is held to our high standards of confidentiality. This questionnaire will take approximately 30 minutes to complete.

Client Information

Last Name:_____ First Name:_____ Initial:_____

Birth date: _____/_____/_____ Age: ____ Gender: ___ Male ___Female Height:_____ Weight:_____

Address: _____ City: _____ State: _____ ZIP: _____

Child's School:_____ Teacher's name:_____ Child's grade:_____

Is the child in special education? ___ YES ___ NO If so, what type?_____

Is the child adopted? ___ YES ___ NO If yes, at what age:_____

Parent or Guardian

Last Name:_____ First Name:_____ Initial:_____

Birth date: _____/_____/_____

Address if not the same as above:

Address:_____ City:_____ State:_____ ZIP:_____

Parent/Guardian Marital Status: ___ Single ___ Partnered ____ Married ___ Separated ___ Divorced ___ Widowed

Home phone:_____ May we leave a message? ___ YES ___ NO

Cell / Other:_____ May we leave a message? ___ YES ___ NO

Email:_____ May we email you*? ___ YES ___ NO ***NOTE:** emails may not be confidential!

Parent or Guardian

Last Name:_____ First Name:_____ Initial:_____

Birth date: _____/_____/_____

Address if not the same as above:

Address:_____ City:_____ State:_____ ZIP:_____

Parent/Guardian Marital Status: __ Never Married ___ Partnered ____ Married ___ Separated ___ Divorced ___ Widowed

Home phone:_____ May we leave a message? ___ YES ___ NO

Cell / Other:_____ May we leave a message? ___ YES ___ NO

Email:_____ May we email you*? ___ YES ___ NO *NOTE: emails may not be confidential!

Primary Insurance:_____ ID#:_____

Subscriber Name:_____

Secondary Insurance:_____ ID#:_____

Referred by:_____ Phone: (_____) _____ - _____

Assignment of Benefits:

I hereby assign, transfer, and convey all medical benefits to be paid directly to Sunshine Psychiatry, LLC and recognize it is my responsibility to pay for all non-covered services. I also authorize Sunshine Psychiatry, LLC, to release any information necessary to process an insurance claim in the event the patient is a minor, a parent or guardian who will be responsible for the payment of the bill, must accompany the patient. A photocopy of this Assignment will be considered as valid as the original.

Signature:_____ Date:_____

HIPPA COMPLIANCE NOTICE

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide only the minimum information on your health care information, treatment, treatment information, payment or health care operations in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use of disclosure of your Personal Health Information (PHI). If you choose to give consent in this document at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previous signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature:_____ Print Name:_____ Date:_____

Describe the problem: Please explain your present concerns about your child and what you think is causing the problem:_____

_____

Onset: When did you first notice the concern / problem? What else was happening at that time that might be important:_____

_____

What do you hope to gain from this evaluation and/or counseling?_____

_____

_____

Primary Care Physician/pediatrician:_____

Other Physicians/specialists:_____

Pharmacy/Address:_____ Phone: _____

PAST MEDICAL HISTORY

Please list all previous operations

Surgery Approximate Date Surgeon Hospital

_____

_____

_____

Past Major Medical Problems:_____

Please check if you are currently receiving treatment or have received treatment in the past:

____ Anemia	____ Arthritis	____ Asthma	____ Birth Defects
____ Bleeding Problems	____ Cancer	____ Currently Pregnant	____ Diabetes
____ Epilepsy	____ Eye Problems	____ Hearing Problems	____ Heart Disease
____ Hepatitis	____ Intestinal/gastro	____ Kidney Disease	____ Migraines
____ Phlebitis (blood clots)	____ Rheumatic/Scarlet Fever	____ STD	____ Skin disorder
____ Thyroid Disease	____ Other		

MEDICATIONS	**DOSAGE**	**HOW LONG**	**PRESCRIBING PHYSICIAN**

DRUG ALLERGIES

Drug	**Physical Reaction**

INTAKE QUESTIONNAIRE FOR NEW PATIENTS (CHILD/ADOLESCENT)

Marital Status: single married separated divorced

Remarried engaged widowed cohabitating

If applicable, please complete the following:

Partner's name:_____ Partners age:_____

Partner's Occupation: _____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children)

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

SYMPTOMS

Please **check** any symptoms or experiences that you have had **in the last month:**

____ Difficulty falling asleep ____ Difficulty staying asleep

____ Difficulty getting out of bed ____ Not feeling rested in the morning

____ Nightmares ____ Night terrors

Average hours of sleep per night_____

____ Persistent loss of interest in previously enjoyed activities

____ Withdrawing from other people ____ Spending increased time alone

____ Sadness ____ Feeling Numb

____ Worthlessness ____ Hopelessness

____ Increased energy
____ Helplessness
____ Frequent feelings of guilt
____ Irritability
____ Rapid mood changes
____ Thoughts about harming or killing yourself
____ Decreased energy
____ Decreased motivation
____ Outbursts of anger
____ Difficulty concentrating or thinking
____ Self-mutilation / cutting
____ Thoughts about harming or killing someone else

____ Anxiety
____ Difficulty leaving your home
____ Tremors
____ Dizziness
____ Unusual sweating
____ Racing thoughts
____ Increased muscle tension
____ Difficulty catching your breath
____ Fear
____ Frequent worry
____ Panic attacks
____ Intrusive memories
____ Repetitive behaviors or mental acts (i.e. counting, checking doors, washing hands)
____ Fear of certain objects or situations (i.e. flying, heights, bugs) Describe:_____
____ Avoiding people, places, activities or specific things

____ Experienced/witness Traumatic event
____ Flashbacks
____ Avoidance behavior
____ Persistent re-experiencing traumatic event
____ Easily started, felling "jumpy"
____ Increased vigilance/easily startled

____ Feeling as if you were outside yourself, detached, observing what you are doing
____ Feeling puzzled as to what is real and unreal
____ Persistent, repetitive, intrusive thoughts, impulses, or images
____ Unusual visual experiences such as flashes of light, shadows
____ Physical sensations others don't have
____ Hear voices when no one else is present
____ Feeling that your thoughts are controlled or placed in your mind
____ Feeling or acting like a different person
____ Feeling that the television or the radio is communicating with you

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____ Difficulty problem solving
____ Dependency on others
____ Inappropriate expression of anger
____ Difficulty or inability to say "no" to others
____ Sense of lack of control
____ Abusive relationship
____ Concerns about your sexuality
____ Difficulty meeting role expectations
____ Manipulation of others to fulfill your own desires
____ Large gaps in memory
____ Ineffective communications
____ Decreased ability to handle stress
____ Difficulty expressing emotions

____ Changes in eating/appetite ____ Excessive exercise

____ Eating more ____ Eating Less

____ Voluntary vomiting ____ Use of laxatives

____ Excessive exercise to avoid weight gain ____ Binge eating

____ Are you trying to lose weight?

____ Weight gain: _____ lbs. ____ Weight loss: _____ lbs.

Sexual Orientation: ____ Heterosexual ____ Homosexual ____ Bisexual ____ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

_____

_____

_____

_____

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

____ NO ____ YES If so:

Name of therapist:_____ Dates of Treatment

Reason for seeking help:_____ _____

Name of therapist:_____ Dates of Treatment

Reason for seeking help:_____ _____

Name of therapist:_____ Dates of Treatment

Reason for seeking help:_____ _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ____ NO ____ YES If YES, please list:

Medication	**Dosage**	**How long have you been Taking it?**	**Has it been helpful?**

Are you CURRENTLY taking NON-PSYCHIATRIC medication? ____ NO ____ YES If YES, please list:

Medication	**Dosage**	**How long have you been taking it?**

Have you been on PSYCHIATRIC medication in the past? ____ NO _____ YES If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? ____ NO ____ YES If YES, describe:

Hospital	Dates	Reason

Have you attempted suicide? ____ NO ____ YES If YES, describe:

_____

_____

_____

Have you engaged in any self-harm behaviors? ____ NO _____ YES If YES, describe:

_____

_____

_____

EMPLOYMENT

Are you currently employed? _____

If yes, employer's name: _____

What type of work do you do? _____

Employment History (most recent first, use back of paper if necessary):

Type of Job	Dates	Reason for Leaving

Have you been arrested? _____

If yes, please describe:_____

Do you have a religious affiliation? _____

If yes, what is it?_____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems?_____

Have you ever been abused?

____ Verbally ____ Emotionally ____ Physically ____ Sexually ____ Neglected

Please describe: _____

_____

_____

FAMILY HISTORY

FATHER: Age:_____ ____ Living ____ Deceased Cause of death:_____

If deceased, HIS age at time of his death: _____ YOUR age at time of his death:_____

Occupation:_____ Health:_____

Frequency of contact with him:_____ Are you/have you been close to him?_____

MOTHER: Age:_____ ____ Living ____ Deceased Cause of death:_____

If deceased, HER age at time of her death:____ YOUR age at time of her death:_____

Occupation:_____ Health:_____

Frequency of contact with her:_____ Are you/have you been close to her?_____

BROTHERS and SISTERS:

Name	Sex	Age	Whereabouts	Are you close to him/her	
				YES	NO
				YES	NO
				YES	NO
				YES	NO

During your childhood, did you live any significant period of time with anyone other than you natural parents? ____ NO ____ YES

If so, please give the person's name and relationship to you

Name:_____ Relationship:_____

Please place a check mark in the appropriate box if these are or have been present in your relatives:

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous problems							
Depression							
Hyperactivity							
Counselling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							
Drug Problem							

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol?_____ If yes, age of first use:_____

How much do you drink? _____

How often do you drink? _____

Have you ever passed out from drinking?_____ How often?_____

Have you ever blacked out from drinking? _____ How often? _____

Have you ever had the "shakes"? _____ How often? _____

Have you ever felt you should cut down on your drinking / drug use?_____

Have people annoyed you by criticizing your drinking / drug use?_____

Have you ever felt bad or guilty about your drinking / drug use?_____

Have you ever drank / used drugs in the morning to steady your nerves or relieve a hangover? _____

Do you use tobacco? _____ If yes, how often? _____

Do you use coffee/caffeine/energy products? _____ If yes, how often? _____

Other Drugs

Please indicate for each drug listed below:

Drug	Ever used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

SUNSHINE PSYCIATRY, LLC

PATIENT HEALTH QUESTIONNAIRE

NAME:_____ DATE:_____

Date of Birth:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "X" to indicate your answer)	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)	Add columns	+	+	
	TOTAL:			

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not Difficult _____
	Somewhat Difficult _____
	Very Difficult _____
	Extremely Difficult _____

OFFICE POLICIES
EFFECTIVE 5/1/2018

1. Medication refills should be requested at time of the patient's appointment. If the patient fails to notify the practitioner that a refill is required before the next appointment, there may be a $25 charge rendered for the service.

2. Should there be a change of pharmacy requested after a prescription is written, there may be a charge of $25 rendered.

3. If a patient is more than 10 minutes late for the scheduled appointment, they may not be seen and the appointment will have to be rescheduled. The patient will be charged with a late cancellation fee of $100 for that appointment.

4. When a patient finds a need to call to change an appointment, they should be aware that there might not be sufficient supplies of medication to last until the next appointment. It is the patient's responsibility to ask for a medication extension at the time of the appointment change. Failure to take this initiative may result in the charge of a fee for this service.

5. Should a patient fail to show for a scheduled appointment, there will be a $100 fee for this first occurrence; for 2nd occurrence the fee is $125; the 3rd occurrence is $175. Sunshine Psychiatry, LLC, may elect to not make any further appointments after three failures to show. **Please note that NO-SHOW charges are the patient's responsibility and cannot be billed to any insurance company.

6. We will be performing random drug screens two times per year. If you refuse this, Sunshine Psychiatry, LLC, has the right to refuse to provide your psychiatric services.

7. It is our expectation that all accounts will be kept up-to-date at the time of each visit.

Sunshine Psychiatry, LLC

POLICIES & PROCEDURES FOR OUR PATIENTS
RECEIPT ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have received, reviewed, understood and will comply with the policies and procedures explained in the Sunshine Psychiatry, LLC, form.

Printed Name:_____

Signature:_____

Date:_____

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, check √ the box that corresponds to the response that seems to describe your child *for the last 3 months*. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe.				PA/SO
2. My child gets headaches when he/she is at school.				SCH
3. My child doesn't like to be with people he/she doesn't know well.				SOC
4. My child gets scared if he/she sleeps away from home.				SEP
5. My child worries about other people liking him/her.				GA
6. When my child gets frightened, he/she feels like passing out.				PA/SO
7. My child is nervous.				GA
8. My child follows me wherever I go.				SEP
9. People tell me that my child looks nervous.				PA/SO
10. My child feels nervous with people he/she doesn't know well.				SOC
11. My child gets stomachaches at school.				SCH
12. When my child gets frightened, he/she feels like he/she is going crazy.				PA/SO
13. My child worries about sleeping alone.				SEP
14. My child worries about being as good as other kids.				GA
15. When my child gets frightened, he/she feels like things are not real.				PA/SO
16. My child has nightmares about something bad happening to his/her parents.				SEP
17. My child worries about going to school.				SCH
18. When my child gets frightened, his/her heart beats fast.				PA/SO
19. He/she gets shaky.				PA/SO
20. My child has nightmares about something bad happening to him/her.				SEP

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 2 of 2 (to be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.				GA
22. When my child gets frightened, he/she sweats a lot.				PA/SO
23. My child is a worrier.				GA
24. My child gets really frightened for no reason at all.				PA/SO
25. My child is afraid to be alone in the house.				SEP
26. It is hard for my child to talk with people he/she doesn't know well.				SOC
27. When my child gets frightened, he/she feels like he/she is choking.				PA/SO
28. People tell me that my child worries too much.				GA
29. My child doesn't like to be away from his/her family.				SEP
30. My child is afraid of having anxiety (or panic) attacks.				PA/SO
31. My child worries that something bad might happen to his/her parents.				SEP
32. My child feels shy with people he/she doesn't know well.				SOC
33. My child worries about what is going to happen in the future.				GA
34. When my child gets frightened, he/she feels like throwing up.				PA/SO
35. My child worries about how well he/she does things.				GA
36. My child is scared to go to school.				SCH
37. My child worries about things that have already happened.				GA
38. When my child gets frightened, he/she feels dizzy.				PA/SO
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).				SOC
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.				SOC
41. My child is shy.				SOC

The SCARED is available at no cost at www.pediatricbipolar.pitt.edu under resources/instruments.

January 19, 2018

Screen for Child Anxiety Related Disorders (SCARED) PARENT Version

TO BE COMPLETED BY CLINICIAN

Name: _____ Date: _____

SCORING:

A total score of ≥ **25 may** indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 **may** indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PA/SO =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 **may** indicate **Generalized Anxiety Disorder**. **GA =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 **may** indicate **Separation Anxiety**. **SEP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 **may** indicate **Social Phobic Disorder**. **SOC =**

A score of **3** for items 2, 11, 17, 36 **may** indicate **Significant School Avoidance**. **SCH =**

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D.,
Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230–6.

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January 19, 2018