Patient Name: _____ Date:

New Patient Information: Child/Minor Form

Last:	First:	Middle:
DOB:	Sex: ☐M ☐F	SS#:
Educational level: Marital Status:	Cell:	**Email:**
Address St.:	City:	Zip:
	Emergency **Contact**	
Last:	First:	Relationship: Ph. #:
	Insurance Information	
Primary Insurer:	ID:	Group #:
Secondary Insurer:	ID#:	Group #:
Policy Holder:	Relationship:	DOB:
SS #:	Employer:	Ph #: Ph#:
Insurance coverage is your responsibility. Please check your coverage benefits.	**Benefit Verification Information:**	
	☐**Individual** ☐ **Family** ☐ **Group**	**F Code:**
Policy Effective Date:	☐ **Calendar year plan** ☐ **Monthly plan**	
Copay:	**Deductible: $**	**Deductible *Remaining*:** **Individual:** **Family:**
Auth. Required? Y N 96130/96131 **Phone #:**	**Auth. #:**	**# Sessions:_____**

REASON FOR APPOINTMENT:

Patient Name:_____ Date:

Financial Policies

Payment is due at the time of service, including co-pays. We do not carry balances. We accept most insurances and provide instructions for Zelle© and Pay Pal button are on the "Patient Forms" page of our website: www.KenfieldWalters.com. KWI accepts most insurances but each patient is responsible for payment of *services in full* at the time that services are rendered until the annual deductible, if applicable, is fully paid. We do not guarantee payment by your insurer. Know your own benefits.

Please initial in the designated places to signify that you have read and agree to each of the policies below:

X_____ I agree to a charge of $110.00 for missed appointments and for cancellations given within less than a 48-hour notification. This does not apply to Evaluation Services. Evaluation Service obligations are covered *in signature documents* specifically written for Evaluation Services.

X_____ I agree to pay immediately a $35.00 "returned check fee" in addition to replacing the amount of a check returned by my bank.

X_____ I agree to report to KWI any changes in my contact information (address, phone #, etc.), insurance, or responsible party prior to the next session appointment.

X_____ KWI does not carry balances of any kind. I agree that if my account remains unpaid for more than 30 days, KWI may take legal action to collect the balance at my expense. I agree that if my account remains unpaid for more than 90 days, KWI may take legal action to collect the balance. I agree, as my sole responsibility, to pay all attorney fees and court costs for both parties in any dispute a*t the time of the hearing.*

X_____ I understand that I am financially responsible for services provided, whether reimbursed by my insurer or not. Any service charges not covered by my insurer for any reason are my responsibility.

A FEE MAY BE CHARGED FOR ADDITIONAL SERVICES

X Patient Initials: **Date:**_____

Initialed Acknowledgement of Receipt of HIPAA Privacy Practices

X_____ I hereby **initial** here to acknowledge that I have been apprised of the availability of a copy of Kenfield Walters Intl LLC "Privacy Policy" that can be downloaded in its entirety at http://www.kenfieldwalters.com on the "Patient Forms" page."

Consent for Treatment

X_____ hereby consent to receive treatment for therapeutic/psychological services through Kenfield Walters Intl LLC. I have been notified that the "Consent for Treatment" form must be downloaded at http://www.kenfieldwalters.com on the "New Patient Forms" page."

Patient Name: _____ Date:

Coordination of Care with Primary Care Physician

I, **X** (Patient/Guardian Initials) _____☐ Authorize / ☐ Do Not Authorize, the release of any information to my physician by Kenfield Walters Intl LLC and the release of any information to Kenfield Walters Intl LLC by:

Physician Name:	Ph. #:	Fax #:	
Address:	City:	MI	Zip:
X Patient/Guardian Signature: _____		**Date:**	

Please Check Current Symptoms

☐ Anger	☐ Hyperactivity	☐ Abuse History: _____
☐ Anxiety	☐ Irritability	☐ Academic Issues
☐ Appetite Change	☐ Mood Swings	☐ Behavior Issues:_____
☐ Crying Spells	☐ Paranoia	☐ Financial Problems
☐ Decreased Concentration	☐ Racing Thoughts	☐ Health Issues
☐ Excessive Worry	☐ Sleep Problems	☐ Legal Issues
☐ Feeling Hopeless	☐ Suicidal Feelings	☐ Grief/Loss
☐ Weight Change	☐ Homicidal Thoughts	☐ Relationship Issues
☐ Depression	☐ Overwhelmed	☐ Sexual Issues
☐ Delusions	☐ Hallucinations	☐ Substance Abuse: _____
❑ Self-esteem issues	❑ Grief/loss	☐ Work Issues
❑ Leaves Home	☐ Cutting	❑ Peer Problems
❑ Rebelliousness	❑ Theatrical	❒ ADHD/ADD
❑ Substance Abuse	❑ Secretive	❑ Autism
❒ Truancy	❑ Disrespectful	Other:
❑ Isolated	❑ Asperger's	

Patient Mental Health Questionnaire – Circle one answer/number for each question.
Over the past two weeks, how often have you been troubled by any of the following problems?

	Not at all	Several days	More than half of the time	Nearly every day
1. Little interest in doing things.	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless.	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep.	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy.	**0**	**1**	**2**	**3**
5. Poor appetite or overeating.	**0**	**1**	**2**	**3**
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading.	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed, or being so fidgety that you	**0**	**1**	**2**	**3**

Patient Name: _____ Date:

have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead, or hurting yourself.	**0**	**1**	**2**	**3**
Column Totals				

SOCIAL INFORMATION

1. Does child/you usually spend leisure time: ☐ Alone ☐ With family ☐ With friends

2. Describe your strengths: _____ _____ _____ _____

3. List your hobbies: _____ _____ _____ _____

SUICIDAL ISSUES

1. Have you ever thought about suicide? ☐ No ☐ Yes Dates:_____

2. Do you have a history of suicide attempts? ☐ No ☐ Yes Date of most recent if yes: _____

How?: _____

3. Do you currently feel suicidal? ☐ No ☐ Yes Explain: _____

EDUCATION

☐ Did not complete High School ☐ High School Diploma ☐ GED ☐ Vocational Training
☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate / Psy D. ☐ MD/DO
School: _____ Major: _____ Final GPA: _____

1. Have you experienced academic difficulties? ☐ No ☐ Yes If, yes, When ?:_____

2. Have you experienced behavior problems in school? ☐ No ☐ Yes _____

OCCUPATION

☐ Student ☐ Homemaker ☐ Retired ☐ Unemployed

☐ Employed Name of Employer: _____ Job Title: _____
Primary Sources of support: ☐ Self-support ☐ Full/Part Time Job ☐ Parents ☐ Spouse
☐ Retirement ☐ Disability

MILITARY SERVICE

Have you ever been in the military? ☐ No
☐ Yes: ☐ Army ☐ Air Force ☐ Coast Guard ☐ Navy Marines

Enlistment Date: _____ (Circle): Honorable / Dishonorable Discharge Date: _____

Patient Name: _____ Date:

FAMILY INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widow(er)
Children: ☐ I do not have children

Name(s)	Age		Lives with you?
Spouse(s)		Dates of Marriage/of Divorce	
			☐ No ☐ Yes
			☐ No ☐ Yes
Children:		Biological/Step/Adopted	
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
Siblings:		Biological/Step/Adopted	
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes
			☐ No ☐ Yes

Describe your relationships with <u>family members</u>:
At Childhood: ☐ Poor ☐ Strained ☐ Good ☐ Excellent:-_____
At Adulthood: ☐ Poor ☐ Strained ☐ Good ☐ Excellent-_____
At Present: ☐ Poor ☐ Strained ☐ Good ☐ Excellent -_____

RELIGION

Were you raised in a home that practiced a religion? ☐ No ☐ Yes
Do you currently practice a religion? ☐ No ☐ Yes
☐ Catholic ☐ Christian ☐ Hindu ☐ Jewish ☐ Protestant ☐ Muslim
☐ Other: _____

ETHNIC GROUP

☐ African-American/Black ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American

☐ Other: _____

LEGAL HISTORY

(Circle) Are you <u>currently</u> and/ or have been <u>in the past</u> involved in a:

☐ Custody Suit, Date: _____ ☐ On Probation, Date(s): _____

☐ DUI/OWI Conviction(s), Date(s): _____ ☐ Divorce(s), Date(s): _____

☐ Other: _____

MEDICAL HISTORY

Patient Name: _____ Date:

Describe Your current health: ☐ Poor ☐ Fair ☐ Good ☐ Very good	**Are you experiencing physical pains at this time?** ☐ No ☐ Yes: Where? _____

Check all that apply to yourself or an immediate family member:

	Myself - Insert Dates Below		**Family Member**
	Current/Recent	**Past**	☐ Mother ☐Father ☐Sibling
Abuse: Emotional/Physical/Sexual			☐ Mother ☐Father ☐Sibling
Alcohol Abuse…&/or Inpatient hospitalization…			☐ Mother ☐Father ☐Sibling ☐ Mother ☐Father ☐Sibling
ADD/ADHD			☐ Mother ☐Father ☐Sibling
Anxiety			☐ Mother ☐Father ☐Sibling
Asthma			☐ Mother ☐Father ☐Sibling
Appendicitis			☐ Mother ☐Father ☐Sibling
Bed wetting			☐ Mother ☐Father ☐Sibling
Birth defects			☐ Mother ☐Father ☐Sibling
Bulimia			☐ Mother ☐Father ☐Sibling
Cancer			☐ Mother ☐Father ☐Sibling
Chest pain			☐ Mother ☐Father ☐Sibling
Constipation			☐ Mother ☐Father ☐Sibling
Chicken Pox			☐ Mother ☐Father ☐Sibling
Diabetes			☐ Mother ☐Father ☐Sibling
Diarrhea			☐ Mother ☐Father ☐Sibling
Fainting			☐ Mother ☐Father ☐Sibling
Hearing			☐ Mother ☐Father ☐Sibling
High blood pressure			☐ Mother ☐Father ☐Sibling
Migraines			☐ Mother ☐Father ☐Sibling
Nausea			☐ Mother ☐Father ☐Sibling
Psychiatric hospitalization			☐ Mother ☐Father ☐Sibling
Stroke			☐ Mother ☐Father ☐Sibling
Other hospitalization(s)			☐ Mother ☐Father ☐Sibling
Gender Issues: Specify			☐ Mother ☐Father ☐Sibling

MEDICATION LOG

List Prescribed medication(s) or herbal supplements you currently take. Add sheets of paper if needed.

Medication Name	**Daily Dosage/mg.**	**Reason for Use**	**Use Dates: mm/yyyy**

Allergies/Side Effects:

_____

SURGERIES

List any major accidents or surgeries: ☐ Not applicable

Surgeries(s): Type: _____ Reason: _____ Date: _____

Type: _____ Reason: _____ Date: _____

Accidents(s): Type: _____ Reason: _____ Date: _____

Type: _____ Reason: _____ Date: _____

Patient Name: _____ Date:

MEDICAL HISTORY - CONTINUED

FOOD

Do you have any diet or nutritional concerns: ☐ No ☐ Yes: Your Height: _____

Have you gained weight in the last 60 days: ☐ No ☐ Yes: Lbs:_____

Have you lost weight in the last 60 days: ☐ No ☐ Yes: Lbs:_____

Do you ever: ☐ overeat ☐ induce vomiting ☐ Use laxatives ☐ Exercise to get rid of calories ☐ Skip meals

SUBSTANCE USE

ALCOHOL USE:

Do you currently drink? ☐No ☐ Yes What is your consumption weekly? -
_____

Have you ever been told to cut down on your drinking? ☐ No ☐ Yes

Have you ever felt bad about your drinking habits? ☐ No ☐ Yes

Have you ever attended an AA group? ☐No ☐ Yes: When: _____

Have you ever been convicted of an: ☐MPI ☐DWI ☐ OWI? When? _____ _____
_____

Have you been treated as an *outpatient* for alcohol use: ☐ No ☐Yes - Dates:_____ Therapist:
_____

Have you been treated as an *inpatient* for alcohol use? ☐ No ☐Yes - Dates: _____
Facility?_____

DRUG USE:

Do you / have you use/(d) illegal drugs, or non-prescription medication now or in the past? ☐ No ☐ Yes

Drugs Used: ☐ Amphetamines ☐ Crack/Cocaine ☐ Heroine/Opiates Marijuana ☐ Vaping Substance

Have you ever attended an NA meeting? ☐ No ☐ Yes Date(s):_____

Have you ever been treated as an *outpatient* for drug use? ☐No ☐Yes Date(s): _____

Have you ever been treated as an *inpatient* for drug use? ☐ No ☐Yes Date(s):_____

CAFFEINE USE: ☐ Not applicable

Coffee: Cups per day ☐ 1 ☐2 ☐3 ☐4+

Tea: Cups per day: ☐1 ☐2 ☐3 ☐4+

Energy Drinks: ☐1 ☐2 ☐3 ☐4+

Patient Name: _____ Date:

SMOKING: Check the response that best summarizes your cigarette/vaping smoking status: ☐ Never smoked ☐ Former smoker: Month/Year Quit: _____ ☐ Current Smoker: Average number of cigarettes/cartridges smoked/vaped per day: _____
THERAPY GOALS **Please list what you hope to accomplish during therapy**
1.
2.
3.

X_____ **Date:** _____
Patient & Guardian Signatures