Patient’s Full Name

Today’s Date

Patient’s Date of Birth\_\_\_/\_\_\_\_/\_\_\_\_

Patient’s Current Age\_\_\_\_\_years\_\_\_mos

Gender

Address where patient lives:

Secondary address where patient lives:

Parent 1 Name

Phone

Email

Parent 2 Name

Phone

Email

Who referred you to this clinic?

Patient Phone

Email

Emergency Contact Name

Phone

Can this person pick your child up in the event of an emergency? Y/N

If not, who can?

Patient’s Physician or Pediatrician Name, Office and Phone Number

Can I speak with your child’s pediatrician about relevant medical history? Y/N

If Yes, we will complete an ROI

Patient’s Psychiatrist or Prescribing ARNP (if applicable)

Names of Medications and Dosages (List all)

* Med 1
* Med 2
* Med 3
* Med 4

Previous Therapist Name

Dates of Prior Treatment

Has your child received formal psychological assessment (e.g. at school or by a neuropsychologist?) Y/N

Name of clinician who conducted previous assessment

Dates of previous assessment

Name of Current School

Name of Current Teacher

Current Grade

Name of School Psychologist or Counselor

*If Summer or Transitioning Schools*

Name of New School

Future Grade

Name of Future Teacher

Does your child have a 504 Plan or IEP in place at school? N/Y If Yes, circle applicable

Please write down any other health care providers, specialists, or school related support that you have previously worked with regarding mental health and related issues:

INSURANCE FOR BEHAVIORAL HEALTH

**At your first appointment, I will make a photocopy of your insurance cards.** In addition, the following information should be filled out by the parent or individual who holds the insurance (i.e., the primary subscriber):

Primary Insurance

Patient relationship to insured subscriber

Subscriber name

Date of birth

Gender

Address (if different than above)

Employer Name

Date of insurance expiration or renewal

Secondary Insurance

Patient relationship to insured subscriber

Subscriber name

Date of birth

Gender

Address (if different than above)

Employer Name

Date of insurance expiration or renewal

Are you aware of plan coverage for mental health? Y/N

Are you aware of the need for prior authorization or referral for mental health services? Y/N

*Please notify Dr. Lord as soon as any of your insurance information or physical address changes to avoid gaps in coverage. Thank you!*