CHILD/ADOLESCENT INTAKE FORM

Patients under the age of 18 must be accompanied by a parent or legal guardian at all Telehealth visits.

PATIENT INFORMATION

Name: ____
First Last

Date of Birth: __________________ Age: _____ Gender: _____ Race: __________________

Address: ____
Street City State Zip

PARENT CONTACTS

Mother's Name: ____ Age: ______
First Last

Father's Name: ____ Age: ______
First Last

Marital Status of Parents: (circle) Single Married Cohabiting Divorced Separated Widowed

Mother's Address: ____
Street City State Zip

Contact phone number(s): ____
Home Cell Work

Father's Address: ____
Street City State Zip

Contact phone number(s): ____
Home Cell Work

If divorced, who has legal custody? ____

Who has physical custody? ____

What is the schedule for parenting time? ____

____

REFERRAL INFORMATION

Who referred you to this practice? ____
Name

____
Address

____
Phone Fax

PRESENTING PROBLEM

Patient Name: ____ **Account:** ____________

What is the **PROBLEM** for which you are seeking assistance for your child/adolescent? ____________

____

____

____

What concerns you most about your child/adolescent? ____________________

____

____

____

When did you first notice this problem? ____________________________

What caused you to seek assistance at this time? _______________________

____

How has this problem affected his/her functioning? At home: _______________

____

At school/work: ____

____

In the community: ____

____

Do you have other concerns that you would like addressed? ______________

____

____

____

What are your goals/expectations for treatment? _______________________

____

____

____

Have you recently worried that your child/adolescent has any of the folllowing? **(IF YES, PLEASE CIRCLE EACH INDIVIDUAL ITEM THAT IS RELEVANT TO HIM/HER.)**

- ❑ Yes ❑ No **DEPRESSION** (sad, irritable, hopeless, helpless, crying, difficulty sleeping, sleeping too much, decreased energy/fatigue, feelings of worthlessness or guilt, difficulty thinking or concentrating, difficulty making decisions, social withdrawal / isolative behaviors, lack of interest in things, suicidal thoughts)
- ❑ Yes ❑ No **MOOD SWINGS** (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)
- ❑ Yes ❑ No **ANXIETY** (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomachaches, frequent school / work absences, etc.)
- ❑ Yes ❑ No **BEHAVIORAL PROBLEMS** (fights/physical aggression, anger, arguing, destruction of property, fire setting, hurting animals, etc.)

Patient Name: ________________________________ **Account:** ____________

ATTENTION / HYPERACTIVITY PROBLEMS (difficulty paying attention, easily distracted, difficulty completing tasks, hyperactive, impulsive)

ABNORMAL EATING BEHAVIORS (too much/significant weight gain, too little/ significant weight loss, fear of weight gain, distorted body image, excessive exercising, etc)

SOCIAL ANXIETY (shy and/or afraid to be around others, fear of being judged by others, avoidance of crowds, avoidance of public places)

REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)

AUTISM (social and language impairments, rigidity)

PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)

DISSOCIATION (feeling outside his/her body or like things are not real, etc.)

❑ Yes ❑ No Has your child/adolescent ever **HARMED HIM/HERSELF INTENTIONALLY?** If yes, please explain: ______________________________

❑ Yes ❑ No Has your child/adolescent ever **ATTEMPTED SUICIDE?** If yes, please explain:

____

❑ Yes ❑ No Has your child/adolescent ever **HARMED OTHERS?** If yes, please explain:

____

❑ Yes ❑ No Has your child/adolescent ever been the **VICTIM OF ABUSE OR NEGLECT?** If yes, what was the nature of the abuse/neglect? ______________________________

____

❑ Yes ❑ No Has your child/adolescent experienced a **SIGNIFICANT LOSS?** If yes, please explain: ______________________________

❑ Yes ❑ No Has your child/adolescent experienced any **PROBLEMS RELATED TO RACE, RELIGION, OR CULTURE?** If yes, please explain: ______________________________

____

Has your child/adolescent ever been involved with the following? If yes, please explain:

❑ Yes ❑ No Child Protective Services: ______________________________

❑ Yes ❑ No Probation / Juvenile Probation / Detention / Police: ______________________________

____

Patient Name: ______________________________ **Account:** ______________

MENTAL HEALTH HISTORY

OUTPATIENT TREATMENT for your child/adolescent:

	Name	Location	When (month/year)	For how long
Psychiatrist:				
Therapist:				

PSYCHIATRIC HOSPITALIZATIONS for your child/adolescent (residential or day treatment programs, including any alcohol and drug treatment programs):

Where	When (month/year)	Length of Stay	Type of Treatment	Diagnosis

CURRENT PSYCHIATRIC MEDICATIONS for your child/adolescent:

Name	Dosage	When Prescribed	Prescribed By	Response

PREVIOUS PSYCHIATRIC MEDICATIONS for your child/adolescent (if greater than 6 medications, please attach separate list):

____

____

____

____

____

____

SUBSTANCE USE of your child/adolescent:

	Type Average Usage	Current	Past	When Last Used
Caffeine		☐	☐	
Nicotine		☐	☐	
Alcohol		☐	☐	
Marijuana		☐	☐	

Patient Name: ______________________ **Account:** ____________

Type	Average Usage	Current	Past	When Last Used
Inhalants		☐	☐	
Hallucinogens (LSD/Ecstasy/PCP/Mushrooms		☐	☐	
Opiates (Heroin/Morphine/Other Narcotics)		☐	☐	
Sedatives		☐	☐	
Steroids		☐	☐	
Stimulants (Meth/Crack/Cocaine/Crank)		☐	☐	
Synthetic Drugs/Bath Salts		☐	☐	
Misuse of Other Prescription Drugs		☐	☐	

PREGNANCY AND BIRTH HISTORY

How old were this child's biological parents when he/she was conceived? ____________________
Baby's birth weight and length: ____________________
Length of pregnancy (in weeks): ____________________

Did you take any medication (prescription and over the counter) during this pregnancy? __________
(If yes, please complete the following table:)

Medication	Month(s) taken (1-9)	Reason for Taking

Did you consume alcohol during this pregnancy? ______ If yes, how much and how often?
____

Did you smoke or use tobacco products during this pregnancy? ______ If yes, how much and how often? ____________________

Did you use any drugs during this pregnancy? ______ If yes, please name drug(s), how much, and how often used: ____________________
____
____

Were there any problems with the baby's health right before or immediately after delivery? _______
If yes, please describe: ____________________
____
____
____

Apgar Scores: ____________________

Patient Name: ____________________ **Account:** ______________

DEVELOPMENTAL HISTORY

At what age did your child achieve the following milestones?

_____ Language (first using words, sentences, etc.)?______________________________

_____ Fine Motor Skills (building towers with cubes, drawing circles?______________________

_____ Gross Motor Skills (rolling over, standing, walking)?______________________________

_____ Daytime Toilet training?______________________________

_____ Nighttime Toilet training?______________________________

Has your child experienced any regression of these? If yes, explain: ______________________

____

____

SOCIAL HISTORY

Is your child/adolescent your biological child? ______ If no, at what age was he/she adopted?______

Is there any contact with his/her biological parents? ______________________________

Where was your child/adolescent born and raised?______________________________

FAMILY MEMBERS (including parents, stepparents, siblings, stepsiblings, and half-siblings):

Name	Age	Lives at home?	Relation to child	Quality of relationship with child

Who disciplines your child and what kind of discipline is used?______________________________

____

Do you have a religious preference in the household? ______ If yes, what is that preference?_______

____

Do you have an ethnic heritage that is an influence on your child's life? ______ If yes, please explain:

____

SCHOOL:

Where does your child/adolescent attend school?______________________________

In what grade level is he/she?______________________________

What are his/her typical grades?______________________________

What are your child's academic strengths?______________________________

____

Academic weaknesses?______________________________

____

Patient Name: ______________________________ **Account:** ______________

Has there been a change in your child's performance at school? ______ If yes, please describe:

____

____

Has your child received IQ or Academic Testing? ______ If yes, what were the results: __________

____

Has your child participated in any of the following? If yes, please explain:

❑ Yes ❑ No Resource Room (for which classes/how many hours)?__________

____

❑ Yes ❑ No Gifted, Accelerated, or Honors programs:__________

____

❑ Yes ❑ No 504 Plan:__________

❑ Yes ❑ No Individual Education Plan (IEP):__________

❑ Yes ❑ No Head Start:__________

❑ Yes ❑ No Early Intervention Services (ages 0-3) or Birth through Five:__________

____

Has your child had problems with any of the following? If yes, please explain:

❑ Yes ❑ No Truancy __________
❑ Yes ❑ No Fights __________
❑ Yes ❑ No Absenteeism __________
❑ Yes ❑ No Detention __________
❑ Yes ❑ No Suspension __________
❑ Yes ❑ No School refusal __________

PEERS

Does your child/adolescent have quality relationships with other children/adolescents? ______ If not, please explain: __________

____

____

Has your child/adolescent had a recent change in friendships? ______ If yes, what changes, if any, are of concern to you? __________

____

____

Do you have any concerns regarding your child/adolescent's friendships?

❑ Too old	❑ Too much time togethe	❑ Drug/alcohol use
❑ Too young	❑ Truant	❑ Violence
❑ Too many	❑ Gang	❑ Sexual promiscuity
❑ Too few	❑ Fringe	❑ Other: __________

Patient Name: __________ **Account:** __________

Is your child/adolescent sexually active? ______ If yes, are you concerned about your child/adolescent's sexual activities? ______________________________

Does your adolescent have a job? ______ If yes, explain: ______________________________

What are your child/adolescent's hobbies/interests? ______________________________

FAMILY MENTAL HEALTH HISTORY

Consider your child's immediate family and all of his/her relatives on both sides. (Maternal is mother's side of the family, and Paternal is father's side of the family.) Include parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins. Review the list below. If any relative has one of these disorders, check it and describe his/her relation to your child/adolescent and his/her treatment history (if applicable).

____ Depression ______________________________
____ Anxiety ______________________________
____ ADHD ______________________________
____ Bipolar (manic depressive) ______________________________
____ Schizophrenia ______________________________
____ Alcohol problems ______________________________
____ Drug problems ______________________________
____ Learning disabilities ______________________________
____ Autism / Asperger's / Pervasive developmental disorder ______________________________
____ Mental retardation / Intellectual disability ______________________________
____ Nervous breakdown ______________________________
____ Psychiatric hospitalizations ______________________________
____ Suicide attempts ______________________________
____ Completed suicide ______________________________
____ Panic disorder ______________________________
____ PTSD (posttraumatic stress disorder) ______________________________
____ OCD (obsessive compulsive disorder) ______________________________
____ Seizures ______________________________
____ Other ______________________________

MEDICAL HISTORY

Primary Care Provider ______________________________
Address: ______________________________
Phone: ______________________________ Fax: ______________________________
When was his/her last physical exam with bloodwork? ______________________________
Are there other physicians/specialists your child sees on a regular basis? ______________________________

Patient Name: ______________________________ **Account:** ______________

CHECK IF YOUR CHILD/ADOLESCENT HAS EVER HAD:

- ❑ Loss of consciousness
- ❑ Head injury
- ❑ Seizures

CHECK IF YOUR CHILD/ADOLESCENT HAS ANY OF THE FOLLOWING:

- ❑ Allergies
- ❑ Anemia / low iron
- ❑ Arthritis
- ❑ Asthma
- ❑ Bedwetting / toilet issues
- ❑ Back or neck pain
- ❑ Chronic nosebleeds
- ❑ Diabetes
- ❑ Hearing problem
- ❑ Heart problem
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ IBS/Crohn's disease/celiac disease
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Menstrual problems
- ❑ Migraine headaches
- ❑ Obesity
- ❑ Skin conditions/eczema/dermatitis
- ❑ Stomach problems
- ❑ Thyroid problems
- ❑ Vision problems
- ❑ Cancer If yes for cancer, what type and any required treatment? ______________________________

____

____

- ❑ Surgeries If yes for surgeries, what type? ______________________________

____

____

Are there any other medical problems not listed above? If so, please list here: ______________________

____

____

CURRENT NONPSYCHIATRIC MEDICATIONS:

Name	Dosage	When Prescribed	Response

Drug allergies and reactions: ____

____

____

Signature: ______________________________________ **Date:** ______________
(*Please circle*: Parent / Guardian / Other ______________________)

Signature: ______________________________________ **Date:** ______________
(*Please circle*: Adolescent / Child)

Patient Name: ______________________________________ **Account:** ______________

KIRBY MEDICAL CENTER

What Is Telepsychiatry?

There is no question that telemedicine has become an essential service within healthcare in the United States. The lack of access to proper psychiatric care is one of the biggest struggles of the American public health system, and telepsychiatry has opened doors to obtaining quality care- despite geographical location.

Telepsychiatry is one of the most promising developments in the fight to provide more patient-centered, affordable, and effective interventions for individuals who need psychiatric care.

How It Works

If seen from the clinic, at the time of your appointment, you will be led into a private room by our Medical Assistant. The Medical Assistant will take your vitals, communicate them to your provider, and then leave the room (you may request her/him to stay) and your consultation with your provider will begin. If you are being seen from your home, you will be provided a link to access the virtual appointment with your provider.

These telepsychiatry sessions are private and confidential. Over time, patients and practitioners develop a strong relationship.

Learn More

We pride ourselves in being telepsychiatry experts. Check out our website at www.iristelehealth.com or follow us on social media for more!

- www.facebook.com/iristelehealth
- @IrisTelehealth
- Iris Telehealth

Meet Dr. Julie Baldinger, DO!

Dr. Julie Baldinger was born and raised in Northern Virginia, outside of Washington, D.C. She attended college at the University of Virginia where she was selected to be a member of Phi Beta Kappa, and she attended medical school at the Edward Via Virginia College of Osteopathic Medicine in Blacksburg, Virginia, graduating with Honors. In medical school, she spent time rotating through hospitals in Florida and South Carolina before returning to Virginia to complete a Psychiatry Internship at the University of Virginia, followed by an Adult Psychiatry Residency at Georgetown University. She then went on to attend the University of Virginia again for her Child/Adolescent Psychiatry Fellowship. Dr. Baldinger is a member of the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry.

Dr. Baldinger enjoys all realms of Psychiatry with a passion for children, young adults, as well as older adults dealing with depressive and anxiety-related disorders. While she has a breadth of experience in both inpatient as well as outpatient centers, she most enjoys the outpatient realm in which she can follow with her patients long-term. She focuses on treatment of the individualized patient and caters her pharmacological treatment to the individual. She provides care in an open and non-judgmental way, and she effortlessly seeks to destigmatize mental healthcare with the goal of greater access of care to all populations.

Outside of Medicine, Dr. Baldinger enjoys all things fitness-related, the outdoors and spending time with family/friends and her two rescue pups, a Great Dane and Terrier mix. With a passion for animals, she has a dream of one day opening a sanctuary for abandoned animals and integrating this into her care of patients.

Dr. Baldinger is excited to join the team at Kirby Medical Center!

KIRBY MEDICAL CENTER

MENTAL HEALTH RECORDS AUTHORIZATION

1. PATIENT INFORMATION

Patient's Name: ______________________ Date of Birth: ______________

Address: ______________________ SS#: ______________

City: ______________ State: ________ Zip: ________ MR#: ______________

Maiden/Other Names: ______________ Phone #: (Home) ________ (work) ________

*The following persons are entitled upon request to inspect and copy a mental health record or any part thereof: 1) parent or guardian of a patient under 12 years of age; 2) the patient if 12 years or older; 3) the parent or guardian of a patient who is at least 12 but under 18 years, if the informed patient does not object or if the therapist does not find a compelling reason to deny access; 4) the guardian of a patient 18 years or older. 5) an attorney or guardian ad litem; 6) an agent appointed under patient's health care power of attorney; 7) an attorney-in-fact appointed under the Mental Health Treatment Preference Declaration Act; or 8) any person in whose care and custody the patient has been placed pursuant to Section 3-811 of the Mental Health and Developmental Disabilities Code.

I authorize the use/disclosure of my, or as legal representative or guardian of patient's, mental health records and/or information as follows:

2. PARTY WHO HAS MY MENTAL HEALTH RECORDS AND / OR INFORMATION TO USE / DISCLOSE:

☐ Kirby Medical Group (KMG) ☐ Kirby Medical Center (KMC)

☐ Other: ______________________

3. PARTY OR PARTIES WHO I WANT TO RECEIVE MY MENTAL HEALTH RECORDS AND / OR INFORMATION:

Name: ______________________

Address: ______________________ City: ______________

State: ________ Zip: ________ Phone #: ( ) ______________

4. PURPOSE OF USE / DISCLOSURE OF MY MENTAL HEALTH RECORDS AND / OR INFORMATION:

☐ Medical treatment ☐ Employment reasons ☐ Underwriting (insurance)

☐ Legal ☐ Patient request

☐ Involvement in my care

☐ Other: ______________________

5. THE DATES OF RECORDS AND / OR INFORMATION TO BE USED OR DISCLOSED:

☐ Records or information from: ______________ to ______________

(Beginning Date) (End Date)

6. DESCRIPTION OF MY MENTAL HEALTH RECORDS AND / OR INFORMATION TO BE USED AND DISCLOSED:

☐ Psychiatry / psychology initial evaluation ☐ Independent medical / psychological exam

☐ Psychiatry / psychology consultation ☐ Billing records

☐ Psychiatry / psychology progress notes ☐ Consent forms

☐ Appointment information ☐ Other: ______________________

7. EXPIRATION

This authorization will expire 6 months from the date this release is received by our office. If I want it to expire on a different date, then that date is: ______________________

8. CANCELING THIS AUTHORIZATION

I understand that I may cancel this authorization at any time. Canceling this authorization must be done by sending a signed and dated letter, and having a person who can identify me sign it as my witness. The letter must be delivered to Kirby Medical Center Health Information Management at the address shown at the bottom of this page. The cancellation will take effect when Kirby receives the letter. I understand the letter will not apply to the uses/disclosures of my health information that were made in reliance on the authorization before Kirby received my letter.

[Please turn to the back of this page]

9. **RE-DISCLOSURE OF MY HEALTH RECORDS AND / OR INFORMATION:**
I understand that the person who receives my mental health information may NOT disclose it to someone else without my permission, unless permitted by law.

10. **EFFECT OF NOT SIGNING THIS AUTHORIZATION:**
I am not required to sign this authorization in order to receive most health care services at KMG/KMC. However, I understand that if the ONLY reason I am seeing a Kirby provider is to create health information for someone else's use (such as my employer), Kirby may refuse to see me if I do not sign this authorization. For example, if I am here for pre-employment testing, then I must sign this authorization in order for Kirby to perform the pre-employment test.

11. **FEES:**
I may be charged a processing fee for this request to disclose my health information. I may ask Kirby for a fee estimate. If I receive a bill for processing this request, the bill may come from a company that processes health information requests for Kirby.

12. **RIGHT TO INSPECT & COPY:**
I understand that I have a right to inspect and receive a copy of the records to be disclosed pursuant to this authorization.

13. **MY AUTHORIZATION:**

X ______________________ (Signature of Patient) X ______________________ (Date Signed)

______________________ (Signature of Legal Representative or Guardian) ______________________ (Date Signed)

______________________ (Printed Name of Legal Representative or Guardian) ______________________ (Relationship to Patient if signed by Representative or Guardian)

X ______________________ (Signature of Witness) X ______________________ (Date Signed)

14. **INSTRUCTIONS FOR RECORD COPY REQUESTS ONLY (CHECK ONE IF APPLICABLE):**
- ☐ Mail record copies out to party or parties I named in #3
- ☐ I will pick up records

15. **RETURN THIS COMPLETED FORM TO:**

Kirby Medical Center
Health Information Management Department
1000 Medical Center Drive
Monticello, IL 61856

Phone (217) 762-1865
Fax (217) 762-1862

16. **PROVIDER RELEASE NOTIFICATION:**
- ☐ ______________________ has been notified of this release ______________(initials/date)
- ☐ ______________________ has been notified of this release ______________(initials/date)
- ☐ ______________________ has been notified of this release ______________(initials/date)
- ☐ ______________________ has denied this release ______________(initials/date)

PROVIDE COPY OF SIGNED FORM TO PATIENT