

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 following? **(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: _____

KIRBY MEDICAL
GROUP

CHILD/ADOLESCENT INTAKE FORM
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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: _____

KERBY MEDICAL
GROUP

CHILD/ADOLESCENT INTAKE FORM
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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 _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nicotine _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marijuana _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Name: _____ Account: _____



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

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: _____



CHILD/ADOLESCENT INTAKE FORM

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?

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Too old | <input type="checkbox"/> Too much time together | <input type="checkbox"/> Drug/alcohol use |
| <input type="checkbox"/> Too young | <input type="checkbox"/> Truant | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Too many | <input type="checkbox"/> Gang | <input type="checkbox"/> Sexual promiscuity |
| <input type="checkbox"/> Too few | <input type="checkbox"/> Fringe | <input type="checkbox"/> 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: _____



CHILD/ADOLESCENT INTAKE FORM

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CHECK IF YOUR CHILD/ADOLESCENT HAS EVER HAD:

- Loss of consciousness Head injury Seizures

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

- | | |
|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Anemia / low iron | <input type="checkbox"/> IBS/Crohn's disease/celiac disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Bedwetting / toilet issue: | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> Back or neck pain | <input type="checkbox"/> Migraine headache |
| <input type="checkbox"/> Chronic nosebleeds | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin conditions/eczema/dermatiti |
| <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Heart problem | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Vision problem: |
| <input type="checkbox"/> 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: _____

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: Kirby Medical Center, HIM Dept
 Address: 1000 Medical Center Drive City: Monticello
 State: IL Zip: 61856 Phone #: (217) 762-1860

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:

(Signature of Patient)

(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)

(Signature of Witness)

(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

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](https://twitter.com/IrisTelehealth)
-  [Iris Telehealth](https://www.linkedin.com/company/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!