# 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 <u>NONPSYCHIATRIC</u> MEDICATIONS:**

| Name | Dosage | When Prescribed | Response |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Drug allergies and reactions: _____

_____

_____

**Signature:** _____ **Date:** _____
(*Please circle*: Parent / Guardian / Other _____)

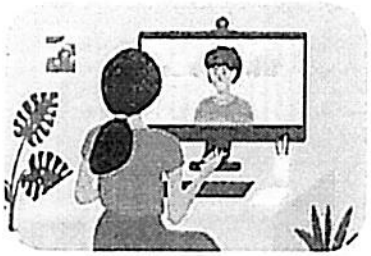
**Signature:** _____ **Date:** _____
(*Please circle*: Adolescent / Child)

**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!

PLEASE COMPLETE THE FOLLOWING MENTAL

HEALTH RECORDS AUTHORIZATION FORM ONLY IF

THE PATIENT HAS MENTAL HEALTH RECORDS

FROM OUTSIDE OF

KIRBY MEDICAL GROUP/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: Kirby Mediical Group

Address: 1000 Medical Center Dr City: Monticello

State: IL Zip: 61856 Phone #: 217-762-6241; Fax 217-762-1702

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

- ❑ Medical treatment
- ❑ Employment reasons
- ❑ Patient request
- ❑ Legal
- ❑ Involvement in my care
- ❑ Underwriting (insurance)
- ❑ Other: _____

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

❑ Records or information from: _____ (Beginning Date) to _____ (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 in 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's Health Information Management at the address shown on the back 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]**

Next 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:**

Click here to sign

**Patient Signature**

Click here to sign

**Witness Signature**

Click here to sign

**Legal Representative or Guardian Signature**

(Printed Name Legal Representative or Guardian)

(Relationship to Patient if signed by Representative or Guardian)

**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 been notified of this release _____(initials/date)

**PROVIDE COPY OF SIGNED FORM TO PATIENT**

Previous Page | Save | Complete