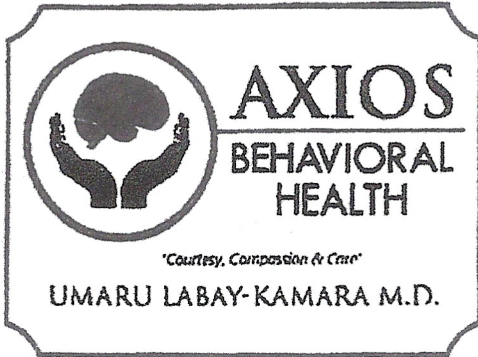

101 East Charles Street
Suite 202
La Plata, MD 20646
Phone Number:(301)934-3415
Fax Number:(301)934-3417

Adolescent

PATIENT REGISTRATION:

First: ______________ Middle: ______________ Last: ______________

Address: ______________ City: ______________ State: ______ Zip: __________

Home #: ______________ Cell #: ______________ Work #: ______________

Employer: ______________ Social Security #: ______________

Birth Date: ______________ Age: ______ Gender: __________ Marital Status: ______________

Race: ______________ Email: ______________

EMERGENCY CONTACT: NAME ______________ PHONE: ______________

Legal Guardian Information (If patient is less than 18 years old)

Legal Guardian Name: ______________ Relationship to Patient: ______________

Home #: ______________ Cell #: ______________ Work #: ______________

Financial and Policy Holder Information

Primary Insurance

Insurance Company: ______________ Contract #: ______________ Group #:

Effective Date: ______________ Policy Holder Name: ______________

Policy Holder SS#: ______________ Birth Date: __________ Relationship to Patient: ______________

Policy Holder Address: ______________ City, State & Zip: ______________

Policy Holder Phone #: ______________ Sex: ☐M or ☐F

Secondary Insurance

Insurance Company: ______________ Contract #: ______________ Group #: ______________

Effective Date: ______________ Policy Holder Name: ______________

Policy Holder SS#: ______________ Birth Date: __________ Relationship to Patient: ______________

Policy Holder Address: ______________ City, State & Zip: ______________

Policy Holder Phone #: ______________ Sex: ☐M or ☐F

Behavioral Health Intake Form – Child & Adolescent

	Today's Date
Child's Name	Date of Birth
Address	
City State	ZIP Code
Primary Telephone:	☐ home ☐ cell ☐ work
Alternate Telephone:	☐ home ☐ cell ☐ work

We were referred by:

Household Composition

Who lives in the primary residence with the child?

Name	*Age*	*Relationship to Client*	*Name*	*Age*	*Relationship to Client*

Does the child live in a second home? ☐ Yes: How often? ☐ No

Name	*Age*	*Relationship to Client*	*Name*	*Age*	*Relationship to Client*

Parents' Marital Status/Family of Origin

☐ Never Married	☐ Is the child adopted? If so, is child aware?
☐ Married/Civil Union	Siblings names & ages:
☐ Separated, when:	
☐ Divorced, when:	
☐ Widowed, when:	Other significant relationships:
☐ Remarried, when:	

Current Medications

Medication	Dates	Reason	Effectiveness

Child's Medical History		
☐ Asthma	☐ Bowel problems	Allergies:
☐ Recurrent ear infections/tubes	☐ Thyroid disease	
☐ Eye/Vision problems	☐ Diabetes (Type I/Type II)	
☐ EEG, MRI, or CT	☐ German Measles, Whooping Cough, Measles, Mumps, Scarlet Fever, Chicken Pox	Hospitalization:
☐ Headaches/Migraines		
☐ Meningitis/Encephalitis		Surgery:
☐ Seizures	☐ Lead/Toxic chemical exposure	
☐ Head injury/Concussion	☐ Irregular menstrual period	Other:
☐ Developmental delay	☐ Pregnant	
☐ Slow weight gain	☐	

Please check all that that have applied to your child in the past 30 days:		
☐ Can't concentrate/Pay attention	☐ Bedwetting/soiling self	☐ Sees/hears things that are not real
☐ Restless/Hyperactive	☐ Has been bullied	☐ Confused thinking
☐ Talks too much/out of turn	☐ Frequent sadness/irritability	☐ Feels people are "out to get" him/her
☐ Impulsive/Acts without thinking	☐ Tearful/Cries easily	☐ Odd/bizarre thoughts/behavior
☐ Trouble staying seated	☐ Low energy level	☐ Behaves like a younger child
☐ Makes careless mistakes	☐ Loss of interest in favorite activities	☐ Has trouble communicating
☐ Fails to finish things he/she starts	☐ Low self-esteem/Guilt	☐ Sensory experiences/issues
☐ Feeling irritable	☐ Dislike of his/her body	☐ Makes repetitive sounds/movements
☐ Daydreams/Gets lost in thought	☐ Feelings hurt easily	☐ Fascinated with parts of toys
☐ Inattentive/Easily distracted	☐ Has trouble making & keeping friends	☐ Is not affectionate
☐ Has trouble following directions	☐ Severe changes in mood	☐ Lack of imaginary/pretend play
☐ Forgetful/Often loses things	☐ Talks too much/fast/changes topic quickly	☐ Avoids/seems obsessed with certain things
☐ Police contact		
☐ Angry/Resentful	☐ Thoughts racing	☐ Does not seek to share interests
☐ Argues/Does not follow rules	☐ Inflated self-esteem	☐ Does not make friends/is in own world
☐ Annoys others purposely	☐ Difficulty controlling emotions	☐ Does not keep eye contact
☐ Bullies/Threatens/Intimidates	☐ Worries about safety of self/others	☐ Rituals/routines must be followed
☐ Physical aggression	☐ Unusual worries/fears	☐ Needs little sleep (rested after 3-4 hours)
☐ Has set fires	☐ Panic attacks	☐ Cannot fall asleep even though tired
☐ Stealing/Shoplifting	☐ Obsessive thoughts	☐ Problems staying asleep/Nightmares
☐ Temper tantrums/Loses temper easily	☐ Panics when separated from parent	☐ Unable to care for hygiene/nutrition/basic needs
☐ Lies/Blames others for own misbehavior	☐ Unusual behaviors dressing, bathing, mealtime, or counting rituals	☐ Nervous tics or other repetitive, abrupt nervous movements or vocal noises
☐ Cruel to animals	☐ Picky eater	☐ Grief/Loss
☐ Violates curfew/Has run away	☐ Self-injury/Cutting/Burning	☐ LGBTQ concerns
☐ Suspected alcohol/drug use	☐ Suicidal thoughts/threats/actions	☐ Friendship/Relationship problems
☐ School suspensions/Alternative school	☐ Witness to domestic violence	Other:
☐ Inappropriate sexual activity	☐ History of physical abuse	
☐ History of unwanted sexual contact	☐ History of sexual abuse	

CHILD INTAKE FORM
(Please complete in Ink)

CHILD

1. Child's Name______________________________ Sex______ Age_____ DOB________

2. Natural Child Yes / No If adopted, at what age______ Foster since ____________

3. Parent's Names (include step-parents, foster parents, inc.)

____

____

4. Comments about custody and visitation (if applicable):

____

____

5. Primary reason you are concerned about your child?

____

____

____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

a.
_____ Sleep problems
_____ Lack of interest in activities
_____ Unassertive
_____ Fatigue/low energy
_____ Concentration problems
_____ Appetite/weight changes
_____ Withdrawal

_____ Morbid thoughts
_____ Suicidal thoughts or threats
_____ Suicidal plans / attempts
_____ Mood swings
_____ Depression
_____ Changed level of activity
_____ Cries easily

b.
_____ Forgetful/memory problems
_____ Short attention span
_____ Aggressive behavior
_____ Can't sit still
_____ Not interested in peers
_____ Picked on / bullied by peers

_____ Talks excessively / interrupts
_____ Easily distracted
_____ Irritable
_____ Impulsive
_____ Difficulty following rules
_____ Problem completing schoolwork

c.
- _____ Excessive worry / fearfulness
- _____ Anxiety or panic attacks
- _____ Social fears, shyness
- _____ Separation problems
- _____ Bedwetting / soiling
- _____ Headaches, stomachaches
- _____ Odd beliefs / fantasizing
- _____ Nightmares
- _____ Frequent tantrums
- _____ Resistive to change
- _____ School refusal
- _____ Perfectionism
- _____ Odd hand / motor movements
- _____ Hallucinations

d.
- _____ Lying
- _____ Trouble with the law
- _____ Running away
- _____ Truancy, skipping school
- _____ Hurting others sexually
- _____ Alcohol / drug use
- _____ Argumentative / defiant
- _____ Swears
- _____ Blames others for mistakes
- _____ Stealing
- _____ Being destructive
- _____ Fire setting
- _____ Hurting others / fighting
- _____ Acts as if has no fear
- _____ Short tempered
- _____ Easily annoyed / annoys others
- _____ Discipline problem
- _____ Angry and resentful

Brothers and Sisters

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

1. Present School: ______________________ Grade: _____ Teacher: ______________
2. Has child ever repeated any grade? ______________________
3. Is child in special education services? No _____ Yes, what kind? ______________
4. Please describe academic or other problems your child has had in school

____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. **Pregnancy**

Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____

Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____
Full-term _____ Premature _____ if premature, number of weeks _____

Birth Weight: __________

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

____

2. **Developmental History**

- State approximate age when child did the following:

  Walked alone _____ Said first word _____ Used 2-word phrases _____

- Understood and followed simple directions _____
- Reasonably well toilet trained _____
- Did child cry excessively? _____ Rarely cried _____

3. **Health History of Child**

In the first two years, did your child experience: ___Separation from mother, ___Out of home care, ___Disruption in bonding, ___Depression of mother, ___Abuse, ___Neglect, ___Chronic pain, ___Chronic Illness, ___Parental Stress

- Child's Doctor: ______________________________________
- Date of last physical exam: ____________________
- Vision problems? Yes _____ No_____ Hearing problems? Yes _____ No _____
- Dental problems? Yes ____ No ____
- Any head injuries or loss of consciousness? Yes _____ No _____
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No _____ Yes – describe and give dates __________________

- Is your child currently taking any medications? No ____ Yes ____ name medications

  ____

- List any medicines previously used for emotional problems: were they helpful? ____

  ____
- Allergies to drugs or medicines? No ____ Yes ____ (list) ____________________
- Allergies to any foods? No ____ Yes ____(list) ____________________________
- Are there any foods that you limit or do not give this child? No ____ Yes ____

  (list) ____.
- Allergies to environmental conditions? No ____ Yes ____(list) ________________
- Does anyone in the household smoke? No ____ Yes ____
- About how many hours does this child watch TV, videos, etc per day ______
- Are you afraid someone you know may injure/harm this child? No ____ Yes ____

  National Domestic Violence Hotline 1-800-799-7233
- Does this child have a Health Care Directive? No ____ Yes ____

  If yes, please list where (clinic) it is on file ______________________________
- Any previous psychological or psychiatric treatment? No _____ Yes _____

  Whom/where ______________________________when_____________
- Any previous testing (school/psychological)? No _____ Yes _____

  Whom/where ______________________________when_____________
- Do you think your child's use of chemicals is a problem? No _____ Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs ____________________

  Comments: ____

Family History:

Chemical use (now & past): No _____ Yes _____ Which parent ________________

Type: Alcohol _____ Marijuana _____ Other drugs_____________________

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): ______________________________

____

Has child witnessed domestic violence? __Y, __N, Specify: ______________________________

____

How is your child disciplined? Please list each method and frequency of use: ______________

____

____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify: ______________

____

2. Has your child been physically abused? __Y, __N, __Suspected. Specify: ______________

____

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify: ______________

____

4. Other stressors or traumas? ______________________________

____

What are your child's strengths?

AXIOS BEHAVIORAL HEALTH

PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by **AXIOS BEHAVIORAL HEALTH** (hereinafter referred to as "ABH") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of BH.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. ABH is not required to agree to the restrictions that I may request. However, if ABH agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that ABH has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ABH 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of ABH. The Notice of Privacy Practices also describes my rights and ABH 's duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your expressed written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

ABH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by email or asking for one at the time of my appointment.

Initial ________ **Date** ____________

AXIOS BEHAVIORAL HEALTH
EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse
- The client is required to undergo a court-ordered examination
- The client discloses information about abuse. neglect, or exploitation of a minor
- The client discloses information about abuse. neglect. or exploitation of an aged or disabled adult
- The client's mental or emotional condition is used as a legal defense
- A civil. criminal. or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action

I hereby give my consent for service to be provided under these conditions.

AXIOS BEHAVIORAL HEALTH INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I can discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations. procedures. benefits. and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, psychotherapy. and evaluation is an interview process requiring self-disclosure, self-exploration. and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling. psychotherapy, or evaluation procedure unless otherwise specified by law.
- I have the right to question any procedure, intervention. rationale. or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged. and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information. I understand that if my provider is a resident or inter, then the treatment will be discussed with a supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.

Initial _______ **Date** __________

TELEHEALTH CONSENT FORM

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to assist in the evaluation, diagnosis, management and treatment of their patients.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional and unintentional corruption

By signing this form, I understand the following:

1. The consulting healthcare provider/ specialist will be at a different location than me.
2. I hereby authorize Axios Behavioral Health to use the telehealth practice platform of telecommunication for evaluating, testing and diagnosing my medical condition(s).
3. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment can not be started or finished as intended.
4. I accept that the professionals can conduct interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed and internet connection cannot be met.
5. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
6. I understand that although I may have not spoken with my healthcare provider for the full time that was billed (either to my insurance or myself) that the additional time was used to complete any medical charting and sending needed medications to my pharmacy.
7. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation but still be kept private and confidential.

I have read and understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my healthcare.

Patient Signature: ____ Date: ____________________

CONTROLLED SUBSTANCES AGREEMENT FORM

The purpose of this agreement is to prevent any misunderstandings regarding controlled substances that you may be prescribed by the providers at this clinic. The goal is to treat you safely with these potent medications and also to prevent abuse of or addiction to these medications. This agreement is also set forth to assist you and your provider to comply with the law regarding controlled pharmaceuticals.

Because these medications have the potential for abuse or diversion, strict accountability is necessary for both medical safety and legal reasons. Therefore, the following polices are agreed to by you, the patient, to help maintain safety and provide quality, effective care.

I agree to the following:

- I am responsible for my medications. I will not share, sell or trade my medication. I will not take anyone else's medication.

- I will not increase my medication until I speak with my provider. If I do so on my own, the provider may taper and d/c medication. Use of medication at a greater rate than prescribed may result in my being without medication for a period of time.

- My medication may not be replaced if it is lost, stolen or consumed earlier than prescribed. My prescription for a controlled substance may not be replaced if lost/stolen.

- Renewals are contingent on keeping scheduled appointments. I will not phone/text for prescriptions after hours or on weekends. Early refills will not be given.

- I will exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery.

- I will not obtain any controlled medications, including benzodiazepines, controlled stimulants or anti-anxiety medications to treat the same symptoms from any other doctor.

You must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

Pharmacy Name:____

Address: ____

I understand that if I break this Agreement, my provider may stop prescribing me certain medications and /or release me from the practice. I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding this agreement have been adequately answered.

Patient Name: ________________________________ DOB: ___________________

Patient Signature: ______________________________ Date: ___________________