

DAVID C. HALL, M.D.,
Child, Adolescent and Family Psychiatry

1019 21st Street, Anacortes, WA 98221 • Office (360)588-9470 • FAX (360)299-4372 • Pager (206)998-4702

DX:

**PATIENT INFORMATION and
TREATMENT AGREEMENT
(Child)**

Date: _____

Child's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ School Contact: (____) _____

Age: _____ Date of Birth: _____ Sex: M F Social Security Number: _____

Parent/Guardian name: _____ Relationship to patient: _____ Phone: _____

Parent/Guardian Employer: _____ Title: _____ Work Telephone: _____

Parent/Guardian name: _____ Relationship to patient: _____ Phone: _____

Parent/Guardian Employer: _____ Title: _____ Work Telephone: _____

List of any medications taking currently: _____

MEDICATION ALLERGIES: _____

INSURANCE INFORMATION

Do you want insurance billed? _____ If so, please fill in insurance info. Is this self-pay? _____

DOES YOUR INSURANCE REQUIRE REFERRAL TO DR. HALL? YES _____ NO _____ (initial)

IS THAT REFERRAL IN PLACE FOR YOUR FIRST VISIT? YES _____ NO _____ (initial)

Who referred you to Dr. Hall? _____ Phone Number: _____

Primary Insurance

Secondary Insurance

Name of Insured:	Relation to Patient:	Name of Insured:	Relation to Patient:
Employer:	WK Number:	Employer:	WK Number:
Insurance Company:		Insurance Company:	
ID/SS Number:	Group Number:	ID/SS Number:	Group Number:

PERSON TO CALL IN CASE OF EMERGENCY:

Name:	Address:	Phone:	Relationship:
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If you should have a medical emergency, call 911. If you need to reach me URGENTLY, dial 206-998-4702 and at the beep touch in your 10-digit phone number then hang up. If I haven't called you back soon enough, please try again to be sure the page worked.

Although services may be covered by insurance, I understand I am fully responsible for payment for care I receive. I understand an administrative service charge of 1% or \$2.00 per month, whichever is greater, will be charged on all unpaid balances due more than 90 days. I authorize payment of medical benefits to Dr. Hall for services rendered.

I authorize the doctor or insurance company to release any information required for payment of services rendered by this office.

I understand that 24-hour notice of cancellation is required and that I may be billed \$40 for late cancellation of a 45 min. appointment or \$20 for late cancellation of a 25 min. appointment. I understand that I am responsible for my bill and will follow the payment option of:

1. Payment in full at each session. _____
2. Copayment at each session _____
3. Full payment within 10 days of statement _____
4. Payment as follows: _____ (Describe). (Please initial option)

I HEREBY AUTHORIZE Dr. Hall to provide treatment for my child _____.
(child's name)

Signed: _____ Print your name: _____ Date: _____
(parent or legal guardian)

Co-signature for child 13 to 17 years of age AUTHORIZING TREATMENT BY DR. HALL:
_____ Date: _____

I AUTHORIZE Dr. Hall to *EXCHANGE MEDICAL/PSYCHIATRIC INFORMATION* with my child's primary care physician:

PCP's name: _____ Phone _____

PCP's address: _____ Fax _____

Other person(s) authorized to exchange information: _____
(teacher, counselor, grandparents, etc)

This authorization remains in effect until (initial one): _____ I rescind it in writing
_____ 90 days from today.

Signed: _____ Print your name: _____ Date: _____
(parent or legal guardian)

Co-signature for child 13 to 17 years of age: _____ Date: _____

Thank you.

David C. Hall, MD, Child & Adolescent Psychiatry

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Intake Questionnaire - Child
(Complete and bring with you to first appointment)

Date: _____

Patient's name: _____ **Birthdate:** _____ **Sex:** _____

Parents' marital status: **Single Married Separated Divorced Remarried Partnered**

Parent/Legal Guardian: _____

Home address: _____ **Home phone:** _____

Phone: Work _____ **Cell** _____ **Email:** _____

Parent/Legal Guardian: _____

Home address: _____ **Home phone:** _____

Phone: Work _____ **Cell** _____ **Email:** _____

Primary care physician: _____ **Phone:** _____

Grade in school/name of school: ____/ _____

Who lives in the same household with your child? _____

Please state briefly the problem(s) you wish Dr. Hall to address and why you seek help at this particular time.

Problem #1 _____

Problem #2 _____

Problem #3 _____

Other Problems _____

Is anyone currently at risk of serious harm? Yes No Please describe:

Past diagnoses or mental health care:

Please write a brief history of each problem above, including when it started, how it developed, what was helpful and what was not, any medications tried, and why you seek help now.

(Use back of this sheet for additional writing space)

Developmental History

Pregnancy, birth, and infancy of this child was normal and healthy
difficult (please describe):

Toddler years: walked by 14 months clear words by 18 months simple sentences by 2 years
Comment _____

Preschool years: socializes well learns letters & sounds counts to 100 behavior problems
Comment _____

Elementary school years: makes friends easily well-focused in school good physical skills for age
behavior problems school problems
Comment _____

Middle school years: makes friends easily well-focused in school good physical skills for age
behavior problems school problems
Comment _____

High school years: makes friends easily well-focused in school good physical skills for age
behavior problems school problems
Comment _____

Academic strengths: _____

Academic difficulties: _____

Medical history

Medicines your child takes (include when started, doses, time of day taken):

name _____	start date _____	dose _____	times of day _____
name _____	start date _____	dose _____	times of day _____
name _____	start date _____	dose _____	times of day _____
name _____	start date _____	dose _____	times of day _____
name _____	start date _____	dose _____	times of day _____

Other medicines your child used to take (list them): _____

Allergies to medicine (list all of them)	NONE: [__]
name of medicine: _____	reaction: _____
name of medicine: _____	reaction: _____
name of medicine: _____	reaction: _____
Allergies to food: _____	

Hospitalizations: _____

Surgeries/broken bones: _____

Head injuries: _____

Drug or alcohol use (what, when, how long): _____

Family psychiatric history (mental or emotional problems that run in the family, ie, siblings, parents, aunts, uncles, cousins, grandparents):

Family medical history (medical problems that run in the family, ie, siblings, parents, aunts, uncles, cousins, grandparents):

Related concerns. Does your child:

snore or make odd breathing sounds while asleep? Yes No

seem to stop breathing while asleep? Yes No

feel unduly tired or sleepy during the day? Yes No

become excessively anxious? Yes No

become excessively moody, irritable, explosive or depressed? Yes No

have unusual difficulty making and/or keeping friends? Yes No

have compulsive rituals or complain of obsessive thoughts? Yes No

have a problem with alcohol or drugs? Yes No

have a history of legal difficulties or school expulsions? Yes No

have unusual difficulties with a particular subject in school? Yes No

have unusual difficulties with focus, concentration, or boredom? Yes No

give up easily when faced with schoolwork, sports, or other tasks? Yes No

have a history of emotional, physical, or sexual assault? Yes No

have a history of severe emotional loss? Yes No

have a relative who has killed himself or herself? Yes No

have firearms in the home? Yes No If Yes, are they kept loaded? Yes No Locked? Yes No

Please list prior mental health providers below:

Provider's name: _____ Phone: _____ Fax: _____
Approximate dates of service: _____

Provider's name: _____ Phone: _____ Fax: _____
Approximate dates of service: _____

Provider's name: _____ Phone: _____ Fax: _____
Approximate dates of service: _____

Comments/other information:

Your Treatment Goals (what will be accomplished if treatment is successful):

1) _____

2) _____

3) _____

4) _____

Person filling out this form: _____

Relation to patient: _____

Date: _____

Thank you.