Anastasia Banicki-Hoffman, MD
Integrative Child & Adolescent Psychiatry, PLLC
1343 Rochester Road, Suite 104
Troy, MI 48083
PH 248 918-4911
FAX 579-0076

PATIENT INFORMATION

NAME_____

HOME ADDRESS_____

CITY_____STATE_____ZIP CODE_____

HOME (_____)_____CELL (_____)_____

DATE OF BIRTH_____/_____/_____ AGE_____GENDER_____

EMAIL ADDRESS_____

SOCIAL HISTORY

FATHER'S
NAME_____OCCUPATION_____

MOTHER'S
NAME_____OCCUPATION_____

Is your child adopted? _____
If yes, at what age?_____
If yes, does he/she know of the adoption?_____

Please list all persons living in the home with your child

Name	Age	Relationship to child

If parents are separated or divorced:
How long have they been separated/divorced?_____
Who has legal custody?_____
Who has physical custody?_____

If the child/adolescent does NOT live with biological or adoptive parent(s), are you
_____A legal guardian who is not a biological relative
_____A legal guardian who is a biological relative: Relationship_____

INFORMED CONSENT FOR ASSESSMENT & TREATMENT

NAME_____ DATE OF BIRTH_____

I understand that as a patient of Integrative Child & Adolescent Psychiatry, I may receive a range of mental health services. The type and extent of services that I choose to receive will be determined following an initial assessment. The goal of the assessment process is to determine the best treatment options for me.

I understand that after an initial assessment process it may be determined that Integrative Child & Adolescent Psychiatry is not the appropriate treatment center for me, and if so this will be communicated to me and my parent/guardian directly.

I understand that all information shared with Dr. Banicki-Hoffman at Integrative Child & Adolescent Psychiatry is confidential and no information will be released without my consent. During the course of my treatment at Integrative Child & Adolescent Psychiatry it may be necessary for Dr. Banicki-Hoffman to communicate with other physicians. In this case, consent to release information would be given through written communication. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and Integrative Child & Adolescent Psychiatry are bound by law to comply with such requests.

I understand that while medication may provide significant benefits, it may also pose risks. Medications or supplements may have unwanted side effects.

If I have any questions regarding this consent form or about the treatment services offered at Integrative Child & Adolescent Psychiatry, I may discuss them with Dr. Banicki-Hoffman. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Integrative Child & Adolescent Psychiatry. I understand that either Integrative Child & Adolescent Psychiatry or I may discontinue treatment at any time.

_____ _____

PARENT OR GUARDIAN SIGNATURE DATE

1343 Rochester Road, Suite 104 ~ Troy, Michigan 48083 ~ PH 248 918-4911 ~ FAX 248 579-0076

FINANCIAL POLICY

Thank you for choosing Integrative Child & Adolescent Psychiatry.for your mental health needs. Please read our financial policy and sign below, prior to your initial appointment.

A. Payment for services is due at the time of your appointment. We accept cash, checks, VISA, Mastercard or Discover.
B. Please NOTE that Integrative Child & Adolescent Psychiatry DOES NOT ACCEPT ANY INSURANCE PLANS. We are out-of-network providers for all insurance plans and as such, will not bill your insurance company for payment of services. As a courtesy to you, we will provide you with the necessary paperwork for you to file for reimbursement from your insurance company.
C. Please be aware that some, and perhaps all, of the services provided may be "non-covered" services and not considered reasonable and necessary under your insurance plan. You are responsible for payment in full, regardless of your insurance company's final determination of coverage.

CANCELLATION POLICY

We understand that there may be times that you need to cancel or reschedule your appointment. If you are unable to keep your appointment, please notify the office at 248 918-4911 as soon as possible.

A "cancelled appointment" is defined as any cancellation within 2 business days of your scheduled appointment. A "No show" is defined as an appointment where there was no attendance and no notice or call was made.

Appointments cancelled with less than 2 business days notice and no show appointments will result in a full fee charge. Your $50 nonrefundable deposit can be applied to a different appointment time if the change is made at least 2 business days prior to your appointment date.

I understand Integrative Child & Adolescent Psychiatry's financial & cancellation policies and understand my responsibility in planning my appointments accordingly. I will notify the office at 248 918-4911 if I have difficulty with my appointments.

_____ _____

PARENT OR GUARDIAN SIGNATURE DATE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Integrative Child & Adolescent Psychiatry, PLLC
1343 Rochester Road, Suite 104
Troy, MI 48083
PH 248 918-4911
FAX 248 579-0076

To use or disclose the following protected health information from the medical record of the patient below:

Patient Name_____DOB_____

Address_____

_____

Phone_____

_____I hereby give permission for _____to release information as checked below concerning the above patient to the office of Integrative Child & Adolescent Psychiatry, PLLC.

_____I hereby give permission to the office of Integrative Child & Adolescent Psychiatry, PLLC to release the information as checked below concerning the patient to:

_____ _____
Name Address

_____ _____
Agency City, State, Zip Code

_____ _____
Phone FAX

The information to be released includes:

_____Medical History _____Social History
_____Diagnosis _____Discharge Summary
_____Progress Notes _____Initial Assessment
_____Lab results _____Other

I understand that I may request a copy. This consent is subject to revocation by me in writing at any time, but revocation has no effect on action previously taken.

I expressly understand and agree that no liability of any nature shall attach to the physician, clinician or employee in acting upon this authorization and request.

I further understand that this information cannot be re-disclosed without my authorization.

_____ _____
Signature Print

_____
Date

Current Medical Providers

Primary Care Physician

Name _____

Address_____

_____

Phone _____

Psychiatrist (if no current then list previous psychiatrist)

Name _____

Address_____

_____

Phone _____

Therapist

Name _____

Address_____

_____

Phone _____

Nutritionist

Name _____

Address_____

_____

Phone _____

Other

Name _____

Address_____

_____

Phone _____

CURRENT MEDICATION LIST

Please bring ALL of your current medications with you for your initial appointment.

NAME_____

DOB_____

_____Check here if you currently do NOT take any medications.

MEDICATION	DOSE	FREQUENCY	REASON	POSITIVE/NEGATIVE EFFECTS

MEDICATION ALLERGIES

_____NO known medication allergies

MEDICATION ALLERGIES	FOOD ALLERGIES

PAST MEDICATIONS

Please recall any psychiatric medications that you have taken in the past and their positive/negative effects.

_____Check here if you have NEVER taken any psychiatric medications.

Medication Name	Dose	How did you take it? (ie by mouth)	Frequency	Positive/Negative Effects

CURRENT SUPPLEMENT LIST

Please bring ALL of your current supplements (in original bottles) with you for your initial appointment.

NAME_____

DOB_____

_____Check here if you currently do NOT take any supplements.

SUPPLEMENT	DOSE (how much)	HOW IT IS TAKEN?(ie by mouth)	FREQUENCY (how often)	POSITIVE/NEGATIVE EFFECTS

PAST SUPPLEMENTS

Please recall any medications that you have taken in the past and their positive/negative effects.

_____Check here if you have NEVER taken any supplements.

Supplement Name	Dose (how much)	Frequency	Reason	Positive/Negative Effects

CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Describe your child to me and your current concerns. Be as detailed as possible.

When did you notice your child's problem? Describe any triggers or potential causes.

Was there any event or illness that you or others think brought on your child's symptoms?

Goal(s) of Consultation

1.
2.
3.
4.

MEDICAL HISTORY

Current Medical Problems

_____

_____

_____

Past Medical Problems (Any history of seizures, head injury, loss of consciousness, ear infections, thrush, kidney, liver, lung, heart, thyroid problems, etc…)

_____

_____

_____

Past surgical history

_____

_____

STRESSORS – Describe which apply to your child.

Social (Family, Peer, Financial, Recent Loss, Other)	
Trauma/Abuse (Physical, Sexual, or Verbal Abuse, or Witnessed Trauma)	
Child Protective Services (Involved in the past, case closed or current case open)	
Legal (Past charges, Current charges, On Probation)	

SLEEP BEHAVIOR (circle one)

Any problems falling asleep? YES NO

Any problems staying asleep? YES NO

Any problems waking up? YES NO

On average, how many hours of sleep does your child sleep per night?_____

Any history of SLEEPWALKING SLEEP TALKING NIGHTMARES NIGHT TERRORS

SLEEP APNEA TEETH GRINDING HEAVY SNORING

ALCOHOL AND DRUG HISTORY

DRUG	KNOWN AGE OF FIRST USE	DATE OF LAST USE
Alcohol (hard liquor, beer, wine)		
Nicotine (cigarettes, tobacco chew)		
Marijuana		
Inhalants (glue, gasoline, etc…)		
Cocaine or crack		
Amphetamines		
Steroids		
Opiates (heroin, oxycodone, etc…)		
Barbiturates		
Hallucinogens (LSD, mushrooms, ecstasy)		
K2 or spice		
Prescription drugs (Xanax, Adderall)		
Other		

Check those items that apply to substance involvement.

_____ Witnessed intoxication/high

_____Found alcohol (ie. Empty or partially empty bottles, alcohol missing from home)

_____Found drugs in or outside of the home or in his/her possession

_____Legal consequences as a result of use

_____History of past counseling or substance abuse treatment

CHILD DEVELOPMENTAL HISTORY

PRENATAL HISTORY

Maternal age at delivery?_____ # of pregnancies/births prior_____ After this child_____

Medications during pregnancy?_____

Heavy Metal Exposure during pregnancy (increased tuna/swordfish consumption; dental work; root canal, amalgams, fluvax, Rhogam injection

Any complications during pregnancy?

BLEEDING EXCESSIVE VOMITING OR DIARRHEA INFECTIONS XRAYS SMOKING

ALCOHOL/DRUG USE

OTHER

BIRTH AND POSTNATAL PERIOD

Birth weight_____

Full term/premature?_____How many weeks?_____

Delivery VAGINAL C-SECTION If C section, WHY?_____

Problems/complications?_____

_____

_____

List the age when the following skills/milestones were mastered and any problems associated with these skills:

Language Development

First words_____

Naming several objects: ball, car, etc…_____

Phrases or sentences_____

Any problems compared with peers' vocabulary, articulation, and comprehension?_____

_____

Motor Development

Sitting up unsupported _____

Crawling_____

Walking_____

Social Development

Smile_____

Shy with strangers_____

Separate from parent easily_____

How does your child interact with other children?_____

_____

Emotional Development

Early temperament

_____

_____

Current personality

_____

_____

Fears/phobias

_____

_____

Habits

_____

_____

Mood

_____

_____

Has your child in the present or past:

	Yes	No
Talked about suicide		
Attempted suicide		
Purposefully cut, burned or used other forms of self harm		
Is there access to a firearm in the child's home?		

Academic/school history

School_____

Current grade_____

Academic Achievement (circle one): Above Average Average Below Average Failing

Describe any that apply:

Repeated a grade	Grade:
Assessed for Special Education Services	In:
Special Education services in past or present	When:
Current IEP (Individualized Education Plan)	For:
Current 504 Plan	For:
Repeated detentions or suspensions	For:
Learning disability	In:
Attentive Problems	
Hyperactive	
Peer Problems or bullying	

Comments teachers have made?

SIGNS & SYMPTOMS CHECKLIST

Please indicate if your child/teen has or had any of the symptoms/problems listed.

Symptom/problem	Describe behavior and age
Stimming (repetitive actions)	
Rocking	
Head banging	
Self mutilation	
Nail biting	
Hand/arm biting	
Nail/skin picking	
Aggressiveness (hiting, kicking, biting others)	
Mood swings	
Irritability	
Tantrums	
Fears/anxiety	
Hyperactivity	
Inability to concentrate/focus	
Fidgety in seat	
Impulsive	
Seizures	
Poor coordination	
Problems with buttons, ties, snaps, zippers, shoe laces	
Problems with social interactions	
Sensitive to crowds	
Trouble remembering	
Low self esteem	
Fatigue	
Cold hands/feet or cold intolerance	
Recurrent illness/fevers	
Flushing	
Excessive sweating	
Difficulty falling asleep	
Night waking	
Difficulty waking	
Bed wetting/soiling	
Daytime wetting/soiling	
Numbness/tingling in hands/feet	
Headaches	
Dark circles/puffiness under eyes	
Congestion	
Earaches	
Sensitive to sounds/noise	
Bad breath (halitosis)	
Sensitive to smells/odors	
Sore throats	
Wheezing	
Canker sores	
Dry lips/mouth	
Diarrhea	

Constipation	
Foul-smelling stools	
Bloating	
Foul smelling gas	
stomachache	
Sensitivity to texture of food	
Picky eater	
Food cravings	
Grinding teeth	
Mucous/blood in stools	
Anal itching	
Muscle cramps or muscle twitching	
tremors	
eczema	
psoriasis	
acne	
Seborrhea (cradle cap)	
Sensitive to texture of clothes	
Tics	
Soft nails	
Ridges/pitting of nails	
White lines on nails	
Bumps behind arms/rough skin	

DIETARY/NUTRITIONAL HISTORY

Breast fed? If yes, how long?_____months

Bottle fed? Began at what age?_____ How long?_____

Solid foods….. Began at what age?_____

Known allergies to foods? (please list)

Suspected sensitivities to foods? (please list)

Food cravings? (foods your child could not go without)

Has your child ever been on a gluten-free diet? _____
If yes, please list the results:

Has your child ever been on a casein-free diet? _____
If yes, please list the results:

Any concerns about weight loss or weight gain?
If yes, please describe:

FOODS MY CHILD EATS

FOOD	Daily	3-5 times per week	1-3 times per week	Never or almost never
Cookies				
Candy				
Sweet foods				
Caffeine (soda pop, tea, coffee, etc…)				
Chocolate				
Milk				
Cheese				
Ice cream				
Meat				
Pasta				
Bread				

Which of the following best describes your child's diet?

_____Mostly baby food.

_____Mostly carbohydrates (bread, pasta, etc…)

_____Mostly dairy (milk, cheese, etc…)

_____Mostly fast food.

_____Mostly meat.

_____Mostly vegetarian.

_____Other – Describe:

Please describe your child's stool pattern (daily, every other day, once weekly, foul, large, mushy, smelly, etc…)

3 DAY DIET DIARY – Please list the foods and beverages normally consumed by your child for three typical days.

DAY 1

Breakfast
Morning snack
Lunch
Afternoon snacks
Dinner
Other (Desserts, etc…)

DAY 2

Breakfast
Morning snack
Lunch
Afternoon snacks
Dinner
Other (Desserts, etc…)

DAY 3

Breakfast
Morning snack
Lunch
Afternoon snacks
Dinner
Other (Desserts, etc…)

PSYCHIATRIC/MEDICAL SYMPTOM CHECKLIST

Please indicate if your child or any of your biological family members (including grandparents, aunts, uncles, and cousins) have had any of the symptoms/illnesses listed.

Symptom/problem	Child/Teen	Biological Mother	Biological Father	Brother	Sister	Other relative
Anxiety						
Panic attacks						
Depression						
Postpartum Depression						
Bipolar disorder						
Irritability						
Temper/anger/rage problems						
Self injurious behavior						
Suicide attempt						
Suicide						
Psychiatric Hospitalization						
Hallucinations						
Schizophrenia						
Psychosis						
ADD/ADHD						
Learning difficulties						
Juvenile Delinquency						
Defiant/oppositional behavior						
Fire setting						
Cruelty to animals						
Legal problems						
Obsessions or Compulsions						
Anorexia or Bulimia						
Alcohol Abuse						
Other illicit drug or substance abuse						
Tics or Tourette's syndrome						
Mental retardation						
Autism						
Asperger's Disorder						
Pervasive Developmental Disorder						
Sensory issues to light, sound, touch, odors						
History of abuse (physical, sexual or verbal) – please specify						