NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

REGISTRATION

Patient ____
Last Name **First Name** **Middle Initial**

Street Address ____

City ______________________________ **State** ________ **Zip** ________-______

Phone Numbers: Home- ________________**Work:** ________________**Cell:** ______________

Gender: □ **M** □ **F** **Age:** ______**Birth Date** ______________**E-mail:** ____________________

Race: □ **White** □ **Black** □ **Asian** □ **Other** ____________ **Ethnicity** __________ **Preferred Language** __________

Emergency contact ____________________ **Phone #** ________________ **Relationship** ________

If patient is a minor or has a legal representative or guardian, please fill out the information below.
(Guardian/Legal Representative is required to attach supporting legal documentation)

Responsible Party ____

Street Address (if different from patient) ____

City ______________________________ **State** ________ **Zip** ________-______

Date of Birth ______________ **Phone Number** ____________ **E-mail** ____________________

Insurance Information

1. Primary Insurance ____

Policyholder Name ____________________ **Relationship to Patient** ________________

Date of Birth ______________ **Policy #** ____________________ **Group #** __________

2. Secondary Insurance ____

Policyholder Name ____________________ **Relationship to Patient** ________________

Date of Birth ______________ **Policy #** ____________________ **Group #** __________

√ **Can we leave a text or message at the phone number provided with family member/s or on the voicemail for appointment reminders or other information? – Yes** □ **No** □

Name:____________________ **Signature** ________________ **Date:**______________

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ASSIGNMENT/RELEASE/CONSENT TO TREATMENT

Patient Name ______________________________ **Date of Birth** ____/____/______

(All patients/guardians sign below)

I authorize and request treatment/s from **RAVI KANT, M.D**. and/or his associates to perform routine diagnostic procedures and to provide medical treatment as is medically necessary in his/their professional judgment.

I hereby authorize release of protected health information, including mental health and/or substance abuse (drug and alcohol), necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to **RAVI KANT, M.D. PC** as indicated on the insurance claim form. I understand that this facility and its providers are mandated reporters of any and all suspected or witnessed child abuse and/or neglect. (Section 6383 (b) of Title 23 of the Pennsylvania Consolidated Statutes/Act of July 1, 2015, P.L. 94, No. 15). I also understand that I am financially responsible for any balance not covered by my insurance carrier(s) (including but not limited to deductibles and/or co-payments) and agree to pay the full charges if payment is/are denied by my insurance carrier(s) for any reason or if no insurance coverage exists at the time of services. It is my responsibility to update any changes in insurance. I understand it is mandatory to notify the health care provider of any other party who may be responsible for payments (section 1128 B, Social Security Act and 31 U.S.C. 3801- 3812 provides penalties for withholding this information). Medicare regulations apply. I have received, read and agree with the billing and other office policies.

With my consent, Ravi Kant, M.D., his associates, and office staff can call my home and leave messages on an answering machine or with a person, text, or e-mail me regarding appointments and contact the designated emergency contact person if needed. I may revoke my consent in writing except to the extent that the practice has already acted upon in reliance upon my prior consent. If I do not sign this consent, Ravi Kant, M.D. and his associates may decline to provide services to me. I agree with the above.

All the information provided in this Registration-Assignment/Release/Consent to Treatment is true and current.

Notice of Health Information Practices - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the above Notice of Health Information Practices. I recognize that this is a federal mandate that this facility must comply with. Patient Initials _____

Notice of Patient Rights and Responsibilities - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the Patient Rights and Responsibilities provided at the office. Patient Initials _____

Notice of Grievance Procedure – Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the Grievance Procedure provided at the office. Patient Initials _____

Patient Signature ______________________________ Date ____________
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name ______________________________

Responsible Party Signature ______________________________ Date ____________
(Parent/Guardian/Legal Representative)

Print Name ______________________________

Relationship to Patient ______________________________
(Guardian/Legal Representative is required to attach supporting legal documentation)

Office use only
Witness ____________________ Name ____________________ Date ____________

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OFFICE POLICIES

Patient Name ____ **Date of Birth** _____/_____/_______

Insurance Coverage:

Due to frequent changes in insurance coverage (benefits, exclusions, deductibles and/or prescription coverage, etc.), we cannot inform or advise you about your benefits. In some insurance policies, certain diagnoses may be excluded, such as ADHD, Autism, Mental Retardation and related conditions. We do not routinely do the paperwork for non-formulary medicines not covered by your insurance company. You are responsible for keeping track of number of visits allowed in your plan and how many visits you have used with your therapist and prescriber. You will be charged for additional visits. If you do not have insurance coverage, you are responsible for the full charges. Please inquire in advance about our charges if you do not have insurance.

Payments:

It is our policy to collect all **co-payments and/or deductibles** at the time of service unless arrangements are made ahead of time. **We accept checks, cash, and debit or credit cards (Visa, MasterCard American Express or Discover).**

A service charge of **$10.00** plus interest (1.5%/month) will be added to any outstanding balance over 30 days past due. Also, all delinquent accounts (over 90 days past due) may be turned over to a collection agency. An additional **$40.00** as a handling fee and the costs of collection (including attorneys' fees and costs) will be added to the total amount due.

Attendance Policy:

We understand that it is not always possible to keep a scheduled appointment or give 24 hours notice of cancellation. If a pattern of same day cancellation or "No Shows" develop, we reserve the right to bill you **$50.00** fee for the missed appointment time. Your insurance company is not responsible for this charge. Prescriptions may not be called in for No Show or Canceled appointments. Additionally, if there are frequent No Show for appointments or non-compliance with treatments, you may be discharged from the practice.

Lost Prescription Fee:

A service fee of **$20.00** will be charged to replace lost scripts. Scripts will need to be picked up from the office after payment of the fee.

Returned checks – Fee of **$40.00** will be charged for checks returned for any reason.

****Fees may be changed without notice.**

I have read and agree to be legally bound by the terms of these office policies including the financial responsibility provisions hereof. I understand that I am financially responsible for any amounts not covered or paid by my insurance carrier and that I am responsible for providing current insurance information and inform the office of any address and/or insurance changes.

Patient Signature ____ Date ______________
(If patient is a minor (ages 14-18), he/she must sign this Office Policy Form)

Print Name ____

Responsible Party Signature ____________________________________Date ______________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative is required to attach supporting legal documentation)

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Witness _______________________ Name _______________________Date ______________

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ________________________________ date of birth __________, do hereby consent to and authorize to
Patient's Name (Print)
disclose health information about me and that can be identified with me from my records relating to my identity, diagnoses, prognosis, and/or treatment, which records may include information related to medical conditions, tests, mental or behavioral health, and substance abuse (drug and alcohol), and HIV-related. These records are called protected health information and are protected by federal and/or state law.

From ______________________________ **Ravi Kant, MD, P.C.** ______________________________
(Name and address of provider or facility releasing records)

To ____
(Name and address of provider, facility, or family member where records are being released to)

I authorize the entities named above to share the health related information related to my care. Initial ________

The purpose or need for this disclosure is ☐ Coordination of Care ☐ Disability Application or
☐ Other ____

I understand that the specific types of records to be released (identify all records or all that apply) are:

☐ All records including Psychiatric/psychological evaluation ☐ Laboratory reports & tests
☐ Physician notes only ☐ Acupuncture ☐ Other (specify) ________________
☐ Insurance claims and payments only (including Medicare and Medicaid)

****Mental or behavioral health, substance abuse, and HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.****

DO NOT RELEASE: ☐ Mental/Behavioral Health (Psychiatric) ☐ HIV-Related ☐ Substance Abuse (Drug and Alcohol)

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon and that this consent will remain in force unless revocation from the patient or legal guardian is received. I also understand that any revocation of this authorization must be in writing and sent or delivered to health care provider's office. I also understand that my decision to revoke this authorization may result in my insurance company not being able to pay for my medical care and I will be liable for payment for the services rendered.

Patient Signature ______________________________________ **Date** ____________________
(If patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information Form)

Print Name ____

Responsible Party Signature ______________________________ **Date** ____________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only
Witness __________________________ Name ____________________ Date ____________________

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CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

Patient Name: ____ Date of Birth: ______/_____/_______

Parent/Legal Guardian Name: _______________________________________ Relationship__________________

By signing below, I permit NeuroPsychiatry Center to communicate protected health information for the above patient via e-mail at______________________________________@____________________.__________

E-MAIL RISKS AND YOUR RESPONSIBILITY:

You and your provider/s at NeuroPsychiatry Center (NPC) and its employees and staff have agreed to correspond using e-mail. These e-mails may contain personal protected health information including, mental health issues. You need to be aware of the risks and your responsibilities.

A.) As the internet is not secure or private, unauthorized people may be able to intercept, read, and possibly modify e-mail/s you send or receive from NPC. You must protect your e-mail account and password against unauthorized use. Hackers can get access to your account.
B.) Viruses can be spread via e-mail and some may cause e-mail messages to be sent to unintended people.
C.) E-mails can be copied, printed, and forwarded by recipients; be careful with whom you send or share e-mails.

1. CONDITIONS FOR THE USE OF E-MAIL:

By consenting to the use of e-mail with NPC you agree that:

A.) NPC may forward e-mails, as appropriate, for diagnosis, treatment, billing, and other related reasons. Employees and medical staff other than the intended recipient may have access to your e-mails.
B.) Although NPC will try to read and respond to your e-mail, we may not read your e-mail immediately. If you do not receive a response within a reasonable time, it is your responsibility to contact us to follow up.
C.) You should carefully consider the use of e-mail for the communicating sensitive medical and personal information.
D.) E-mail messages should be **short, clear, and concise**.
E.) NPC reserves the right to save your e-mail including the information contained there in the medical records.
F.) You agree not to abuse the right to communicate with your physician's office and your communications will be professional in content.
G.) E-mail access to staff is being provided as a convenience to our patients and NPC has the right to restrict your ability to communicate with us via e-mail at any time for any reason, including cases where NPC reasonably believes that it is not in your best interest to continue to seek advice via e-mail and an in person appointment is needed or that e-mail is being used excessively in lieu of in person care.

2. INSTRUCTIONS:

A.) You should immediately inform the staff at NPC of any changes in your e-mail address.
B.) **E-mail should be used only for non-sensitive and non-urgent issues such as prescriptions, scheduling, general questions or advice. E-mail is not a substitute for psychotherapy or medication management appointments.**
C.) Please put the patients name and date of birth in the body of the e-mail for proper identification.
D.) If you wish to withdraw your consent to communicate via e-mail, you must inform NPC in writing.

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CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

ACKNOWLEDGEMENT AND AGREEMENT

NeuroPsychiatry Center will use reasonable means to protect the privacy of the patient's health information. However because of the risks outlined above, NPC cannot guarantee e-mails will be confidential. Also NPC will not be liable in an event that you or anyone else inappropriately uses or accesses your e-mail. NPC will not be liable for improper disclosure of your health information that is not caused by our intentional misconduct.

NPC is not responsible for e-mail messages that are lost due to technical failure during composition, transmission and/or storage. NPC may impose restrictions to communicate with me by e-mail. I have read and understand the information above, and had any questions answered to my satisfaction. I have received the copy of this consent form. I agree to the guidelines for e-mail communication. I understand that this consent is valid until such time as I revoke the consent outlined above, except to the extent that a staff has already acted in reliance upon this authorization.

Patient Signature ______________________________ **Date** ________________
(If patient is a minor (ages 14-18) he/she must sign this Release of Protected Health Information via Electronic Communication Form)

Print Name ______________________________

Responsible Party Signature ______________________________ **Date** ________________
(Parent/Guardian/Legal Representative)

Print Name ______________________________

Relationship to Patient ______________________________
(Guardian/Legal Representative may be required to attach supporting legal documentation)

DO NOT SEND E-MAIL FOR EMERGENCIES

GO TO THE NEAREST HOSPITAL, CALL 911, OR CONTACT YOUR COUNTY'S EMERGENCY CRISIS NUMBER

We will not read e-mails on weekends, holidays, or when on vacation.

Office Use Only

Witness ____________________ Name ________________ Date ________________

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PRESCRIPTION REFILL POLICIES AND PROCEDURES

Patient Name: ____ **Date of Birth:** __________________

Parent/Legal Guardian Name: ________________________________ **Relationship**____________________

In order to make the prescribing medication and requesting temporary refills process efficient, we will follow the procedures listed below. Patients or a parent/legal guardian should initial and sign below.

● Check which medications need refilled before coming to your appointment. It is **YOUR** responsibility to get your medications refilled during your visit. Schedule your next visit at least **1 week prior** to running out of your current refill(s).

● If you require a medication refill in-between scheduled appointments, it is **YOUR** responsibility to request it from our website - www.drkant.com and fill in the "Medication Refill Request" online. Refill requests are **NOT** accepted via phone. We need at least **72** hours notice (excluding weekends or holidays) to respond to your request. Please note that we do **NOT** accept medication refill requests from pharmacies.

I understand the above: X_________________

● Regular office visits are required for monitoring and prescribing medications as determined by your provider. Medications will not be called in without required office visits.

I understand the above: X_________________

● Blood work is needed for some medications to assess the safety and effectiveness. For patients who do not get the blood work done in a timely fashion, we will refuse to fill their prescriptions.

I understand the above: X_________________

● If prescribed a controlled substance as identified by the DEA, per office policy, patients must be seen at least every 4-8 weeks, at the discretion of the provider. Refills for controlled substances will only be provided during appointments. Random urine screens may be requested to assess the use of narcotics or abuse of illicit drugs.

I understand the above: X_________________

I have read the **Prescription Refills Policies and Procedures** and by initialing above and signing below, I agree to abide by them in full and have been given a copy if requested.

Patient Signature ____ **Date** _______________________
(If patient is a minor (ages 14-18) he/she must sign this Prescription Refill Policies and Procedures Form)

Print Name ____

Responsible Party Signature _______________________________________ **Date** _______________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only

Witness _____________________________ Name _______________________ Date _________________________

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E-PRESCRIBING MEDICATION HISTORY CONSENT

Patient Name ____ **Date of Birth** _____/_____/_______

I understand that NeuroPsychiatry Center utilizes e-prescribing. I understand that e-prescribing allows the practice to send prescriptions electronically to pharmacies, eliminating the need for prescribing via paper, phone, or fax.
E-Prescribing is fast, convenient, legible, secure, cost-effective and safe. In some cases, it also allows the health care provider to access critically important information about patient's current and past medications from pharmacy benefit managers and community pharmacies. This helps to alert the provider to other potential medication interactions or if patient is getting same or similar medications from multiple providers.

I have been given an opportunity to ask questions about the e-prescribing process and have had those questions answered to my satisfaction. I hereby consent to the practice requesting and using my medication history from other health care providers, pharmacies, or third party pharmacy benefit payers for treatment purposes.

Patient Signature ____ **Date** _______________________
(If patient is a minor (ages 14-18) he/she must sign this Authorization for E-Prescribing Medication History Consent Form)

Print Name ____

Responsible Party Signature ____ **Date** _______________________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only

Witness _____________________________ Name ______________________ Date ________________________

Ravi Kant, MD, P.C. NeuroPsychiatry Center

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Name ____ DOB ______/______/______ Date_________

PERSONAL CRISIS PLAN

My Triggers: ____

____

Thoughts/Inside Warnings: ____

____

Outside Warning Signs: ____

____

When Notice My Triggers I will: ____

____

When Others Notice I'm Upset I'd like them to: ____

____

Things That Help Me Stay Better Now: ____

____

Things That Help Me Stay Well on a Regular Basis: ____

____

Things That Make Me Feel Worse: ____

____

*If I'm feeling unsafe, I will go to the ER of local hospital, call Suicide Hotline 1-800-273-8255, or call my county's crisis number.

Patient Signature ____ Date ______________
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name ____

Responsible Party Signature ________________________________ Date ______________
(Parent/Guardian/Legal Representative)

Print Name ____

Relationship to Patient ________________________________

(Guardian/Legal Representative is required to attach supporting legal documentation)

Office use only

Witness ___________________________Name ____________________________ Date _________________

Ravi Kant, MD, P.C. NeuroPsychiatry Center

300 Old Pond Rd., Suite 201, Bridgeville, PA 15017 Tel. 412-220-7323

Name ______________________________ DOB ____/____/____ Age________

Parents/Legal Guardians ____

**** If minor is not living with both parents or minor has a legal guardian, a legal custody agreement MUST be provided in order for the minor to be seen. ****

*****If patient is under the age of 14 years, please have ALL parents/legal guardian(s) sign consent for treatment documentation as well as release of information*****

You will be responsible for full payment if your insurance company denies payment for any reasons

Co-Payments are due at each visit. Bring all relevant medical records with you. (No X-Ray)

Current healthcare providers	Address	Phone	Fax
General Practitioner:			
Therapist/Psychologist:			
Other Health Care Provider:			

Who can we thank for recommending our practice? ________________________________

Current Pharmacy: Name ______________ City __________ Zip ________ Phone __________

Allergies: Y N If yes what?______________________________________

Reaction(s) ____

Height - ________________ **Weight** - ________________

Chief Complaints (Please circle)

Depression	Y	N	Psychosis	Y	N
Anxiety	Y	N	Attention/Concentration	Y	N
Panic Attacks	Y	N	Eating Disorder	Y	N
Hypomanic/Manic Episodes	Y	N	Drugs/Alcohol	Y	N
Anger	Y	N	Headaches	Y	N

Other: ____

Current stressors (Please circle)

School	Y	N	Social	Y	N	Family	Y	N
Medical	Y	N	Pain/Disability	Y	N	Work/Job	Y	N

Other: ____

Describe in your own words your current symptoms:

____

____

____

History

When did your symptoms start? ____Years or ____ Months ago   Have you had similar symptoms in the past? Y N

What, if any, triggered the symptoms? ______________________________

____

What has been helpful to control the symptoms? ______________________________

____

Mood Symptoms:

Circle the appropriate answer, then rate IF YES: ***(Rate symptoms on scale of 0 to 10; 0 good, 10 worse)***

Symptom	Y	N	Rating
Depression	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Mania/Hypomania	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Anger/Irritability	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Depression:

Symptom	Y	N				
Irritability	Y	N				
Tearfulness	Y	N				
Loss of Interests/ Motivation	Y	N				
Decreased Appetite	Y	N	Weight loss	Y	N	How much ______
Increased Appetite	Y	N	Weight gain	Y	N	How much ______
Difficulty falling or staying asleep	Y	N	Total Hours of Sleep per day			______hrs.
Fatigue	Y	N				
Negative Thoughts	Y	N	Self-Injury	Y	N	
Low Self Esteem	Y	N	Suicidal Thoughts	Y	N	
Social isolation	Y	N	Thoughts of Death/Dying	Y	N	
Feeling Worthless	Y	N				
Feeling Hopeless/Helpless	Y	N	Access to firearms	Y	N	
Homicidal Thoughts	Y	N	If yes, is firearm in secure location?	Y	N	

Would you reach out to someone if you feel strongly suicidal? Y N Who? ______________________

(You can call ER of local hospital / Suicide Hotline 1-800-273-8255 / Resolve Crisis Hotline 1-888-796-8226)

Hypomania/Mania:

Has there ever been a period of time when you were not your usual self and:

Question	Y	N
You were much more talkative?	Y	N
You had much more energy?	Y	N
You were more social or outgoing than usual?	Y	N
You did things that were unusual or that other people might have thought were excessive, foolish or risky?	Y	N
You spent excessive amounts of money or got your family into trouble?	Y	N

Give details of above symptoms: ______________________________

____

____

____

Anxiety:

Excessive Worrying Y N How often? ______________________

If yes give examples ______________________

____

____

Do you find it difficult to control the worry?	Y N		Bothered by Crowds	Y N
Restlessness	Y N		Avoid Going Places	Y N
Fatigue	Y N		Social Isolation	Y N
Irritability	Y N		Muscle Tension	Y N
Difficulty falling or staying asleep	Y N			

Panic Attacks: Y N How often? ______________________

Duration? ______________________ Where? ______________________

Triggers? ______________________

Palpitations	Y N		Nausea	Y N
Chest pressure	Y N		Fear of Dying	Y N
Sweating/Chills	Y N		Dizziness	Y N
Shakiness	Y N		Numbness/Tingling	Y N
Out of Breath	Y N		Fear of Losing Control	Y N
Feelings of Choking	Y N		Fear of Being Trapped	Y N

Obsessions	Y N	Describe: ______________________
Repetitive Behaviors	Y N	Describe: ______________________
Fears	Y N	Describe: ______________________
Flashbacks	Y N	Describe: ______________________
Nightmares	Y N	Describe: ______________________
Delusions	Y N	Describe: ______________________
Paranoia	Y N	Describe: ______________________
Hallucinations	Y N	Describe: ______________________

Cognitive Symptoms

Long Term Memory ______ Intact---------------Impaired a Little---------------Impaired a Lot

Short Term Memory ______ Intact---------------Impaired a Little---------------Impaired a Lot

Symptom			Symptom		
Make Careless Mistakes	Y	N	Forgetful	Y	N
Difficulty Sustaining Attention	Y	N	Easily Confused	Y	N
Easily Distracted	Y	N	Word Finding Difficulties	Y	N
Fail to Finish Tasks	Y	N	Difficulties with Info. Processing	Y	N
Frequently Lose Things	Y	N	Restless/Fidgety	Y	N
Impulsive	Y	N	Intrusive and interrupting often	Y	N
Reading	Y	N	Math	Y	N
Issues with classroom behaviors	Y	N	Concerns from teachers	Y	N

Give details of the above symptoms: ______

Normal Hearing Y N   Normal Vision Y N

If no, please describe: ______

Physical Changes **(If Yes, Describe Symptoms and Identify Treatment)**

Change			Description
Neurological Changes	Y	N	
Changes in Thyroid	Y	N	
GI Symptoms	Y	N	
Gynecological	Y	N	
Sexual Dysfunction	Y	N	
Severe PMS	Y	N	
Neck Pain	Y	N	
Back Ache	Y	N	
Headache	Y	N	
Migraines	Y	N	

Other: ______

For girls

Item			Description
Menstrual changes	Y	N	
PMS symptoms	Y	N	
Other gynecological issues	Y	N	

Family Member Observations:

How is this person different now? Please describe.

______

Past Psychiatric History:

Out Patient Treatments (where and for what reason): ____________________

Inpatient Treatments (where and for what reason): ____________________

Therapists/Psychiatrist(s) seen: ____________________

Medications tried in the past: ____________________

History of suicide attempt(s)? ______ Y ___ N

If yes provide details: ____________________

Family History:

Medical problems ____ Y ____ N ____ If yes, who? ____________________

Diagnosis: ____________________

Emotional problems ____ Y ____ N ____ If yes, who? ____________________

Diagnosis: ____________________

Alcohol/Drug Abuse ____ Y ____ N ____ If yes, who? ____________________

Describe: ____________________

Medical History

Diabetes	Y	N	Asthma	Y	N	High Blood Pressure	Y	N
Heart Disease	Y	N	Multiple Sclerosis	Y	N	Fibromyalgia	Y	N
Seizures	Y	N	High Cholesterol	Y	N	Hypothyroidism	Y	N

Other ____________________

Surgeries Y N Please describe: ____________________

Hospitalizations Y N Please describe: ____________________

Have you ever suffered a stroke, head bleed, concussion or other type of head injury? Y N

If yes, please explain: ____________________

Test results (if any)

X-Rays	Y	N	Results:
CT / MRI	Y	N	Results:
Psychological Tests	Y	N	Results:
Blood Work	Y	N	Results:

Developmental History:

Issues during pregnancy Y N Use of drugs/Alcohol/Tobacco during pregnancy Y N

Normal Labor & delivery Y N

If no, please explain: ______

______

At what age did you/your child begin: Walking: ______ Talking ______ Toilet training ______

Developmental delays Y N

If yes, please describe ______

______

Any significant medical problems during early childhood including hospitalizations Y N

If yes, please describe ______

______

Are your/your child's immunizations up to date? Y N

Social History

Who are you currently living with? ______

Are your parents currently married? Y N

*****If no and the patient is under the age of 14, BOTH parents must complete the consent for treatment and release of information documents and a legal custody agreement must be provided*****

School name: ______ Grade: ______

Special Education Y N Repeated any grade Y N

Discipline problems Y N

If yes, please describe: ______

______

Involved in Sports Y N If yes, what sports do you play? ______

Attend Alternative School Program? Y N Name: ______ IEP or

Service Agreement Y N Reasons: ______

Any school testing done Y N Results: ______

If applicable: Are you currently working? Y N

Do you spend time with friends after school or on weekends? Y N

Do you enjoy being around friends Y N

Are you bullied at school, on the bus or on social media? Y N

If yes: please describe ______

______

Social History

Involved in community/social activities? Y N

Please Circle: Church/Temple Clubs Sports AA/NA Volunteer work Other:__________

Hobbies ____Last enjoyed ______________________________

Do you have a history of past physical/psychological/sexual abuse, neglect, trauma, domestic violence, or have you witnessed domestic violence? Y N

If yes, please describe: ____

If yes, have you had treatment for the trauma? Y N

If you have not received treatment, would you like to address the trauma during treatment? Y N

Caffeinated Drinks Y N _______cups per day

Current Tobacco Use Y N If yes, do you want to quit? Y N

Type of Usage: ____

Amount Per Day: How Often? How Long?

Have you ever received treatment? Y N Do you want treatment? Y N

Former Tobacco Use Y N

When Did You Start? When Did You Quit?

Drink Alcohol Y N _______drinks per day/week for_________years

Have you ever received treatment? Y N Do you want treatment? Y N

Impact social/family life Y N

Have you ever felt that you should cut down on your drinking? Y N

Have people annoyed you by criticizing your drinking? Y N

Have you ever felt bad or guilty about your drinking? Y N

Have you ever had a drink first thing in the AM to steady your nerves? Y N

Do your family/friends complain about your alcohol/drug use? Y N

Current Drug Use/Misuse Y N

IV drug use Y N

Type of Usage: ____

Amount Per Day: How Often? How Long?

Have you ever received treatment? Y N Do you want treatment? Y N

Former Drug Use/Misuse Y N

Type of Usage: ____

Amount Per Day: How Often? How Long?

Any other relevant information ____

____

____

____

Current Medications **(bring the bottles with you)**

Name	Dose	How Long	For What	Who Prescribed
1.				
2.				
3.				
4.				
5.				
6.				

Do you take any over the counter and/or herbal/natural products? Y N

If yes, please list:

Do you take any medications that belong to a friend/family member? Y N

If yes, please list:

What do you identify as your strengths? -

What do you identify as your weaknesses? -

What are your perceived barriers to treatment, if any? -

I certify that I have reviewed the above information provided by me, and to the best of my knowledge it is true and complete. I am aware that this information may be released to other parties such as insurance co., attorneys, and other medical professionals/hospitals as per my consent/authorizations, or via court orders as allowed by prevailing federal, state and/or local laws. This information may be shared with treating professionals and/or law enforcement authorities without your consent in case of an emergency, when relied upon in good faith. I will hold Dr. Kant and/or his designees harmless for any loss, injuries, damage that may arise from the actions taken.

I/We will be responsible for payment of charges billed if payments are denied by the insurance company/ies for any reason/s. It is my responsibility to update my insurance information for billing whenever there are any changes.

Patient Signature____

(If the patient is a minor (age 14-18) and received mental health and/or substance abuse treatment, S/he must sign this release)

Patient Name____

Parent/Guardian/Legal Representative of Patient Signature____

Parent/Guardian/Legal Representative of Patient Name____

Relationship to Patient____

(Guardian/Legal Representative may be required to attach supporting legal documentation)

Date_________________

Office use only:

This information was reviewed with patient and/or guardian by

1.________________________________ Signature ________________________________ Date __________

2.________________________________ Signature ________________________________ Date __________