Registration Information _____
Please Print (Date)

Patient Name: Last_____**First**_____**M.I.**_____

Address_____

City_____**State**_____**Zip**_____-_____

Home Phone( )_____**Work Phone( )**_____

Cell/Other Phone( )_____**Email Address**_____

Age_____ **Date of Birth**_____-_____-_____**Female/Male** _____**Social Security #**_____

Marital Status_____**Employer/School**_____

Referred by_____**Email**_____

Primary Care Physician/Address/Phone_____

In Case of Emergency call: Name_____**Phone#( )**_____

Person responsible for payment_____**DOB:**_____

-Relationship to patient_____**Social Security #**_____

-Employer of person responsible for payment_____

-Address of responsible party unless same as above_____

-City_____**State**_____**Zip**_____-_____

I am responsible for full & timely payment for services I request:_____
Signature of Responsible Party

Complete this part only if you plan to request reimbursement from insurance. Please discuss any parts of this that need clarification with your physician/therapist.

1. **Check whether your insurance coverage requires pre-certification (the phone number should be on your card.**
2. **Ask a secretary to make a copy of your insurance card(s).**
3. **Primary insurance:**_____**PolicyHolder:**_____**DOB:**_____
4. **Secondary insurance:**_____**PolicyHolder:**_____**DOB:**_____
5. **I authorize my physician/therapist to release information about my condition and treatment to my medical insurance carrier for reimbursement. I am responsible for full and timely payment for services I request. It is my responsibility to contact the insurance carrier promptly when payment is delayed or miscalculated.**

   Signature of responsible party_____**Date**_____

6. **I authorize the insurance company to reimburse my physician/therapist directly.**

   Signature of responsible party_____**Date**_____

For office use only: C_____**D**_____**E**_____**F**_____

Patient will submit for insurance themselves _____**Yes** _____ **No. Other arrangements agreed upon:**

_____

Therapist Name:_____

Velissarios Karacostas, M.D., Ph.D.

Phone # (513) 961-8484
Fax # (513) 487-3760

CHILD AND ADOLESCENT PATIENT QUESTIONNAIRE

Who referred your child? _____

What was their concern? _____

_____

What is your primary concern? _____

What is the school's primary concern? _____

When did you first become aware of concerns? _____

Name of Child: _____ _____ _____
First Middle Last

Street Address: _____

City _____ State/Zip _____

Phone # _____ Social Security # _____

Date of Birth _____ Place of Birth _____

Religion _____ National Heritage _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

Who has legal custody or guardianship of child? _____

FAMILY DATA

FATHER:
Name _____ DOB _____

Address _____

Home Phone ( ) _____ Work Phone ( ) _____

Place of Employment _____ Title _____

Highest Level of Education _____ Religious Affiliation _____

MOTHER:
Name _____ DOB _____

Address _____

Home Phone ( ) _____ Work Phone ( ) _____

Place of Employment _____ Title _____

Highest Level of Education _____ Religious Affiliation _____

STEPMOTHER:
Name _____ DOB _____

Phone # ( ) _____ - _____
Fax # ( ) _____ - _____

Address _____

Home Phone ( ) _____ Work Phone ( ) _____

Place of Employment _____ Title _____

Highest Level of Education _____ Religious Affiliation _____

STEPFATHER:
Name _____ DOB _____

Address _____

Home Phone ( ) _____ Work Phone ( ) _____

Place of Employment _____ Title _____

Highest Level of Education _____ Religious Affiliation _____

Please identify marital status including dates of all marriages, divorces and remarriages, for both natural and stepparents.

_____

_____

_____

_____

_____

List on this page in chronological order the names of all children including the applicant, stepbrothers and sisters, half brothers and sisters, and any miscarriages or stillbirths. Also give a brief description of each child. (Birth date, school status, significant characteristics). Please state their relationship to applicant.

NAME	RELATIONSHIP TO YOUR CHILD	SEX	DOB	EDUCATION AND/OR OCCUPATION

_____

_____

_____

_____

_____

_____

List other children or adults who have lived or are now living in the home and their relationship to the applicant.

_____

Phone # ( ) _____ - _____
Fax # ( ) _____ - _____

List dates of moves and for what reasons.

How long at present address? _____

DEVELOPMENTAL INFORMATION

Length of Pregnancy _____ Birth Weight _____

Planned or unplanned pregnancy _____

Was the pregnancy complicated or involved with drugs or alcohol? _____

Nature of delivery: _____ Natural _____ Caesarian _____ Breech

Condition of child at time of birth _____

If child was adopted, from where? _____

At what age was child adopted? _____

Age of parent at time of birth or adoption: Father _____ Mother_____

Please give age your child: crawled_____, walked_____, talked_____, toilet trained_____

What have the significant stressors or traumas been to the family and child?

EDUCATION HISTORY

Where is child attending school now? _____

What grade? _____

If it is an ungraded class, state approximate grade achieved _____
If child is not enrolled, name last school attended, grade achieved, date withdrawn.

List in order of attendance, all school enrollments child has had; also names of tutors, if any. Give name and address. Indicate if it was a public or private school and the grade attended.

School **Address** **Public/Private** **Average Grade Made**

_____

_____

_____

_____

Have any grades been repeated? _____

Has the child been identified for special education, learning support or emotional support? Please state year identification and provisions made.

_____

_____

Please check those items that pertain to your child:

_____ Often fails to finish things he or she starts
_____ Easily distracted
_____ Has difficulty concentrating
_____ Shifts excessively from one activity to another
_____ Frequently is disruptive in class
_____ Has difficulty awaiting his/her turn (i.e. games)
_____ Has difficulty sitting still.
_____ Impulsive or acts without thinking

_____ Abusive to animals
_____ Physically violent towards property (i.e. vandalism, destructive)
_____ Physically abusive to self (scratches self, suicidal attempts)
_____ Firesetting
_____ Stealing, Shoplifting, Breaking and Entering
_____ Runaway
_____ Lying
_____ Chronic violation of parental limits
_____ Drug Abuse (what kind?) _____
_____ Alcohol Abuse (what kind?) _____
_____ Any involvement with juvenile court
_____ Unrealistic fears (Explain) _____
_____ Acts too young for his/her age
_____ Clings to adults or too dependent
_____ Feels no one loves him/her
_____ Gets teased a lot
_____ Complains of loneliness
_____ Demands a lot of attention
_____ Easily made jealous
_____ Refusal to attend school
_____ Avoidance of being left alone
_____ Excessive need for reassurance
_____ Very self-conscious or easily embarrasses
_____ Often appears tense and unable to relax
_____ Frequent physical complaints (i.e. headaches, stomach aches, nausea)

Phone # ( )_____-_____
Fax # ( )_____-_____

_____ Overly concerned with future events
_____ Nervous mannerisms (i.e. nail biting, thumb sucking, rocking)
_____ Feelings of inadequacy
_____ Panic – feelings of intense fear/discomfort with palpitations, tremors, shortness of breath, choking feelings, etc.
_____ Obsessions – unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. (Fear of contamination, recurring doubts about danger, extreme concern with order, symmetry or exactness).
_____ Can't get his/her mind off certain thoughts
_____ Fears he/she may do something bad
_____ Fears she/he has to be perfect

_____ Strange thoughts or ideas (Explain) _____
_____ Hallucinations – visual or auditory-Describe_____
_____ Inappropriate expression of feelings (i.e. laughing at something sad)
_____ Concern that people are out to get him/her
_____ Severe mood changes (i.e. very sad to very happy)
_____ Often appears sad
_____ Confused or seems to be in a fog
_____ Day dreams or gets lost in his/her thoughts
_____ Doesn't seem to have much energy
_____ Social withdrawal
_____ Overtired
_____ Pessimistic outlook toward the future
_____ Excessive tearfulness or crying
_____ Recurrent thoughts about death or preoccupation with death
_____ Suicidal thoughts or verbalized intentions
_____ Concerns about sexual identity
_____ Sexually promiscuous
_____ Inappropriate sexual behavior (Explain) _____

_____ Poor relationship with parents
_____ Sibling rivalry
_____ Negative peer associates-hangs with others that get in trouble
_____ Argues a lot, bragging, boasting
_____ Mean to others
_____ Has difficulty making or keeping friends
_____ Does not associate with people his or her own age
_____ Avoids unfamiliar social situations
_____ Is easily led by others
_____ Has difficulty participating in organized activities (sports)
_____ Avoids competitive situations.

_____ Sleep difficulties (i.e. sleepwalking, restless, inability to fall asleep or sleeps too much)
_____ Eating difficulties (i.e. has difficulty keeping food down, overeats, does not have much of an appetite, fear of trying new foods, tremendous concern about weight).
_____ Poor personal hygiene (does not keep self clean or take an interest in appearance)
_____ Enuretic (urinates during the day or night on self)
_____ Encopretic (soils self)
_____ Deliberately harms self
_____ Tics (sudden rapid, recurrent motor movements or vocalizations)
_____ Behaves like the opposite sex

PSYCHIATRIC/PSYCHOLOGICAL/MEDICAL

List all doctors and mental health professionals who have examined and/or treated your child. Please give name, address and phone number for each.

Phone # ( )_____-_____
Fax # ( )_____-_____

Family Physician _____

Dentist _____

Orthodontist _____

Psychiatrist/Psychologist/or Mental Health Facility _____

_____

_____

Medications your child has been on in the past for mood or behavior:

_____

_____

_____

_____

What medication(s) is your child taking now?

_____

_____

List any allergic reactions to medications:

_____

_____

List any allergies that your child may have and how it is treated.

_____

_____

If your child has ever been **hospitalized** please explain when and for what reason.

Name of Hospital **Date** **Diagnosis**

_____

_____

_____

Has this child ever been exposed to abuse? Please state whether it is/was physical, emotional or sexual and whether he was the object to the abuse or exposed to it.

_____

_____

Please check if any of the following pertain to your child and explain (use back of page if necessary).

_____ Heart Disease	_____ Nausea or vomiting	_____ Concussions
_____ Lung Disease	_____ Drug or alcohol abuse	_____ Nervous disorders
_____ Liver Disease	_____ Diarrhea (frequently)	_____ Neurological testing

Phone # ( )_____ - _____
Fax # ( )_____ - _____

_____ Jaundice
_____ Seizures
_____ Fainting
_____ Asthma
_____ Dietary problems
_____ Hearing problems
_____ Urinary problems
_____ Diabetes
_____ Tonsillectomy
_____ Orthodontia
_____ Skin Disease
_____ Irregular Sleep Patterns
_____ Visual problems
_____ Bowel or elimination problems
_____ High fevers
_____ Injuries or broken bones
_____ Accident prone
_____ Activity limitations
_____ Speech problems
_____ Other

GYNECOLOGY

_____ Pregnancy
_____ Abortion (if so, when) _____
_____ Miscarriage (if so, when) _____
_____ Menstrual problems
_____ Birth control (if so, what type) _____

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Please check which, if any, of the following conditions/problems apply to your child's blood relatives. If other significant medical/psychiatric problems are present among blood relatives, please list those in the space provided below.

	Child's Mother	Child's Father	Child's Brother(s)	Child's Sister(s)	Child's Grandp(s)	Other
Childhood oppositional/defiant						
Problems with aggression						
Attentional problem						
Learning disability						
Failed high school						
Mental retardation						
Psychosis/schizophrenia						
Depression (greater than 2 weeks)						
Anxiety or adjustment disorder						
Panic disorder						
Other mental disorder (describe below)						
Tic disorder or Tourette's						
Alcohol Abuse						
Substance Abuse						
Antisocial behavior (assault/thefts)						
Arrests/incarcerations						
Physical abuse (victim)						
Physical abuse (perpetrator)						
Sexual abuse (victim)						
Sexual abuse (perpetrator)						

Name of person completing this form: _____

Relationship to applicant: _____

I do certify that all the foregoing information is true and complete.

NAME _____ **DATE**_____