VITAG HEALTH LLC		VIDA SARKODIE INC	
	2816 Morris Avenue, Suite 22, Union, NJ 07083		230 Rte 206, Bldg 3, Flanders, NJ 07836
	908-623-3365		973-298-0812
	908-623-3358		973-874-5194

CHILD AND ADOLESCENT INTAKE FORM

Today's Date: _____ Drug Allergies: _____

_____

Name, Address and Phone number of Pharmacy: _____

Name of Patient _____ Date _____

Date of Birth _____ Sex _____ Home Phone Number _____

Address _____ _____ _____ _____
Street City State Zip

Patient's cell phone number _____ E-Mail _____

Father's Name _____ Age _____ E-Mail _____

Father's Occupation _____ Work phone # _____ Cell phone # _____

Mother's Name _____ Age _____ E-Mail _____

Mother's Occupation _____ Work phone # _____ Cell phone # _____

Stepfather's Name _____ Age _____ E-Mail _____

Stepfather's Occupation _____ Work phone # _____ Cell phone # _____

Stepmother's Name _____ Age _____ E-Mail _____

Stepmother's Occupation _____ Work phone # _____ Cell phone # _____

WHO MAY WE THANK FOR YOUR REFERRAL?

Name: _____ Phone Number: _____
Address: _____

☐Google Search ☐Health Grades ☐Psychology Today ☐ ZocDoc ☐ Yelp ☐ Don't Recall
☐ Other _____

INSURANCE INFORMATION PRIMARY	SECONDARY
Insurance Company	Insurance Company
Insurance Contact Number	Insurance Contact Number:
Insurance ID #	Insurance ID #
Group#	Group#
Copay	Copay:
Name of Insured	Name of Insured
Date of Birth:	Date of Birth
Insured' Employer	Insured' Employer

Worker's Comp: ☐ Yes ☐ No Auto Accident: ☐ Yes ☐ No Date of Accident/Injury: _____
WCB/NF. Insurance Company: _____ Agent Name: _____
Address: _____ Phone Number: _____
Claim Number: _____ **Case/Policy Number:** _____

Please give your insurance card and Picture ID to the receptionist.

I hereby authorize my insurance benefits (e.g. Medicare & Madigan) to be paid directly to VITAG HEALTH LLC/VIDA SARKODIE INC. I will accept financial responsibility for non-covered services. If my account is sent to a collection agency, I agree that I will be responsible for all collection costs. I also authorize the office to release information about services rendered by my provider(s) to my insurance carrier(s) and allow a photocopy of my signature to be used to file insurance claims.

SIGNATURE: _____ DATE: _____

OFFICE PROCEDURES AND INSTRUCTIONS
Please call us during our normal business hours 9:00AM to 5:00PM at phone number 908-623-3365/973-298-0812 If it is a serious emergency situation, do not leave a message in the voice messaging system. Please call back and contact a person. If the office is closed, you will be transferred to our answering service and will be able to talk to an attendant. Please note, we do not check our voicemail or messages when the office is closed or over the weekend and holidays.

If there is a delay in the call back and you are in a serious life-threatening emergency, immediately proceed to the following steps:

- Call 911. In some cases, and depending on the situation, you may call the police or try to reach your PCP, a friend, relative, or neighbor.
- Go to the nearest emergency room for immediate help. If you live close to our offices you may go to the emergency room at Saint Clare's Denville Hospital.
- You may also call 973-625-6000(Morris County) or 908-522-2000(Union County) for psychiatric emergencies.

For regular appointments, please call us at least 1-2 weeks before you run out of your medications. On your regular visits, please inform us of any changes in your health, abnormal lab work, pregnancy or new medications prescribed by other doctors.

On each office visit, please make sure you have enough medication to cover you until your next visit and also over weekends and holidays.

Our office is no longer able to call/fax routine prescriptions to the pharmacy for renewals.

In case you cannot come for your scheduled appointment, please give us at least one to three business days' notice to call your pharmacy. As a courtesy, we will call your pharmacy to cover you until your next visit. Please note that we are unable to call any prescriptions over weekends, holidays, or after our normal business hours.

We do not authorize renewal of narcotics or controlled medications over the phone/fax at any time!

If you need to cancel/reschedule an appointment, we request a 24-hour notice. Our office will charge or bill a fee of $85 for missed appointments/Late Cancellations.

To prevent being billed for unauthorized visits, please provide us with appropriate referrals, authorizations, and changes in your insurance information. Our secretary will gladly help you and provide information. If the office does not have your most current insurance information, you will be responsible for the services provided by the doctor. For billing questions/problems, please contact 908-623-3365/973-298-0812. If you are not satisfied with the response, contact the doctor directly.

I, _____, have read and understood all the above procedures and instructions at VIDA SARKODIE INC.
(Print Name.)

_____ _____
Patient Signature (If under 18, Patient's Parent/guardian) Date

LIMITS OF CONFIDENTIALITY

Content of all therapy sessions are considered to be Confidential. Both Verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the healthcare professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances: Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Insurance Providers (when applicable): Insurance companies and other thirty-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. I agree to the above limits of confidentiality and understand their meanings and ramifications.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, authorize this office and its staff to release protected health information
Patient's Name [Please Print]

related to my evaluation and treatment to the following:

PCP NAME: _____ PCP PHONE NUMBER: _____

THERAPIST NAME: _____ THERAPIST PHONE NUMBER: _____

FAMILY MEMBER NAME: _____ RELATIONSHIP: _____

FAMILY MEMBER PHONE NUMBER: _____

_____ _____

Patient Signature **Date**

Child's current school: _____

School Address: _____

Name of Authorized School Informant: _____

Referral Source: _____ Phone # _____

Pediatrician: _____ Phone # _____

Pediatrician's address _____ _____ _____ _____
Street City State Zip

Siblings, Step-Siblings, Half-Siblings

Names	Ages	School	Occupation):

FAMILY CONSTELLATION

Does your child live with both natural parents? Yes ☐ No ☐

If no please describe your child's living situation and visitation arrangements including other adults or children involved in these arrangements.

CHIEF COMPLAINT

PURPOSE OF THE EVALUATION/ CURRENT BEHAVIORAL CONCERNS:

HISTORY OF PRESENT ILLNESS

Describe when your child's symptom began and if it changed over time):

FAMILY AND SOCIAL HISTORY:

LIFE STRESSORS:

(Please include any significant deaths, separations, moves, accidents, traumatic events, parent lost or changed job, changed schools, family financial problems)

What strategies have been implemented to address these problems? (Please check which have been used and note if successful)

Verbal reprimands _____ Time out _____

Removal of privileges _____ Rewards _____

Physical punishment _____ Acquiescence to child _____

Avoidance of child _____ Other _____

On the average, what percentage of the time does your child comply with initial commands?

0-20% _____ 20-40% _____ 40-60% _____ 60-80% _____ 80-100% _____

On the average, what percentage of the time does your child eventually comply with commands?

0-20% _____ 20-40% _____ 40-60% _____ 60-80% _____ 80-100% _____

To what extent are you and your spouse consistent with respect to disciplinary strategies?

Most of the time _____ Some of the time _____ None of the time _____

PSYCHOLOGICALTREATMENT

Has your child had any of the following forms of psychological treatment? If so, how long did it last? (Please check all that apply)

- ☐ Individual psychotherapy Duration of Therapy _____
- ☐ Group psychotherapy Duration of Therapy _____
- ☐ Family Therapy Duration of Therapy _____
- ☐ Inpatient Evaluation/RX Duration of Inpatient Stay _____
- ☐ Residential Treatment Duration of placement _____

Please give additional elaboration on name of facility and cause/precipitating event of any hospitalization.

What Diagnosis has your child been given by child's treating professional?

List all Medications your child is currently taking (including psychiatric, medical and over the counter):

DRUG	DOSE	START DATE	CONDITION BEING TREATED'

Please describe if there are/were side effects to any of the psychiatric medications (even if you are not sure if they are side effects):

PAST PSYCHIATRIC HISTORY

Describe psychiatric history and other treatments for psychiatric or behavioral symptoms with dates of treatment. Include what diagnosis you were told your child had in the past or presently has now (IMPORTANT).

ADDITONAL INFORMATION

It would be very helpful to provide any additional personal history or relevant information in this section about your child's life not found in these specific questions.

What are the names and phone numbers of the physicians who are prescribing the medications?

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Please describe if there are side effects (even if you are not sure if they are side effects):

DEVELOPMENTAL HISTORY:

(Prenatal, labor, delivery and peri-natal)

Age of mother at baby's birth _____ Age of father at baby's birth _____
Number of full-term pregnancies, abortions or miscarriages and approximate dates:

How was the mother's health during pregnancy? _____
Do you recall using any of the following substances or medications during pregnancy?

Beer or Wine

- ☐ never
- ☐ once or twice
- ☐ 3-9 times
- ☐ 10-19 times
- ☐ 20-39 time
- ☐ 40+ times

Hard liquor

- ☐ never
- ☐ once or twice
- ☐ 3-9 times
- ☐ 10-19 times
- ☐ 20-39 time
- ☐ 40+ times

Coffee or other caffeine (coke, etc.)
Taken together, how many times?

- ☐ never
- ☐ once or twice
- ☐ 3-9 times
- ☐ 10-19 times
- ☐ 20-39 time
- ☐ 40+ times

Cigarettes

- ☐ never
- ☐ once or twice
- ☐ 3-9 times
- ☐ 10-19 times
- ☐ 20-39 time
- ☐ 40+ times

Did you take any medications during pregnancy? ☐ Yes ☐ No

If yes, which medications did you take? (Please include over the counter medications as well as all prescriptions)

Did you develop diabetes during the pregnancy? ☐ Yes ☐ No

Did you develop toxemia, pre-eclampsia or eclampsia? ☐ Yes ☐ No ☐ Not sure

pregnancy? ☐ Yes ☐ No

Was it a breach delivery? ☐ Yes ☐ No

Was it a forceps delivery? ☐ Yes ☐ No

Was there meconium present at delivery? ☐ Yes ☐ No

Was an epidural used during delivery? ☐ Yes ☐ No

Were any medications used during delivery? ☐ Yes ☐ No

Was the baby delivered by c-section? ☐ Yes ☐ No

What was the baby's birth weight? _____ lbs

How much weight did the mother gain? _____

How long did the baby remain in the hospital after delivery? _____days

If longer than 2 days, please state the reason.

Were there problems with the infant's responsiveness (alertness)? ☐ Yes ☐ No ☐ Not sure

What was the Apgar score? _____ ☐ not sure

Did your child experience any health problems during infancy? ☐ Yes ☐ No ☐ Not sure

DEVELOPMENTAL MILESTONES

Did your child have any congenital problems? ☐ Yes ☐ No

If so, please describe

Please check one answer for each of the following questions.

1. Was your child an easy baby? (By that I mean did (s)he cry a lot? Did (s)he follow a schedule fairly well?) ☐ very easy ☐ easy ☐ average ☐ difficult ☐ very difficult

2. How did the baby behave with other people?
   ☐ more social than average ☐ average sociability ☐ more sociable than average

3. When (s)he wanted something, how insistent was (s)he? ☐ very insistent ☐ pretty insistent
   ☐ average ☐ not very insistent ☐ not insistent at all

4. How would you rate the activity level of your child as an infant? ☐ very active
   ☐ active ☐ average ☐ less active ☐ not active

5. At what age did (s)he smile socially? ☐ 2 months ☐ 3 months ☐ 4 months or more

6. At what age did (s)he sit up? ☐ 3-6 months ☐ 7-12 months ☐ over 12 months

7. At what age did (s)he crawl? ☐ 6-12 months ☐ 13-18 months ☐ over 18 months
   ☐ not sure

8. At what age did (s)he walk? ☐ under one year ☐ 1-2 years ☐ 2-3 years ☐ not sure

9. At what age did (s)he speak single words (other than “mama” or “dada”)
   ☐ 9-13 months ☐ 14-18 months ☐ 19-24 months ☐ 25-36 months
   ☐ 37-48 months ☐ not sure

10. Did your child develop stranger anxiety? ☐ Yes ☐ No

11. If so, how severe? ☐ severe ☐ moderate ☐ mild

12. If so, at what age? _____months

13. Did your child have any separations from her/his mother for over a week before the age of 2 years old?
    ☐ Yes ☐ No
    If so, for how long? _____ What were the reasons? _____

14. Has your child had any accidents resulting in the following? (Please check all that apply)
    ☐ broken bones ☐ severe lacerations ☐ head injury ☐ severe bruises
    ☐ stomach pumped ☐ eye injury ☐ lost teeth ☐ sutures
    ☐ other, please specify _____

15. How many accidents has your child had? ☐ one ☐ 2-3 ☐ 4-7 ☐ 8-12
    ☐ more than12

16. Has your child had any severe illnesses and at what age? _____

Was your child hospitalized? ☐ Yes ☐ No
Please elaborate if yes. _____

17. Has your child had surgery for any of the following? (check all that apply)
☐ Tonsillitis ☐ Adenoids ☐ Hernia ☐ Appendicitis ☐ Eye, ear, nose or throat
☐ Digestive disorders ☐ Urinary tract ☐ Leg or Arm Problems
☐ other _____

18. Please specify number of hospitalizations and length of each stay.

19. Does your child have trouble sleeping?
☐ none ☐ difficulty falling asleep ☐ sleep continuity disturbance
☐ early morning awakening

20. Is your child a restless sleeper? ☐ Yes ☐ No ☐ Not sure

21. Does your child have bladder control problems……..at night? ☐ Yes ☐ No
If yes, how often? _____
If yes, was (s)he ever continent _____
……..during the day? ☐ Yes ☐ No
If yes, how often? _____
If yes, was (s)he ever continent _____

22. Does your child have bowel control problems…….at night ☐ Yes ☐ No
If yes, how often? _____
If yes, was (s)he ever continent _____
……..during the day? ☐ Yes ☐ No
If yes, how often? _____
If yes, was (s)he ever continent _____

23. Does your child have any appetite control problems? ☐ over-eater ☐ average
☐ under-eater

(For Adolescents only)

Is there any use of drugs, alcohol or nicotine? ☐ Yes ☐ No ☐ Not sure

If yes, please explain briefly _____
Is there any history of physical/sexual abuse? ☐ Yes ☐ No ☐ Not sure
If yes, please explain briefly

MEDICAL HISTORY

Primary Physician's Name: _____ Physician's Phone No. _____
Doctor's Address: _____
Date of most recent physical examination. _____

Have you ever been treated for any of the following?

	YES	NO	COMMENTS *(TO BE ENTERED BY PSYCHIATRIST ONLY)*
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Endocrine (including Diabetes)	☐	☐	
Arthritis or Other Bone Problems	☐	☐	
Neurological Problem/Parkinson's	☐	☐	
Cataracts/other eye problems	☐	☐	
Nose/Mouth/Throat	☐	☐	
Hearing Problems	☐	☐	
Lung/Respiratory Diseases	☐	☐	
Skin Diseases	☐	☐	
Urinary Problems	☐	☐	
Gastro-Intestinal	☐	☐	
Growths/Cancer	☐	☐	
Hospitalizations	☐	☐	
Major Operations	☐	☐	
Sexually Transmitted Diseases	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Gynecologic Problems	☐	☐	
Muscular Problems	☐	☐	
Sexual Problems (including. STDs)	☐	☐	
Other Medical Problems	☐	☐	

Have you had?

	YES	NO	COMMENTS *(TO BE ENTERED BY PSYCHIATRIST ONLY)*
Blackouts	☐	☐	
Convulsions or Seizures	☐	☐	
Headaches	☐	☐	
Tremors	☐	☐	
Dizziness	☐	☐	
Forgetfulness	☐	☐	
Major Weight Loss/Gain	☐	☐	

Do you have a history of:

☐ Drug Abuse ☐ Alcohol Abuse

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS

Has anyone in your family been treated for?

	YES	NO	COMMENTS *(TO BE ENTERED BY PSYCHIATRIST ONLY)*
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Endocrine (including Diabetes)	☐	☐	
Arthritis or Other Bone Problems	☐	☐	
Neurological Problem/Parkinson's	☐	☐	
Cataracts/other eye problems	☐	☐	
Nose/Mouth/Throat	☐	☐	
Hearing Problems	☐	☐	
Lung/Respiratory Diseases	☐	☐	
Skin Diseases	☐	☐	
Urinary Problems	☐	☐	

Gastro-Intestinal	☐	☐	
Growths/Cancer	☐	☐	
Hospitalizations	☐	☐	
Major Operations	☐	☐	
Sexually Transmitted Diseases	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Gynecologic Problems	☐	☐	
Muscular Problems	☐	☐	
Sexual Problems (including. STDs)	☐	☐	
Other Medical Problems	☐	☐	

Has anyone in your family had?

	YES	NO	COMMENTS *(TO BE ENTERED BY PSYCHIATRIST ONLY)*
Blackouts	☐	☐	
Convulsions or Seizures	☐	☐	
Headaches	☐	☐	
Tremors	☐	☐	
Dizziness	☐	☐	
Forgetfulness	☐	☐	
Major Weight Loss/Gain	☐	☐	

Does anyone in your family have a history of:

☐ Drug Abuse ☐ Alcohol Abuse

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS

FAMILY HISTORY… MOTHER

Age _____ Fertility problems (specify) _____

_____

Education: Highest Grade Completed _____

Learning Problems (specify) _____Grade Repeat _____

Behavior Problems (specify) _____

Medical Problems (specify) _____

Have any of your blood relatives (not including patient or his/her siblings) ever had problems similar to those your child has? Yes ☐ No ☐

If so, please describe:

MOTHER OF PATIENT AND MATERNAL RELATIVES

	Self	Mother	Father	Brother	Brother	Sister	Sister
Problems with aggressiveness, defiance, & oppositional behavior as a child	☐	☐	☐	☐	☐	☐	☐
Problems with attention, over-activity, and impulse control as a child	☐	☐	☐	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐	☐	☐	☐
Failed to graduate from high school	☐	☐	☐	☐	☐	☐	☐
Cognitive Delays	☐	☐	☐	☐	☐	☐	☐
Psychosis or schizophrenia	☐	☐	☐	☐	☐	☐	☐
Depression for greater than two weeks	☐	☐	☐	☐	☐	☐	☐
Anxiety Disorder that impaired adjustment	☐	☐	☐	☐	☐	☐	☐
Tics or Tourette's Syndrome	☐	☐	☐	☐	☐	☐	☐
Alcohol abuse	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐
Anti-social behavior (assaults, thefts, etc.)	☐	☐	☐	☐	☐	☐	☐
Arrests	☐	☐	☐	☐	☐	☐	☐
Physical abuse	☐	☐	☐	☐	☐	☐	☐
Sexual abuse	☐	☐	☐	☐	☐	☐	☐

FAMILY HISTORY… FATHER

Age _____ Fertility problems (specify) _____

_____

Education: Highest Grade Completed _____

Learning Problems (specify) _____Grade Repeat _____

Behavior Problems (specify) _____

Medical Problems (specify) _____

Have any of your blood relatives (not including patient or his/her siblings) ever had problems similar to those your child has? Yes ☐ No ☐

If so, please describe:

FATHER OF PATIENT AND PATERNAL RELATIVES

	Self	Mother	Father	Brother	Brother	Sister	Sister
Problems with aggressiveness, defiance, & oppositional behavior as a child	☐	☐	☐	☐	☐	☐	☐
Problems with attention, over-activity, and impulse control as a child	☐	☐	☐	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐	☐	☐	☐
Failed to graduate from high school	☐	☐	☐	☐	☐	☐	☐
Cognitive Delays	☐	☐	☐	☐	☐	☐	☐
Psychosis or schizophrenia	☐	☐	☐	☐	☐	☐	☐
Depression for greater than two weeks	☐	☐	☐	☐	☐	☐	☐
Anxiety Disorder that impaired adjustment	☐	☐	☐	☐	☐	☐	☐
Tics or Tourette's Syndrome	☐	☐	☐	☐	☐	☐	☐
Alcohol abuse	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐
Anti-social behavior (assaults, thefts, etc.)	☐	☐	☐	☐	☐	☐	☐
Arrests	☐	☐	☐	☐	☐	☐	☐
Physical abuse	☐	☐	☐	☐	☐	☐	☐
Sexual abuse	☐	☐	☐	☐	☐	☐	☐

SIBLINGS OF PATIENT

	Brother	Brother	Brother	Sister	Sister	Sister
Siblings' Name						
Problems with aggressiveness, defiance, & oppositional behavior as a child	☐	☐	☐	☐	☐	☐
Problems with attention, over-activity, and impulse control as a child	☐	☐	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐	☐	☐
Failed to graduate from high school	☐	☐	☐	☐	☐	☐
Cognitive Delays	☐	☐	☐	☐	☐	☐
Psychosis or schizophrenia	☐	☐	☐	☐	☐	☐
Depression for greater than two weeks	☐	☐	☐	☐	☐	☐
Anxiety Disorder that impaired adjustment	☐	☐	☐	☐	☐	☐
Tics or Tourette's Syndrome	☐	☐	☐	☐	☐	☐
Alcohol abuse	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐
Anti-social behavior (assaults, thefts, etc.)	☐	☐	☐	☐	☐	☐
Arrests	☐	☐	☐	☐	☐	☐
Physical abuse	☐	☐	☐	☐	☐	☐
Sexual abuse	☐	☐	☐	☐	☐	☐

EDUCATIONAL HISTORY

Please summarize your child's progress (e.g. academic, social, testing) within each of these grade levels.

Preschool

Kindergarten

Grades 1 through 3

Grades 4 through 6

Grades 7 through 12

Has your child ever been in any type of special education program and if so how long?

Learning Disabilities Class _____ Duration of placement _____

Behavioral /Emotional disorder class _____ Duration of placement _____

Resource Room _____ Duration of placement _____

Speech & Language Therapy _____ Duration of therapy _____

Other (specify) _____ Duration of program _____

Was your child ever?

1. Suspended from school? Yes ☐ No ☐ Number of suspensions _____
2. Retained in grade? Yes ☐ No ☐ Number of Retention _____
3. Expelled from school? Yes ☐ No ☐ Reason for expulsion

_____

Have any additional instructional modifications been attempted? (check all that apply)

☐ None ☐ Behavior Modification program ☐ Daily/weekly report card

☐ Other (please specify) _____

SOCIAL HISTORY

Does your child get along with his /her brothers and sisters? _____

_____

How easily does your child make friends?

How many friends does your child have? _____

On the average, how long does your child keep friendships? _____

Does your child see friends after school and/or on weekends? _____

DIAGNOSTIC CRITERIA

Which of the following are considered to be significant problems at the present time? (Check all that apply)

- ☐ Fidgets
- ☐ Difficulty remaining seated
- ☐ Easily Distracted
- ☐ Difficulty waiting turn
- ☐ Often blurts out answers to questions before questions are completed
- ☐ Difficulty following instructions
- ☐ Difficulty sustained attention
- ☐ Shifts from one activity to another
- ☐ Difficulty playing quietly
- ☐ Often talks excessively
- ☐ Often interrupts or intrudes on others
- ☐ Often does not listen
- ☐ Often loses things
- ☐ Often engages in physically dangerous activities

When did these problems begin? (specify age) _____

Which of the following are considered to be significant problems at the present time?
(Check all that apply)

- ☐ Often loses temper
- ☐ Often argues with adults
- ☐ Often actively defies or refuse adult requests or rules
- ☐ Often deliberately does things that annoy other people
- ☐ Often blames others for own mistakes
- ☐ Is often touchy or easily annoyed by others
- ☐ Is often angry or resentful
- ☐ Is often spiteful or vindictive
- ☐ Often swears or uses obscene language

When did these problems begin? (specify age) _____

CHILDREN'S ATYPICAL DEVELOPMENT SCALE (CADS)

Below is a list of behaviors. For each item, please Check two if the item is very true or often true of your child. Check 1 if the item is somewhat or sometimes true. If the item is not true of your child Check 0. Please answer all items as well as you can, even if some do not see to apply to your child.

0 = NOT TRUE 1 = SOMEWHAT OR SOMETIMES TRUE 2 = VERY TRUE OR OFTEN TRUE

	0	1	2
1. "Misses the point" or main idea in conversation.	☐	☐	☐
2. Rambling speech- one idea is not connected to the next.	☐	☐	☐
3. Refers to self in the third person (e.g., uses own name instead of I or me)	☐	☐	☐
4. Makes odd noises/talks in odd voices.	☐	☐	☐
5. Obsessive interest in narrow or atypical topic or even (e.g., death, the supernatural, anatomy, fantasy characters)	☐	☐	☐
6. Makes irrelevant comments.	☐	☐	☐
7. Insists on sticking to unusual routines.	☐	☐	☐
8. Lacks interest in toys or uses toys in unusual way.	☐	☐	☐
9. Strong attachments to inanimate objects.	☐	☐	☐
10. Unusual aversions to neutral objects or situations (e.g., will not wear c certain materials, refuses to walk up a certain stairway)	☐	☐	☐
11. Engages in repetitive or stereotypic behavior (e.g., shakes or flaps hands, repeatedly touched hair or other material.)	☐	☐	☐
12. Extreme reactions to minor inconveniences or irritations.	☐	☐	☐
13. Difficulties dealing with change in daily schedule or routines.	☐	☐	☐
14. Marked lack of concern about appearance.	☐	☐	☐

15. Lacks social discretion (e.g. comments on people's behavior in public without concern for their reaction or feelings.)	☐	☐	☐
16. Acts as if other people were not in the same room.	☐	☐	☐
17. Poor judge of other people's reactions or feelings.	☐	☐	☐
18. Reveals overly personal detail to acquaintances or strangers.	☐	☐	☐
19. Lacks interest in peers.	☐	☐	☐
20. Makes poor eye contact with others.	☐	☐	☐
21. Does not appreciate personal space (e.g., stands too close or talks with Back to person)	☐	☐	☐
22. Mood changes quickly without apparent reason.	☐	☐	☐
23. Describes the details of an event but misses the meaning or importance of it.	☐	☐	☐
24. Sits, stands or walks in odd postures.	☐	☐	☐
25. Attributes meaning to events that are simply a coincidence.	☐	☐	☐
26. Believes others are talking about him/her when others are speaking softly among themselves.	☐	☐	☐
27. Overly suspicious of others.	☐	☐	☐
28. Confuses the sequence in which events occurred when describing	☐	☐	☐
29. Lacks compassion when others are hurt or finds it humorous.	☐	☐	☐
30. Laughs or cries for little apparent reason.	☐	☐	☐
31. Attends to background or distant sound that others would ignore.	☐	☐	☐
32. Excessively preoccupied with violent stores, TV shows or weapons.	☐	☐	☐
33. Confuses the causes of events or fails to understand how events cause other events.	☐	☐	☐
34. Draws excessively detailed pictures.	☐	☐	☐
35. Dislikes being held or touched.	☐	☐	☐
36. Keeps a diary or journal of rambling thoughts or random ideas.	☐	☐	☐
37. Speaks in half-thought or incomplete phrases without concern for whether others can understand or follow his/her ideas.	☐	☐	☐
38. Gets angry for little apparent reason.	☐	☐	☐
39. Has unusual fears not typical for his/her age group (e.g., afraid to take shower or put head under the water after 6 years of age.	☐	☐	☐
40. Hoards worthless objects that have no apparent meaning or value.	☐	☐	☐
41. Speaks in excessively loud or soft voice.	☐	☐	☐
42. Overreacts to pain (e.g., bumps leg and screams and cries excessively)	☐	☐	☐
43. Exhibits ritualistic behaviors (e.g., has to line up toys in a particular order after using the.	☐	☐	☐
44. Spends an unusual amount of time fantasizing.	☐	☐	☐
45. Mouths or chews objects.	☐	☐	☐
46. Seems to be extremely naïve for his/her age (e.g., believes anything he/she is told).	☐	☐	☐
47. Does not respond to the initiations of other children.	☐	☐	☐
48. Picks nose, skin, or other parts of the body.	☐	☐	☐
49. Makes bizarre statements.	☐	☐	☐
50. Interacts with acquaintances and strangers in a similar manner.	☐	☐	☐
51. Hits or bites self.	☐	☐	☐
52. Repeats certain acts over and over.	☐	☐	☐
53. Lacks modesty for his/her age.	☐	☐	☐

YOU MUST COMPLETE THIS SECTION

TEMPERMENTAL TRAITS (PLEASE CHECK ALL THOSE THAT APPLY)

- ☐ Bodily complains: hypochondriasis
- ☐ Dissatisfaction (chronic) or lack of pleasure
- ☐ Easy fatigability
- ☐ Guilt over minor indiscretions.
- ☐ Indecisiveness.
- ☐ Inordinate examination fear.
- ☐ Joylessness.
- ☐ Lack of initiative
- ☐ Pessimism
- ☐ Self-doubt: excessive worrying
- ☐ Terrifying dreams
- ☐ Abusiveness
- ☐ Heightened premenstrual irritability.
- ☐ Impulsivity
- ☐ Irritability
- ☐ Jealousy
- ☐ Mildly irascible
- ☐ Opinionated; dogmatic
- ☐ Alcoholism
- ☐ Arrogance
- ☐ Boastfulness
- ☐ Distractibility.
- ☐ Extraverted; very "out-going"
- ☐ Heightened self-confidence; overoptimism, mild euphoria
- ☐ Hyper-sexuality or promiscuity (for adolescents)
- ☐ Insensitivity or coarseness
- ☐ Lack of insight
- ☐ Over-spending.
- ☐ Stubbornness
- ☐ Taking too much, or too loud.
- ☐ Teasing others inordinately
- ☐ Blames others.
- ☐ Grudge-holding; unforgiving.
- ☐ Humorless.
- ☐ Hypercritical of others.
- ☐ Quarrelsome.
- ☐ Resentful
- ☐ Suspicious (marked) or intense jealousy.
- ☐ Eccentric
- ☐ Excessively reserved.
- ☐ "Loner"
- ☐ Self-consciousness (severe)
- ☐ Shyness (moderate to extreme) 44. Superstitious
- ☐ Unsociable.
- ☐ Withdrawn
- ☐ Overly sensitive

PSYCHOTROPIC MEDICATION INFORMED CONSENT AND CONSENT FOR TREATMENT

NAME_____ DOB _____

I have reviewed the following medications and information with the psychiatrist.

Medication		Date	Initial
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

The following topics have been discussed:

- Name and description of the medication
- Potential for interactions
- Risks and benefits
- Expected outcomes
- Potential complications
- Risks and precautions related to driving
- Risks of addictions, withdrawals, and weight gain
- Risks of falls and other accidents
- Reasonable alternative medications and alternative of NO medication
- In females, risks association with pregnancy and lactation. Please inform us immediately if you become pregnant.
- Risk of concomitant drinking or using
- other drugs.
- Risk of tardive
  - dyskinesia Which may be a permanent condition (certain medications

I agree and consent to be treated by Vida Sarkodie or the covering doctor/nurse practitioner when not available.
I understand and give permission to the office to contact me for appointment reminders, billing/health concerns, and other matters.
I agree to allow the office to message, text, or email me.
I have been given the opportunity to ask questions about the information. I agree to take the above medications.
I have discussed treatment options in emergency situations with the doctor.

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE PHYSICIAN SIGNATURE

_____ _____

Date Date

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____
Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how may I exercise these rights, and the practice's legal duties with respect of my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.

I understand I can obtain this practice's current notice of Privacy Practice on request.

Signature:_____ Date: _____

Relationship to Patient: _____

(If signed by a personal representative of the patient)