Sage Neuroscience Center

Patient Information Sheet for Minors

Date: _____

Patient Name: _____

Last **First** **Middle**

□ **Male** □**Female** **Date of Birth:** _____ **SS#:** _____

Street Address: _____

City/State/Zip: _____

Home Phone #: _____ **Work #:** _____

Cell Phone #: _____ **Preferred Number to Call:** _____

Marital Status: □ **N/A** □ **Married** □ **Widowed** □ **Divorced** □ **Single** □ **Domestic Partner**

How Were You Referred to this Clinic? □ **Self** □ **Family** □ **Primary Doctor** □ **Therapist** □ **Insurance**

Grade Level/Occupation: _____

School/Employer: _____

Address: _____

Parent/Guardian Name: _____

Parent/Guardian Name:_____

Address: _____

Emergency Contact Person: _____**Relationship:**_____

Address: _____

Phone #'s: _____

Primary Insurance Company: _____

Address: _____

Policy Holder's Name: _____**Date of Birth:** _____

ID Number: _____**Relationship:** _____

Policy Holders Address: _____

Policy Holders Employer: _____ **Phone:** _____

Address: _____

Secondary Insurance Company: _____

Address: _____

Policy Holder's Name: _____**Date of Birth:** _____

ID Number: _____ **Relationship**: _____

Primary Care Physician: _____**Phone/Fax:** _____

Therapist: _____ **Phone/Fax:** _____

Do you give Sage Neuroscience Center and its providers permission to inform your primary care doctor, therapist, or other medical providers of your diagnosis and medication changes we make for you? Any further information or detail will be discussed with you prior to being released. Sign below if you agree.

□ **Yes** □ **No** _____

Signature **Date**

_____

Guardian Signature **Date**

MEDICAL HISTORY

Please explain the reason for your visit today: _____

_____

Does this visit pertain to worker's compensation, FMLA, or disability? ☐ Yes ☐ No

SEVERE Medication Allergies and Adverse Reactions: _____

_____

Current Psychiatric Meds, Dose/Frequency:

_____

_____

_____

_____

Other Medications You Take:

_____

_____

_____

_____

Past Psychiatric Medications, include dose and duration of time you took them:

_____

_____

_____

_____

_____

_____

Have you, or are you, being treated for any of the following or are you currently having symptoms related to any of the following?

- ☐ None
- ☐ Migraines, Headaches, Dizziness
- ☐ Head Trauma
- ☐ Stroke
- ☐ Vision Problems/Loss
- ☐ Hearing Loss or Ringing in Ears
- ☐ Allergies, Seasonal or Other
- ☐ Heart Attack
- ☐ High or Low Blood Pressure
- ☐ Other Heart Conditions
- ☐ Asthma
- ☐ Gastric Reflux or Ulcers
- ☐ Pancreatic or Gall Bladder Disease
- ☐ Other Digestive Problems
- ☐ Urinary Problems
- ☐ Sexual Dysfunction
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Cancer
- ☐ Bleeding Problems/Easy Bruising
- ☐ Skin Problems
- ☐ Back or Joint pains/Arthritis
- ☐ Nerve Numbness or Sensitivity
- ☐ Seizures
- ☐ Muscle Weakness/Injury
- ☐ Arthritis
- ☐ Menstruation Irregularity
- ☐ Hysterectomy
- ☐ HIV
- ☐ Hepatitis
- ☐ Insomnia
- ☐ Sleep Apnea
- ☐ Other Neurological Disorder(s)
- ☐ Autoimmune Disorder(s)
- ☐ Chronic Pain (please specify below)
- ☐ Currently Pregnant
- ☐ Breastfeeding

Please explain any of the checked items above:_____

_____

_____

Current height:_____ **Current weight:** _____

Current level of pain: (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

Describe, Type and Location: _____

When was your last visit to your primary care doctor? _____

Have you ever been hospitalized? _____

If so, when and for what reason? _____

Have you had any past surgeries? _____

Who raised you? ____Parent(s) ____Grandparent(s) ____Foster Care ____Other

Were you adopted? ____ Yes ____ No

Please list siblings and their ages:

1. _____

2. _____

3. _____

4. _____

Who are the current household members and what is their relationship to the child? _____

_____

What is the primary source of household income/support? _____

Have you worked with a counselor or psychiatrist in the past? _____

How long, and what was the focus of treatment? _____

_____

Personal Psychiatric History (check all that apply):

- ☐ None
- ☐ Depression
- ☐ Psychosis/Schizophrenia
- ☐ Learning Disabilities
- ☐ Attention Deficit Disorder
- ☐ Alcohol Addictions
- ☐ Drug Addictions
- ☐ Other Addictions
- ☐ Suicide Attempts
- ☐ Mania or Bipolar Disorder
- ☐ Anger/violence
- ☐ Anxiety/Panic
- ☐ Trauma/Post Traumatic Stress Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Other

Please explain any of the above items you checked:

_____

_____

_____

Do you have a history of any past or current legal problems? Please Explain: _____

_____

Family Psychiatric History (check all that apply):

- ☐ None
- ☐ Depression
- ☐ Psychosis/Schizophrenia
- ☐ Learning Disabilities
- ☐ Attention Deficit Disorder
- ☐ Alcohol Addictions
- ☐ Drug Addictions
- ☐ Other Addictions
- ☐ Suicide
- ☐ Suicide Attempts
- ☐ Mania or Bipolar Disorder
- ☐ Anger
- ☐ Anxiety/Panic
- ☐ Post Traumatic Stress Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Other

Please explain any of the above items you checked and note your relation to the individual:

_____

_____

_____