Sage Neuroscience Center
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Patient Information Sheet for Minors

Areas in bold are required. Please give as much information as possible.

Patient Name: _____
Last **First** Middle

_Male _Female **Date of Birth: _____** SS#: **_____**

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ext_____

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

Ethnicity: _Caucasian _Hispanic _Other

How Were You Referred? _Self _Friend _Family _Primary Doctor _Therapist _Insurance

Services needed? _Counseling/Therapy _Medication Management

Grade Level/Occupation: _____

School/Employer: _____

Address: _____

Parent/Guardian Names: _____

Address: _____ Phone #_____

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

Address: **_____ Phone #: _____**

INSURANCE INFORMATION

__I will self pay -OR- Primary Insurance Company: _____

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

Relationship to Insured Person: _Self _Child/Parent Group #**_____**

ID Number: _____ (failure to provide ID# may result in delay in processing your paperwork)

Policy Holder's Address: _____ SS#: _____

Policy Holder's Employer: _____ Phone: _____

Do you have secondary insurance? _Yes _No Insurance Co. _____

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

Relationship: _____ Group #_____ **ID Number: _____**

Primary Care Physician: _____ Phone/Fax: _____

Therapist: _____ Phone/Fax: _____

Do you give Sage Neuroscience Center and its providers permission to inform your primary care physician, 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. Please mark & sign below.

_Yes _No _____ _____
Patient Signature (if 14 or older) **Date**

_____ _____
Parent/Guardian Signature **Date**

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MEDICAL HISTORY

Patient Name: _____ **DOB:** _____

Please explain the reason for your visit today: _____

_____

Does this visit pertain to worker's compensation, FMLA, or disability? _Yes _No

MEDICATION HISTORY

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 now or in the past been treated for, or have symptoms of, any of the following conditions?

_None
_Allergies, Seasonal or Other
_Arthritis
_Asthma
_Autoimmune Disorder(s)
_Back or Joint pains
_Bleeding Problems/Easy Bruising
_Breastfeeding
_Currently Pregnant
_Cancer
_Chronic Pain (specify below)
_Diabetes
_Gastric Reflux or Ulcers
_Hearing Loss or Ringing in Ear
_Heart Attack
_Heart Conditions (Other)
_Head Trauma
_Hepatitis
_HIV
_High or Low Blood Pressure
_Hysterectomy
_Insomnia
_Menstruation Irregularity
_Migraines, Headaches, Dizziness
_Muscle Weakness/Injury
_Nerve Numbness or Sensitivity
_Neurological Disorder(s)
_Other Digestive Problems
_Pancreatic/Gall Bladder Disease
_Sexual Dysfunction
_Skin Problems
_Seizures
_Sleep Apnea
_Stroke
_Thyroid Problems
_Urinary Problems
_Vision Problems/Loss

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 of pain and location: _____

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

Have you ever been hospitalized? _Yes _No If yes, 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: _____

_____

_____

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

_____

Have you worked with a counselor or psychiatrist in the past? _ Yes _ No

If yes, when, how long, and what was the focus of treatment? _____

_____

Personal Psychiatric History (check all that apply):

_None
_Alcohol Addictions
_Anger
_Anxiety/Panic
_Attention Deficit Disorder
_Depression
_Drug Addictions
_Learning Disabilities
_Mania or Bipolar Disorder
_Obsessive Compulsive Disorder
_Other Addictions
_Post Traumatic Stress Disorder
_Psychosis/Schizophrenia
_Suicide Attempts
_Other

Please explain any of the above items you checked: _____

_____

_____

Do you have a history of any past or current legal problems? _ Yes _ No If yes, please explain:

_____

Family Psychiatric History (check all that apply):

_None
_Alcohol Addictions
_Anger
_Anxiety/Panic
_Attention Deficit Disorder
_Depression
_Drug Addictions
_Learning Disabilities
_Mania or Bipolar Disorder
_Obsessive Compulsive Disorder
_Other Addictions
_Post Traumatic Stress Disorder
_Psychosis/Schizophrenia
_Suicide
_Suicide Attempts
_Other

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

_____

_____

_____