Program : ___ Child PHP___ Adolescent PHP___ Adolescent AIOP___ Adult PHP____ Adult IOP
Date: ____ MR# _____________ For Office Use Only

BEHAVIORAL HEALTH SERVICES PATIENT REGISTRATION

Patient Name: ___________________________Date of Birth: ____________ Age: _________Sex: M F
Street Address : ____
Street City State Zip Code County
Patient's Primary Contact Phone #: ______________________________Ok to call/leave message __Yes __No
Patient's Primary Email Address: ____

PARENT INFORMATION/EMERGENCY CONTACT

Name: ____ Relationship:_______________________
Address (if different):____
Home Phone: _________________Work Phone: _________________ Cell Phone: __________________

Name: ____ Relationship:_______________________
Address (if different):____
Home Phone: _________________Work Phone: _________________ Cell Phone: __________________

Primary Care Physician: ___________________________ Phone: ______________ Fax: __________
Address: ____
Psychiatric Prescriber: ___________________________ Phone: ______________ Fax: __________
Address: ____
Outpatient Therapist: ___________________________ Phone: ______________ Fax: __________
Address: ____
Pharmacy: ___________________________________ Phone: ______________ Fax: __________
Address: ____

INSURANCE INFORMATION

Primary Insurance :__________________________ Policy # __________________ Group# ________
Insurance Company Phone #: ____
Subscriber's Name: __________________________________ DOB: __________________________
Subscriber's Employer: _______________________________ Relationship to Patient: ______________
Subscriber's Address: (if different from patient): ____
Secondary Insurance :__________________________ Policy # __________________ Group# ________
Insurance Company Phone #: ____
Subscriber's Name: __________________________________ DOB: __________________________
Subscriber's Employer: _______________________________ Relationship to Patient: ______________
Subscriber's Address: (if different from patient): ____

_____________________________ _____________________________ ______________
Patient Signature (if 18 or older) Printed Name Date

_____________________________ _____________________________ ______________
Parent/Guardian Signature Printed Name Date

Rev.1/4/23

DOCUMENT SIGNATURE PAGE CONSENT FOR TREATMENT	Patient Name: Date of Birth:

I am requesting voluntary admission to the Partial Hospital Program and/or Intensive Outpatient. I understand that as a voluntary patient, I can choose to discontinue the program at any time for any reason. However, program staff strongly encourages patients to discuss their intention to leave the program prior to making the final decision. I have received a Patient Guide, which includes patient rights and responsibilities, as well as the programs grievance procedure. I understand that I may go to any clinical staff member if I have questions or concerns about any of my rights or responsibilities. The risks and benefits of the Program have been fully explained to me and I am choosing to participate in the program, being fully aware of these risks and benefits.

Additionally, the prescribing of over the counter medications may occur which will allow for the administration of medications that treat symptoms such as minor aches and pain, stomach upset, cold symptoms or other minor physical complaints. All other medications which are recommended for my / my child's treatment will be reviewed with me prior to the prescribing of such medication.

☐ Yes, I consent to over-the-counter medications ☐ No, I do not consent to over the counter medications

I have received a copy of the following documents (check all documents given to the patient):

☒ Bills Of Rights
☒ Notice of Privacy Practices
☒ Patient Guide
☐ An Important Message from Medicare

Patient Signature:	**Date:**
Parent or Legal Guardian:	**Date:**

I hereby consent to the taking of my photograph for identification purposes only. I understand that, upon discharge, my photograph will be kept by Four Winds Saratoga and filed in my medical record.

Patient Signature:	**Date:**
Parent or Legal Guardian:	**Date:**

I have discussed the above with the patient and his/her family (when available) and he/she has indicated an understanding of the rights guaranteed to him/her while a patient at Four Winds Saratoga.

Patient refuses to discuss above (check if applicable)	☐ Yes	☐ No
Patient refused handouts (check if applicable)	☐ Yes	☐ No

Staff Signature:	**Date/time:**

FAMILY MEDICAL QUESTIONNAIRE
ONGOING MEDICAL PROBLEMS

Patient's Name:

Patient's Date of Birth:

Name of Your/Your Child's Primary Medical Provider:	**Phone Number:**
Date of Last Visit to Your/Your Child's Primary Medical Provider:	**Reason for this Visit:**

HAVE YOU/YOUR CHILD EVER HAD:			**Comments**
Chicken Pox Illness	☐ Yes	☐ No	
Chicken Pox Vaccine	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Allergies	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Heart Condition or Murmur	☐ Yes	☐ No	
Head Injury	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Seizures/Convulsions	☐ Yes	☐ No	
Tuberculosis or Positive Skin Test	☐ Yes	☐ No	
Undescended Testicles	☐ Yes	☐ No	
Last Menstrual Period/Age at 1st Period	☐ Yes	☐ No	
Eye/Ear/or Speech Problem	☐ Yes	☐ No	

List Any Surgeries or Hospitalizations You/Your Child Has Had:

CHECK AND EXPLAIN ANY OF THE FOLLOWING CURRENT OR ONGOING PROBLEMS:			
Weight Loss	☐ Yes	☐ No	
Weight Gain	☐ Yes	☐ No	
Sore Throat	☐ Yes	☐ No	
Frequent Headaches	☐ Yes	☐ No	
Skin Rashes/Eczema	☐ Yes	☐ No	
Difficulty Breathing	☐ Yes	☐ No	
Cough	☐ Yes	☐ No	
Sinus Problems	☐ Yes	☐ No	
Diarrhea	☐ Yes	☐ No	
Constipation	☐ Yes	☐ No	
Vomiting	☐ Yes	☐ No	
Problems with Urination	☐ Yes	☐ No	
Bedwetting	☐ Yes	☐ No	
Joint Problems or Pain	☐ Yes	☐ No	

OTHER:

Please continue on to the back of the form.

DEVELOPMENTAL HISTORY (Only for patients under age 18)		
	YES	NO
1. Were there problems in pregnancy, labor, or delivery?	☐	☐
If yes, what happened?		
2. Did the mother use ☐ cigarettes, ☐ drugs or ☐ alcohol during pregnancy?	☐	☐
3. Did your child experiences any problems during the first year?	☐	☐
If yes, please describe.		
4. Do you believe your child's development was normal?	☐	☐
If no, why?		
5. At what age did your child first walk? At what age did your child first use words correctly?		

MEDICATIONS/ALLERGIES
6. What medication(s) are You/Your Child currently taking?
7. Are You/Your Child allergic to anything? Yes ☐ No ☐
If yes, what?

MEDICAL HISTORY	
8. Do you believe You/Your Child is healthy? Yes ☐ No ☐	
If no, why?	
9. Are You/Your Child's immunizations (shots) up-to-date? Yes ☐ No ☐ Do You/Your Child attend school in NYS? Yes ☐ No ☐ N/A ☐	
10. Have you/your child ever been hospitalized overnight or longer? Yes ☐ No ☐	
If yes, when and for what reason?	
11. Your/Your Child's dentist is:	12. Date of last dental check-up:

TB RISK FACTOR SCREENING			
1) Any history of foreign of birth or travel greater than a three month stay in a country with higher risk of TB than the USA?	☐ Yes	☐ No	If so, which country or countries:
2) Any history of close contact with a person diagnosed with active TB?	☐ Yes	☐ No	Relationship: When:
3) Any current symptoms of TB (i.e., cough greater than two weeks, unexplained weight loss, night sweats or bloody sputum).	☐ Yes	☐ No	If yes, give details:

Signature:	Relationship to Patient:		Date:
Physician/NPP/FNP Signature:	Title:	Date:	Time:

FOR CLINIC USE ONLY

Date:_________

Time:_________ AM/PM

Reviewed by:____________________________

Financial Agreement and Guarantee

Please Print Date________________

Patient Name________________ Medical Record No.________________

Parent's Name ________________ Parent's Name ________________

Other Responsible Party (state relationship)________________

ASSIGNMENT OF BENEFITS

I hereby assign to Four Winds Hospitals all my right, title and interest, including benefit of payment to which I am or may be entitled from ________________ insurance company under policy 1 #________________ for Insured Name________________ and from ________________ insurance company under policy 2 #________________ for Insured Name________________ or from any governmental agency, other insurance carrier and/or their agents, or others who are financially responsible for the hospitalization and medical care and services rendered to me or my dependent at Four Winds Hospitals.

FINANCIAL AGREEMENT AND GUARANTEE

(I)We (jointly and severally) agree to pay and guarantee payment to Four Winds Hospitals the full and entire amount of any and all bills not paid in full by our health insurance plan(s), private or governmental, or combination of plans due to any reason including, without limitation, exhaustion of benefits, a pre-existing condition excluded from coverage, and responsibility for co-payments. I understand that all such bills are due and payable upon presentation at the Hospital's negotiated rate with my health insurance plan(s), or if I do not have health insurance benefits, at the rate I have negotiated with the Hospital. Payment may be demanded at any time from any of the undersigned, and failure to demand payment of the patient shall not be a prerequisite to the guarantor's immediate responsibility for payment. This agreement shall be governed by the laws of the State of New York as a contract deemed executed in New York and to be performed in New York. We expressly consent to the jurisdiction of New York State and federal courts and to venue in Westchester County in any action brought relating to this agreement. We agree to pay any costs and expenses incurred by Four Winds Hospitals to enforce this agreement, including reasonable attorneys' fees. This document constitutes the complete agreement of the parties. We acknowledge that we have not relied on statements, promises, or representations, oral or written, other than as contained herein. Four Winds Hospitals has accepted my check or cash for such amount and provided me with a receipt. Any amounts charged or paid in excess of what is owed will be refunded within 7 to 10 business days.

Four Winds Financial Agreement and Guarantee (continued)

Patient Name______________________________ Med. Rec. No.__________________

RESPONSIBILITY FOR SPECIALIZED SERVICES

(I)We understand that psychiatric and basic medical care is provided by Four Winds Hospitals. However, if specialized medical services not provided at Four Winds are indicated, we agree that the cost of such medical consultation/treatment will be (my)our responsibility. Whenever possible, Four Winds will notify the family or financially responsible person that such specialized care is indicated in advance of the visit to the medical consultant.

DENIAL OF PAYMENT BY THIRD PARTY PAYOR

Four Winds Hospitals has accepted my check or cash for 7 days of hospitalization and provided me with a receipt. **My check will be held until there is a denial of payment.** Any amounts charged or paid in excess of what is owed will be refunded within 7 to 10 business days. A small number of health plans provide that beneficiaries sign an addendum to this financial obligation form at the time of a denial based on lack of medical necessity. (I)we understand that (I)we will be notified by phone or in person of the denial by Four Winds Hospitals staff at the time that the Hospital is notified. If provided by my health plan, I agree to promptly execute an addendum.

If I(we) fail to execute such addendum and (I)we elect to continue to receive services at Four Winds Hospitals, (I)we agree to promptly pay for such uncovered services.

ALL PARTIES MUST SIGN

WE HAVE READ AND UNDERSTOOD THIS AGREEMENT AND ATTEST THAT ALL INFORMATION IS TRUE, COMPLETE, AND ACCURATE.

____
Patient (if 18 or over)

____
Parent

____
Parent

____
Spouse

____
Other Responsible Party (state relationship to patient)

revised 8/4/2022

INSTRUCTIONS FOR COMPLETING THE ATTACHED RELEASES

Attached are RELEASE OF INFORMATION FORMS. Please complete one page for any of the following that pertain to you / your child:

1. Your Medical Dr. (PCP)
2. Your Therapist
3. Your Medication Prescriber
4. Your Insurance Company – check both boxes marked “other” and specify “BILLING”. The name of insurance company goes on top under agency

PLEASE MAKE SURE RELEASES ARE FILLED OUT WITH PROVIDERS FULL NAME - COMPLETE ADDRESS - FAX AND PHONE NUMBER

THANK YOU

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:

DATE OF BIRTH:

FOUR WINDS HOSPITALS

Please forward the request to the location you wish to obtain from/release to:

Westchester	**Saratoga**
800 Cross River Road	**30 Crescent Avenue**
Katonah, NY 10536	**Saratoga Springs, NY 12866**
Phone: (914) 763-8151	**Phone: (518) 584-3600**
Fax: (914) 763-0950	**Inpatient Fax: (518) 580-1514**
	Partial Fax (518) 581-2535

I authorize Four Winds Hospitals to obtain from and/or release to:

Person/Agency/School:

Address:

City, State, Zip:

Phone: Fax:

Covers the period of healthcare: ☐Most recent hospital admission ☐Last 1 year ☐All hospital admissions

Or ☐From Date: __________________ To Date: __________________

Unless a period is specified, the information below will be provided from the most recent hospital location admission only

The Specific Information to be Disclosed is:

- ☐ Diagnosis Only
- ☐ Dates of admission and/or discharge
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- ☐ Discharge Summary
- ☐ Verbal/Written Communication for Discharge
- ☐ Psychological Testing
- ☐ Psychosocial Assessment
- ☐ Medical: H&P, Labs, EKG, other Medical Information
- ☐ Applications
- ☐ Progress Notes
- ☐ Educational Summary / Materials / Verbal Academic Reports
- ☐ HIV-related information, if applicable
- ☐ Entire Medical Record
- ☐ Other (specify):____________________________________

This information will be used for the following purpose(s):

- ☐ Evaluation and Continuing Treatment / Coordinating Care
- ☐ Educational Placement / Other Educational Concerns / Billing School District for Education
- ☐ Legal / Custody / Court / Probation
- ☐ Other (specify):____

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I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Medical Records Department. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district, any school within the home school district, and a school that my child attends which is funded by the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York law.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

If Signed by Legal Guardian, Relationship to Patient	Date
Signature of Patient or Legal Guardian	Signature of Staff Person Releasing Information
	Title / Date Released

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PATIENT NAME:

DATE OF BIRTH:

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- ☐ HIV-related information, if applicable
- ☐ Entire Medical Record
- ☐ Other (specify):___________________________________

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Four Winds Hospitals is a two hospital system comprised of both Four Winds Westchester and Saratoga inpatient hospitals, partial hospitalization programs, and intensive outpatient programs. I understand authorizing this disclosure applies to both hospitals at every level of care. I understand that a separate authorization form is not needed to exchange protected health information between both hospitals at every level of care for the purposes of treatment, payment, and operations.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Medical Records Department. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district, any school within the home school district, and a school that my child attends which is funded by the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York law.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

If Signed by Legal Guardian, Relationship to Patient	Date
Signature of Patient or Legal Guardian	Signature of Staff Person Releasing Information
	Title / Date Released

JONATHAN'S LAW CONTACT SHEET

For Inpatients and Outpatients: Clinical staff completes at the time of screening or admission. If the patient is the qualified person, complete Section A only. If the patient is not the qualified person, complete Section B.

SECTION A (Complete if the patient is the qualified person.)

☐ Patient received Jonathan's Law Information Sheet.

☐ Reviewed Jonathan's Law with the patient and (check one):

- ☐ Patient verbalized an understanding of the above and had an opportunity to ask questions.
- ☐ Patient not able to participate in above.

Patient's Signature:		Date:
Staff Signature:	Title:	Date:

SECTION B (Complete if the patient is not the qualified person.)

☐ Patient/qualified person received Jonathan's Law Information Sheet.

☐ Reviewed Jonathan's Law with the patient and qualified person and (check one):

- ☐ Patient/qualified person verbalized an understanding of the above and had a opportunity to ask questions.
- ☐ Patient/qualified person refused to participate in above.

The qualified person was asked if he/she wanted to be notified of incidents (complete one):

☐ Yes. Complete the following and remind the qualified person to provide updates to telephone numbers should the information change in the future.

Name of Qualified Person:

Address:

Phone Number:	Phone Number:

☐ No. The qualified person indicates that he/she does not wish to be notified of incidents.

Qualified Person Signature:		Date:
Staff Signature:	Title:	Date:

Consent for Medical Emergency Treatment or Diagnostic Testing

PATIENT'S NAME	DATE OF BIRTH	DATE OF ADMISSION
PARENT/GUARDIAN NAME	PARENT / GUARDIAN NAME	
PATIENT / PARENT / GUARDIAN ADDRESS		
PATIENT / PARENT / GUARDIAN TELEPHONE (HOME)	BUSINESS	
PATIENT'S PHYSICIAN/PRIMARY CARE DOCTOR	MD TELEPHONE	
ADDRESS		

EMERGENCY INFORMATION	**MEDICAL INSURANCE INFORMATION**
KNOWN ALLERGIES	NAME OF INSURED PATIENT
CURRENT MEDICATIONS	EMPLOYER
	INSURANCE CO.
DATE OF LAST TETANUS BOOSTER	POLICY No. & ID No. **Bill Four Winds for Medicare/Medicaid Patients**

AUTHORIZATION

1. I authorize Four Winds Hospitals to have verbal and written communication with my/my child's pediatrician/primary care provider, if necessary, for obtaining data on medical history, immunizations, and allergies.
2. I authorize Four Winds Hospitals to provide emergency treatment and/or diagnostic testing for myself ______________________ or my family member ______________________ and to provide emergency transportation for same.
3. I authorize Northern Westchester Hospital Center, Westchester Medical Center, Saratoga Hospital/ Saratoga Care Wilton Medical Arts as appropriate, to provide emergency treatment and/or diagnostic testing for myself ______________________or my family member ________________________
4. I give consent for any diagnostic testing that may need to be provided outside of NWHC, WMC, or Saratoga Hospital/Saratoga Care Wilton Medical Arts.
5. I authorize the release of information from Four Winds Hospitals to the above named facilities for the purpose of treatment, and to Four Winds from the above facilities for the purpose of follow-up treatment.
6. I give consent for my child to go off grounds for authorized visits and be transported by and under the supervision of the Four Winds Hospitals staff. Any exceptions are stated below.
7. If a healthcare worker involved in my care and treatment becomes exposed to certain bodily fluids resulting in the possibility of transmission of a blood borne disease, my/my child's blood will be tested for HIV, Hepatitis B, and Hepatitis C to determine risk of exposure.

Exceptions: ____
____

I understand that in the event of any emergency situation Four Winds Hospitals (Katonah or Saratoga) will make all attempts to notify the following person(s) and the above-stated physician. In the event I am not available, I authorize Four Winds Hospitals to notify the following person(s):

NAME	Phone (AM)	(PM)
ADDRESS		
RELATIONSHIP TO PATIENT		

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: ____**DATE:** __________________

MEDICATION QUESTIONNAIRE

Name:

Date:

Date of Birth:

DIRECTIONS: Please place a check mark in the box that describes your experience with any of the medications listed below.

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
ANTIDEPRESSANTS							
Amitriptyline	Elavil						
Brexanolone	Zulresso						
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL, Aplenzin, Forfivo XL						
Citalopram	Celexa						
Clomipramine	Anafranil						
Desipramine	Norpramin						
Desvenlafaxine	Pristiq						
Doxepin	Sinequan, Silenor						
Duloxetine	Cymbalta						
Escitalopram	Lexapro						
Esketamine	Spravato						
Fluoxetine	Prozac, Sarafem						
Fluvoxamine	Luvox, Luvox CR						
Imipramine	Tofranil						
Isocarboxazid	Marplan						
Levomilnacipran	Fetzima						
Milnacipran	Savella						
Mirtazapine	Remeron, Remeron SolTab						
Nefazodone	Serzone						
Nortriptyline	Pamelor						
Paroxetine	Paxil, Paxil CR						
Phenelzine	Nardil						
Selegiline Transdermal	Emsam						
Sertraline	Zoloft						
Tranylcypromine	Parnate						
Trazodone	Desyrel, Oleptro						
Venlafaxine	Effexor, Effexor XR						
Vilazodone	Viibryd						
Vortioxetine	Trintellix, Brintellix						
ANTIPSYCHOTICS "major tranquilizers"							
Aripiprazole	Abilify, Abilify Maintena, Abilify Mycite, Aristada						
Asenapine	Saphris						
Brexpiprazole	Rexulti						
Cariprazine	Vraylar						

MEDICATION QUESTIONNAIRE

Name:

Date:

Date of Birth:

Chlorpromazine	Thorazine						
Generic Name	**Trade Name**	**Helpful**	**Not Helpful**	**Current Use**	**History of Use**	**Adverse Reaction**	**Patient, Parent, Guardian or Physician/NPP Comments**
Clozapine	Clozaril, FazaClo, Versacloz						
Fluphenazine	Prolixin, Prolixin Decanoate						
Haloperidol	Haldol, Haldol Decanoate						
Iloperidone	Fanapt						
Loxapine	Loxitane						
Lurasidone	Latuda						
Molindone	Moban						
Olanzapine	Zyprexa, Zyprexa Zydis, Zyprexa Relprevv						
Paliperidone	Invega, Invega Sustenna, Invega Trinza						
Perphenazine	Trilafon						
Pimavanserin	Nuplazid						
Quetiapine	Seroquel, Seroquel XR						
Risperidone	Risperdal, Risperdal Consta, Risperdal M-Tab, Perseris						
Thioridazine	Mellaril						
Thiothixene	Navane						
Trifluoperazine	Stelazine						
Ziprasidone	Geodon						
ANXIOLYTICS "anti-anxiety" "minor tranquilizers"							
Alprazolam	Xanax, Xanax XR						
Buspirone	BuSpar						
Chlordiazepoxide	Librium						
Clonazepam	Klonopin, Klonopin Wafers						
Clorazepate	Tranxene						
Diazepam	Valium						
Hydroxyzine	Vistaril, Atarax						
Lorazepam	Ativan						
Oxazepam	Serax						
ANTICHOLINESTERASE/ALZHEIMER'S AGENTS							
Donepezil	Aricept						
Galantamine	Razadyne						
Memantine	Namenda, Namenda XR						
Rivastigmine	Exelon						
Selegiline	Eldepryl						
Tacrine	Cognex						
ALCOHOL/DRUG/SMOKING CESSATION AGENTS							
Acamprosate	Campral						

MEDICATION QUESTIONNAIRE	Name: Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Buprenorphine	Belbuca, Buprenex, Butrans, Probupine, Subutex, Sublocade						
Buprenorphine/ Naloxone	Suboxone, Bunavail, Zubsolv						
Bupropion	Zyban						
Disulfiram	Antabuse						
Methadone	Dolophine						
Naltrexone	ReVia, Vivitrol						
Varenicline	Chantix						
MOOD STABILIZING AGENTS/AED's							
Carbamazepine	Tegretol, Tegretol XR, Carbatrol, Epitol, Equetro						
Fluoxetine/Olanzapine	Symbyax						
Gabapentin	Neurontin						
Lamotrigine	Lamictal, Lamictal XR, Lamictal ODT						
Levetiracetam	Keppra, Keppra XR						
Lithium	Eskalith, Eskalith CR, Lithobid						
Oxcarbazepine	Trileptal						
Pregabalin	Lyrica						
Tiagabine	Gabitril						
Topiramate	Topamax, Trokendi XR, Qudexy XR						
Valproate	Depakene, Depakote, Depakote Sprinkles, Depakote ER, Valproic Acid, Stavzor						
PSYCHOSTIMULANTS							
Amphetamine	Adzenys ER, Adzenys XR-ODT, Dyanavel XR, Evekeo, Evekeo ODT						
Amphetamine Salts (Mixed)	Adderall, Adderall XR, Mydayis						
Armodafinil,	Nuvigil,						
Atomoxetine	Strattera						
Dexmethylphenidate	Focalin, Focalin XR						
Dextroamphetamine	Dexedrine, Dextrostat, ProCentra, Zenzedi						
Lisdexamfetamine	Vyvanse						
Methylphenidate	Ritalin, Ritalin SR, Ritalin LA, Concerta, Metadate ER/CD, Methylin, QuilliChew ER, Quillivant XR, Adhansia XR,						

MEDICATION QUESTIONNAIRE

Name:

Date:

Date of Birth:

	Aptensio XR, Cotempla XR-ODT, Jornay PM, Relexxii						
Methylphenidate Transdermal Patch	Daytrana						
Generic Name	**Trade Name**	**Helpful**	**Not Helpful**	**Current Use**	**History of Use**	**Adverse Reaction**	**Patient, Parent, Guardian or Physician/NPP Comments**
Modafinil	Provigil						
Pemoline	Cylert						
Solriamfetol	Sunosi						
SEDATIVE/HYPNOTICS							
Chloral Hydrate	Noctec						
Eszopiclone	Lunesta						
Flurazepam	Dalmane						
Ramelteon	Rozerem						
Suvorexant	Belsomra						
Temazepam	Restoril						
Triazolam	Halcion						
Zaleplon	Sonata						
Zolpidem	Ambien, Ambien CR, Intermezzo, Edluar, Zolpimist						
OTHER							
Benztropine	Cogentin						
Clonidine	Catapres, Kapvay						
Cyproheptadine	Periactin						
Dextromethorphan/ Quinidine	Nuedexta						
Diphenhydramine	Benadryl						
Doxylamine	Unisom						
Guanfacine	Tenex, Intuniv						
Prazosin	Minipress						
Propranolol	Inderal						
Trihexyphenidyl	Artane						
HERBAL PREPARATIONS							

☐ I am unable or unwilling to complete this form. ☐ I have completed this form to the best of my ability.

Signature of Patient/Parent/Guardian:	**Date:**

☐ Reviewed in person with the patient.

☐ Reviewed over the phone with the parent/guardian of the patient.

MEDICATION QUESTIONNAIRE	Name: Date: Date of Birth:

☐ Reviewed in person with the patient and / or parent/guardian of the patient.	
Signature of Psychiatrist/NPP:	**Date/Time:**

PATIENT CLINICAL INFORMATION	**Child's Name:**

Name of person completing this form: ____

Relationship to child: ☐ **Mother** ☐ **Father** ☐ **Stepparent** ☐ **Grandparent** ☐ **Legal Guardian**

Gender: ☐ **Male** ☐ **Female** ☐ **Transgender M** ☐ **Transgender F** ☐ **Other Preference**

____

____

____

____

Main Concern *What concerns do you have about your child?*

____

____

____

____

____

How long have you been concerned about this behavior? ___________________________

Overall the above concerns are: ☐ **Mild** ☐ **Moderate** ☐ **Severe**
Please check ONE

Are there any other Providers that have been / are currently involved with your child?
List by name the following

Please circle Past / Current

Past / Current	**Primary Care Physician:**
Past / Current	**Psychiatrist/NPP:**
Past / Current	**Social Worker:**
Past / Current	**Occupation Therapist:**
Past / Current	**Speech Therapist:**
Past / Current	**Physical Therapist:**
Past / Current	**Alternative Therapy:**
HISTORY: Child's Past/Current Treatment	
☐ **Y** ☐ **N**	Has your child ever received psychological counseling for any problems?

PATIENT CLINICAL INFORMATION	**Child's Name:**

		Specify:
☐ **Y**	☐ **N**	Has your child ever been diagnosed with a psychiatric disorder: If yes: ______ Year _______ Month Provider's Name: ___________________________ **Circle below those your child has been diagnosed with:** ADHD Autism Spectrum Disorder Mood Disorder ADD Bipolar Obsessive Compulsive Disorder Anxiety Depression Other disorder?
☐ **Y**	☐ **N**	Has your child ever been psychiatrically hospitalized? If so, where?
☐ **Y**	☐ **N**	Has your child ever taken psychiatric medication in the past? ***If yes please complete the attached Medication History sheet***

What Medication(s) including vitamins or herbal supplements is your child currently taking?
☐ None

Name	Dose	Time of day

HISTORY: Health

When was your child's last physical examination? Date: _______________

☐ **Y**	☐ **NKA***	Does your child have any Allergies? Specify: *** No Known Allergies**
☐ **Y**	☐ **N**	Has your child had any major health problems?
☐ **Y**	☐ **N**	Has your child had frequent ear infections?
☐ **Y**	☐ **N**	Has your child had any vision / eye or hearing problems?
☐ **Y**	☐ **N**	Has your child ever been hospitalized or had surgery?
☐ **Y**	☐ **N**	Has your child ever experienced a head injury or loss of consciousness?
☐ **Y**	☐ **N**	Has your child had meningitis or encephalitis?
☐ **Y**	☐ **N**	Has your child had seizures?
☐ **Y**	☐ **N**	Has your child had any difficulties with growth?
☐ **Y**	☐ **N**	Does your child have any birth defects or birthmarks?
☐ **Y**	☐ **N**	Has your child ever been on any long-term medications?

Has your child ever had: *Please check box if yes to any of the following*

☐	**Chicken Pox Illness**	☐	**Diabetes**
☐	**Chicken Pox Vaccine**	☐	**High Blood pressure**
☐	**Asthma**	☐	**Heart Condition/Murmur**

PATIENT CLINICAL INFORMATION	**Child's Name:**

Additional Health History Comments:

Birth History		
How much did your child weigh at birth? pounds ounces Length: inches		
Y	**N**	Were there any problems/illnesses during the pregnancy? Specify:
Y	**N**	Were there any problems during labor / delivery or following the birth? Specify:
Y	**N**	Was your child born by Cesarean /C-Section If yes, circle appropriate response: planned /emergency
Y	**N**	Was your child born two or more weeks before his/her "due date"? If Yes, how many weeks early was your child born? ______Weeks

Y	**N**	Were any substances or medication used by the mother during pregnancy? ____Beer/Wine ______Alcohol ____ Any Prescription ___ Cocaine ____ Tobacco ______ Marijuana ____ Methamphetamine (Crystal/ Ice) ____ Other, please specify: ____
Y	**N**	Were any substances or medication used by the Father around the time child was conceived? ____Beer/Wine ______Alcohol ____ Any Prescription ___ Cocaine ____ Tobacco ______ Marijuana ____ Methamphetamine (Crystal/ Ice) ____ Other, please specify: ____

HISTORY: Developmental Concerns		
Y	**N**	Did your child sit up by 8 months?
Y	**N**	Did your child crawl by 10 months?
Y	**N**	Did your child walk by 15 months?
Y	**N**	Did your child speak 2 word sentences by 2 years?
Y	**N**	Could strangers understand your child by 3 years?
Y	**N**	Did your child stay dry during the day by 3 ½ years?
Y	**N**	Did your child read simple words by 6 years?

PATIENT CLINICAL INFORMATION	**Child's Name:**

HISTORY: Behavioral		
Y	**N**	Did your child cry frequently as an infant?
Y	**N**	Was your child difficult to calm down as an infant?
Y	**N**	Did your child have trouble sleeping as an infant (e.g., was this child fidgety or overly sleepy)?
Y	**N**	Was your child a picky or irregular eater as an infant?
Y	**N**	Did your child have many temper tantrums as a toddler?
Y	**N**	Did you have trouble keeping a babysitter because of your child's behavior?
Y	**N**	Does your child have urine accidents?
Y	**N**	Does your child have stool / bowel accidents?
Y	**N**	Does your child often have nightmares?
Y	**N**	Has your child ever had tics or nervous twitches, such as repeated eye blinking, head jerking, or throat clearing?
Y	**N**	Does your child have any problems falling asleep? Specify:
Y	**N**	Does your child have any problems staying asleep through the night? Specify:
Y	**N**	Does your child have any problems getting up in the morning? Specify:
Y	**N**	Does your child have frequent stomachaches and headaches? Specify

Y	**N**	Does your child have problems with his/her weight? Specify

HISTORY: Social		
Y	**N**	Have there been any major changes or stresses in your child's life (e.g., marital problems, parent(s) in the military, a move, change of school, birth of a brother or sister, a death of a pet)? *If yes, please specify and include how old the child was at the time* ____
Y	**N**	Is this stress still occurring?
Y	**N**	Has there been a serious illness or death in a parent or close family member of your child? If yes, please specify and include how old the child was at the time:
Y	**N**	Has your child experienced or seen any traumatic events (e.g., domestic violence, physical or sexual abuse)? *If yes, please specify and include how old the child was at the time:*
Y	**N**	Is this trauma still occurring?
Y	**N**	Are any major changes or stresses expected in the future? *If yes, please specify:*

Child's Living Arrangement

PATIENT CLINICAL INFORMATION	**Child's Name:**

This child is currently living with: ____________________________ ________________
(Relationship to child)

The **biological** parents of your child are currently (please check one):
___ Married to each other- Year_____ Month_____ Other (please specify): ______________
___ Divorced from each other- Year_____ Month_____ Not Applicable (please specify):
___ Separated from each other- Year_____ Month_____ Don't Know______
___ Never married to each other

Are there any litigation issues currently related to the custody and/or visitation of your child?
Yes ____ No ___
If yes, please specify: ____
____

Please describe the current relationship between your child's biological parents?
Friendly / Amicable / Supportive
Unfriendly / Conflict ridden / Don't Know / No relationship

Y	N	Are the parent(s)/guardian(s) of your child **working outside of the home**?
Y	**N**	Do you have family or social **support locally**

Please list all people who are currently living in your child's household.		
Name	**Relationship to Child**	**Age**

Child's Substance Use History: _____**Not Applicable**

_____ Coffee _____ Cigarettes ____ Alcohol ____ Marijuana ____ Prescription Meds

_____ Other, please specify: ____

Has your child ever received substance abuse treatment of any kind?
____
____

HISTORY: Family Medical Problems:

PATIENT CLINICAL INFORMATION	**Child's Name:**

Is there anyone in your child's family with the following:				**If yes, how is this person related to your child?**
Y	**N**	**Don't Know**	Neurological problems	
Y	**N**	**Don't Know**	Learning or reading difficulty	
Y	**N**	**Don't Know**	Depression	
Y	**N**	**Don't Know**	Anxiety	
Y	**N**	**Don't Know**	Bipolar Disorder / Manic Depression	
Y	**N**	**Don't Know**	Schizophrenia	
Y	**N**	**Don't Know**	History of physical or sexual abuse	
Y	**N**	**Don't Know**	Alcohol problems	
Y	**N**	**Don't Know**	Drug problems	
Y	**N**	**Don't Know**	Autism/ Asperger's/ Pervasive Developmental D/O	
Y	**N**	**Don't Know**	ADHD / ADD (attention problems)	
Y	**N**	**Don't Know**	Tics or Tourette's Disorder	
Y	**N**	**Don't Know**	Trouble with the law	
Y	**N**	**Don't Know**	Medications for nerves or emotional problems.	
Y	**N**	**Don't Know**	Thyroid problems	
Y	**N**	**Don't Know**	Exposure to toxic chemicals	
Y	**N**	**Don't Know**	Cardiac problems or sudden death?	
Y	**N**	**Don't Know**	Psychiatric Hospitalizations	
Y	**N**	**Don't Know**	Completed Suicides	

Please rate your child's behavior using the following **0-Never, 1-Rarely, 2-Occasionally, 3-Often, 4-Very often** *If your child Is currently taking medication, please rate your child's behavior **NOT** on medication.*	
	Fails to give close attention to detail or **makes careless mistakes** (e.g., homework).
	Has **difficulty attending** to what needs to be done.
	Does not seem to listen when spoken to directly.
	Does not follow through when given directions.
	Has **difficulties organizing** tasks and activities.
	Avoids, dislikes, or does not want to start tasks.
	Loses things necessary for tasks or activities (school assignments, pencils, books).
	Is **easily distracted** by noises or other things.
	Is **forgetful** in daily activities.
	Fidgets with hands or feet or squirms in seat.
	Leaves seat when he/she is supposed to stay in seat.
	Runs about or climbs too much when he/she is supposed to stay seated.
	Has **difficulty playing** or starting quiet games.
	Is "**on the go**" or acts as if "driven by a motor".
	Talks too much.
	Blurts out answers before questions have been completed.
	Has **difficulty waiting his/her turn**.
	Interrupts or bothers others when they are talking or playing games.
	Argues with adults.
	Loses temper.

PATIENT CLINICAL INFORMATION	**Child's Name:**

	Actively **disobeys or refuses** to follow adult's request or rules.
	Bothers people on purpose.
	Blames others for his or her mistakes or misbehaviors.
	Is **touchy or easily annoyed** by others.
	Is **angry or bitter**.
	Is **hateful** and wants to get even.
	Bullies, threatens, or scares others.
	Starts physical fights.
	Lies to get out of trouble or to avoid jobs (i.e. "cons" others).
	Skips school without permission.
	Is **physically unkind** to people.
	Has **stolen things** that have value.
	Destroys others' property on purpose.

Please rate your child's behavior using the following **0-Never, 1-Rarely, 2-Occasionally, 3-Often, 4-Very often** *If your child Is currently taking medication, please rate your child's behavior **NOT** on medication*	
	Is physically **mean to animals**.
	Has **set fires** on purpose to cause damage.
	Has **broken into** someone else's home, business, or car.
	Has **stayed out all night** without permission or **run away** from home overnight.
	Has **used a weapon** that can cause serious physical harm (e.g. bat, broken bottle, brick).
	Is **fearful, anxious, or worried**.
	Is **afraid to try new things** for fear of making mistakes.
	Feels **useless or inferior**.
	Blames self for problems, feels at fault.
	Feels **lonely, unwanted, or unloved**; complains that "no one loves me."
	Is **sad or unhappy**.
	Feels **different and easily embarrassed**.
	Is **overly concerned about health/body**.
	Has problems getting along with **you**.
	Has problems getting along with **others his/her age.**
	Has problems getting along with **his /her siblings.**
	Has problems in **group activities** such as games or team play.
	Decreased interest or pleasure in all, or almost all, activities of the day.
	Has **said things like "I wish I were dead"** or has tried to hurt self.
	Recurrent excessive distress when separation from home or caretakers.
	Has **distinct periods of unusually irritable or unusually cheerful mood** (different from normal).
	Has **prolonged temper tantrums** (greater than 20-30 minutes).
	Hears voices or sees things others do not hear or see.
	Has **compulsions** (e.g. child seems driven to wash hands, count, erase until holes appear).
	Has **obsessions** (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).
	Has **recurrent recollections or dreams** of a traumatic event.
	Seems to **avoid or have phobias** of specific people, animals, things or situations.
	Seems **unaware of others' existence**, is **uninterested in interacting with others**.

	Has **odd, eccentric or unusual preoccupations** (e.g. clothing items, toys, neatness)
	Appears **uninterested in activities** children his or her age usually like or participate in.
	Has experimented with or abused **drugs or alcohol.**

School History

Please describe this child's areas of **strengths & weaknesses** in his/her **schoolwork**:

Strengths	Weaknesses

HISTORY: School Intervention		
Y	N	Has your child been in an **Early Intervention Program or Special Day Care/Preschool**?
Y	N	Has your child had **speech, occupational or physical therapy**?
Y	N	Has your child ever **attended summer school**? If Yes, specify subject(s) / grade(s)?
Y	N	Has the school ever **discussed this child attending summer school** with you? Specify: ______________________________
Y	N	Has this child ever **repeated a grade**? If Yes, specify subject(s) / grade(s)? ______________________________
Y	N	Has the school ever **discussed this child repeating a grade** with you? Specify: ______________________________
Y	N	Is there a possibility that **current grade or subjects will need repeating**? Specify:
Y	N	Has this child ever received any **special education services** (like a 504 Plan or an IEP)? Specify: ______________________________
Y	N	Is this child **currently receiving any special education services** (like a 504 Plan or IEP)? Specify:
Y	N	Have any **disciplinary actions** been taken (detentions, suspension, or expulsion)? Specify: ______________________________
Y	N	Does this child need any **special medical assistance**? Specify:

HISTORY: School Problems For each of the following grades this child has completed, were any **academic problems reported?** If Yes, please describe the teacher or parent concerns in the space provided.

Y	N	**Preschool**	
Y	N	**Kindergarten- First**	
Y	N	**Second-Third**	
Y	N	**Fourth and Fifth**	
Y	N	**Sixth through Eighth**	
Y	N	**High School**	

CURRENT: School Performance Please check the appropriate Area

 PATIENT CLINICAL INFORMATION	**Child's Name:**

Above Average	**Average**	**Problematic**	
			Classroom Assignment Completion
			Homework Completion
			Getting Homework to and from school
			Organizational Skills
			Reading
			Spelling
			Mathematics
			Science
			Written Expression
			Handwriting
			Social Studies/History
			Art

Child Summary

HISTORY: Summary

1. Please **summarize your child's OVERALL functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare your child's functioning in **3** settings- - **home, school, and with peers,** to "average children" his/her age that you are familiar with from your experience.

Please circle only one number.

1) **Excellent** functioning / No impairment in settings
2) **Good** functioning / Rarely shows impairment in settings
3) **Mild** difficulty in functioning / Sometimes shows impairment in settings
4) **Moderate** difficulty in functioning / Usually shows impairment in settings
5) **Severe** difficulties in functioning / Most of the time shows impairment in settings
6) **Needs considerable supervision** in **all** settings to prevent from hurting self or others
7) **Needs 24-hour professional care and supervision** due to severe behavior or gross impairment(s)

Do you have any other comments that you think would be helpful?

Parent/Guardian Signature	Parent/Guardian Printed Name	Date	Time

Patient Label

FOUR WINDS HOSPITALS
COVID 19 and Influenza Screening Form

1. Has the patient tested positive for COVID 19 during the past 90 days? ☐ YES ☐ NO

   If yes, please indicate the date of the test _______________

2. For patient with confirmed COVID 19 illness and who is recovering from the illness, please answer the following questions:
   - ☐ YES ☐ NO Has the patient been without fever for the 3 days without using fever reducing medications?
   - ☐ YES ☐ NO Has there been an improvement in respiratory symptoms like cough, shortness-of-breath?
   - ☐ YES ☐ NO Has it been 10 days since the appearance of the first symptom?
   - ☐ YES ☐ NO Does the patient have a documented negative COVID 19 follow-up test?
     If yes, date of negative follow-up test: ________________________
     Patient may present documentation confirming a positive COVID-19 test within the last 30 days in lieu of a negative test.

3. Has the patient ever been hospitalized due to COVID-19? ☐ YES ☐ NO

4. Has the patient been fully vaccinated (received both doses of Moderna or Pfizer vaccine or a single dose of Johnson & Johnson vaccine) against COVID-19? ☐ YES ☐ NO If yes, please provide proof of vaccination.

   Does the patient have a vaccination appointment scheduled? DATE: __________ ☐ 1st Dose ☐ 2nd Dose

5. Did the patient have direct contact with a person confirmed positive or who is suspected to be positive for COVID 19?
   ☐ YES ☐ NO

6. Is the patient currently experiencing the following symptoms (Please check symptoms that are applicable):

☐ Fever (Temperature more than 100°F)/chills	☐ Sore throat	☐ Diarrhea
☐ Shortness of breath/difficulty breathing	☐ Congestion/runny nose	☐ Cough
☐ New loss of sense-of-smell or taste	☐ Headache	☐ Fatigue
☐ Muscle pain/body aches	☐ Nausea/vomiting	

7. Did the patient travel outside of the United States within the last 14 days? ☐ YES ☐ NO

   If yes, where ____________________________________ Please indicate last day of travel: __________

   Patients must provide proof of negative COVID test between 3 and 5 days of return travel.

8. Do you share a home with anyone who is immunocompromised or in a high-risk category for COVID-19 infection?

   ☐ YES ☐ NO If yes, what is the alternate plan at discharge if you/your child requires a quarantine period following a potential exposure?____

______________________________	______________________________	______________________
Signature of patient/parent or legal guardian	Printed Name of patient/ parent or legal guardian	Date/Time

Parent/Guardian Social History

Child's Name: ______________________ Date of Admission: ____________ Age: ____

Who resides in your child's home? ______________________________________

Who has custody of your child? ______________________________________

Caretaker's Name ____________________ Relationship to Child: ____________________

O Check here if you are the parent/guardian completing this form

- Nature of relationship is: Excellent - Good - Fair - Poor (circle one)
- The best part of the relationship is: ______________________________________

  ____
- When there is a problem, its usually about: ______________________________

  ____

Caretaker's Name: ____________________ Relationship to child: ____________________

O Check here if you are the parent/guardian completing this form

- Nature of relationship is: Excellent - Good - Fair - Poor (circle one)
- The best part of the relationship is: ______________________________________

  ____
- When there is a problem, its usually about: ______________________________

  ____

Siblings: List name (s), age(s). Circle names of siblings that live with your child.

- Full Siblings ______________________________________

  ____
- Half Siblings ______________________________________

  ____
- Step- Siblings ______________________________________

  ____

Describe your child's:

Personality ______________________________

____

Social Life ______________________________

____

Academic performance:

____

____

Hobbies/Interests:

____

____

Strengths ______________________________

____

Weaknesses ______________________________

____

What are your primary concerns related to your childs admission? What would you like to see improve prior to your child returning home?

____

____

____

____

Has your child been attending outpatient therapy?______________________________

If yes, when was their last visit?______________________________

How long have they been in therapy? ______________________________

How often is your child seen by their therapist?______________________________

Is your child on any medications? ______________________________

How are your childs medications administered at home?______________________________

Is your child compliant with taking their medication?______________________________

Are there any guns or firearms in your home? ______________________________

If yes, does your child have access to these? ______________________________

Where and how are the guns/firearms stored?______________________________