

James R. Parks, M.D. PLLC
Child & Adolescent Psychiatry

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New Patient Registration

This form requests information about your child which will help us design a treatment plan geared specifically to your child's needs. Please take a few moments to complete the form carefully. We appreciate your time and effort in completing these documents. If you have any questions, please feel free to discuss them with us. Thank you.

Date: _____

Patient Name: _____ Date of birth: _____ Age: ____ Female Male

Address: _____ City, State, Zip: _____

SS#: _____ Phone: (____) _____ Cell: (____) _____

Mother: _____

Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Father: _____

Phone: (____) _____ Cell: (____) _____ Work: (____) _____

May we leave messages on: Home phone Cell phone Work phone

May we send mail to you at the address above? Yes No

Father's address, if different from above _____

Relationship Status of Parents: Never Married Married/Partnership Separated Divorced Widowed

Person responsible for bill: _____

Address: _____

Please list all other persons living in your household, as well as children not living in your home.

Name	Age	Relationship	Employment	Welfare
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
At home / Not at home (Circle one)				
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
At home / Not at home (Circle one)				
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
At home / Not at home (Circle one)				

Household income (\$):

- 0 - 20,000
- 20,000 - 50,000
- > 50,000
- Unknown

Education level (father):

- Kindergarten
- Elementary (grade level: _____)
- Middle Sch (grade level: _____)
- High Sch (grade level: _____)
- Graduate

Education level (mother)

- Kindergarten
- Elementary (grade level: _____)
- Middle Sch (grade level: _____)
- High Sch (grade level: _____)
- Graduate

Primary Care Physician: _____

Address: _____ Phone: (____) _____

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May we exchange information with your treating physicians to coordinate your care? Yes No

By whom were you referred? _____

Insurance Type: Private Public

Please describe your reason(s) for seeking treatment at this time (Include when the problem started):

Please list other health care professionals currently treating your child:

Please list current allergies (be as specific as possible) or other health problems for your child:

Please indicate past problems with a "P" and current problems with a "C"

- | | | |
|---|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Relationship Issues |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Sexuality/Sexual Issues |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Family Conflict |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Eating or Weight Problem | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> LD/ADHD | <input type="checkbox"/> Abuse/victimization | <input type="checkbox"/> Schizophrenia/Psychosis |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Obsessions/Compulsions | <input type="checkbox"/> Manic Episodes | <input type="checkbox"/> Eliminating a Drug/Alcohol Habit |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Legal Matters | <input type="checkbox"/> Eliminating Another Habit (eg, over-spending, gambling, etc.) |

Other: _____ (Please explain)

Please indicate how the problems are affecting the following areas of you and your child's life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Relationships with peers	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A

Total: _____

Have you ever received mental health or substance abuse treatment before? If yes, please describe:

Type of treatment	Provider Name	Phone Number	First Seen	Last Seen
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