Shalva Adult and Child Psychiatry

Dorit Ben-Ami, MD

Richard Linsk, MD, PhD

Please save this file to your desk top and then complete the form using your word processing program. You may leave a question blank if you do not wish to answer it.

21751 West 11 Mile Road, Suite 105
Southfield, MI 48076
248-327-7175
www.benamipsychiatry.com

New Patient History Form

New child or adolescent patient

PLEASE PRINT OUT THE BEHAVIORAL SCREENING FORM AND HAVE IT FILLED OUT BY BOTH PARENTS AND THE RELEVANT TEACHERS IF APPROPRIATE

IDENTIFYING INFORMATION

Child's name:

Date of Birth:

Parents Names:

Telephone Number:

Email :

Address:

What are the names and addresses of physicians to whom I should send a copy of the visit note?

Date of visit:

Child's age at visit (years and months):

What is your insurance?:

How did you hear about our practice?:

REASONS FOR TODAY'S VISIT

What are the most important reasons for coming to see us today?:

Are there any recent events that have prompted today's visit?:

What are you expecting from this visit?:

Are there particular approaches that you want to pursue?

Are there particular approaches that you want to avoid?

What are the most significant symptoms that you see affecting your child?:

Are there any particular issues that you want us to be aware of?:

Does your child have a diagnosis and who gave that diagnosis?:

Has your child seen a biomedical doctor before?:

Please describe your child's behavior at home:

Please describe your child's behavior in school:

How does your child feel about him or herself?:

How does your child interact with other children?:

Does your child seem to have difficulty paying attention at home or at school?

Does your child have

Does your child tend to have problems regulating himself?

Does your child have difficulty with anger or aggression?

Does your child have any unusual interests or behaviors?

Is there a time at which you saw a distinct change in your child? What was happening at that time?

Are there any behaviors that cause problems (aggression, inflexibility, irritability, tantrums, sensory reactivity, etc.)? Please describe a specific event:

Does your child have any other medical problems?:

Describe your child's bowel patterns:

Describe your child's sleep patterns:

Describe your child's diet and eating patterns:

Any hospitalizations?

Any suicide attempts, threats, or thoughts in the past?

PRENATAL HISTORY

Is the child your biological child?:

Does the child's mother have any history of medical problems?:

Did any medical problems arise during the pregnancy?:

Did mom take any medications during the pregnancy?:

BIRTH HISTORY

Was the delivery vaginal or C section?:

If it was by C Section, why?:

How many weeks long was the pregnancy?:

What was the birth weight?:

Were there any complications associated with the delivery?:

Were there any problems in the newborn period?:

NEWBORN AND INFANT HISTORY

What was your child's behavior like as a young infant?:

Did your child have any feeding problems early on?:

Did your child have any feeding issues as an infant?

Did your child have any medical issues in the first 3 years such as ear infections, constipation, asthma, or eczema?

DEVELOPMENTAL HISTORY

Describe your child's development?:

About when did your child walk alone?

About what age did your child start using language to satisfy needs?:

Have you had developmental testing done and what are the results? :

Do you think your child had learning disabilities or processing problems:?

MEDICAL ISSUES

What medical issues has your child had since turning age 3?:

What medications has your child been on in his or her life and why and what has been the effect of these medications?

What medications and doses are your child on now and what symptoms are these medicines intended to treat?

Does your child have any medication allergies?:

Does your child have any known food or environmental allergies and how is this known and what reactions do you see?:

Has your child been on any special diets and what was the effect of these?:

What supplements is your child taking currently and what has been the effect of each as far as you can tell?

Are there supplements your child has taken in the past and what was the effect of them?

Does your child have any self imposed limitations on what he or she will eat?: Are there any apparent sensitivities to the texture, flavor, or color of food?:

What foods does your child eat or drink on an average day?:

Any major injuries?:

Any head injury?

Any previous surgery?:

Has your child seen a dentist? Any dental problems?:

"REVIEW OF SYSTEMS"

Have any of these issues been a problem for your child? If no, leave blank, if yes, please describe:

Apparent pain:

Vomiting or reflux:

Loose bowel movements:

Hard bowel movements:

Particularly foul smelling stool:

Mucous, blood, or undigested food in stool:

Difficulty passing stool:

Soiling of underwear:

Putting pressure on abdomen:

Ear infections:

Fevers:

Low body temperatures:

Breathing problems:

Stuffy nose:

Snoring:

Difficulty settling down to sleep:

Difficulty staying asleep:

Staring spells:

Shaking or tremors:

Posturing:

Hand flapping or finger flicking:

Looking out the side of the eye:

Spins:

Jumps up and down:

Extra sensitive to sounds:

Extra sensitive to the feeling of clothing:

Makes unusual noises:

Lack of sensitivity to pain:

Rashes:

Rashes or redness around the anus:

Unusual odors:

Eating things that are not food:

Dry bumpy skin:

Birthmarks:

Difficulty seeing:

Difficulty hearing:

Are there any things that cause your child particular distress (for example crowds, or noise, or clothing)?:

What has your child's growth been like?:

ADOLESCENT HISTORY (If appropriate)

How has the behavior of your child changed with age?

How would you describe the relationship between each parent and your teen?

What are your hopes and expectations for your child's future?

What are your teen's social relationships like?

Do you suspect your child is sexually active?

Dou you suspect your child is using cigarettes, drugs, or alcohol?

PREVIOUS EVALUATIONS (Please bring in copies of testing results or doctor's notes if available)

Has your child had hearing testing?:

Has your child had developmental testing? By whom, and what were the conclusions?:

Has your child had testing through the school?

Has your child had imaging tests such as a CAT scan or an MRI?:

Has your child had an EEG to look for seizures?:

Has your child had specialty testing such as urine metabolic testing or testing for food allergies or toxic metals?:

Has your child ever been on special diets or supplements? What changes did you see? What happened when your child was re-exposed to foods that had been removed?:

What specialists such as psychiatrists and psychologists has your child seen, when were they seen, and what were the conclusions?:

What previous therapies have you tried, and what was the result of these therapies?:

IMMUNIZATIONS

As far as you know, is your child up to date with immunizations?:

Are there any vaccines your child was offered but didn't receive?:

Has your child had any apparent problems with immunizations?:

What are your plans for future immunizations?:

CURRENT TREATMENT PROGRAM

What is your child's current educational program?:

What other therapy is your child getting?:

EXPOSURE HISTORY

Was the pregnancy assisted in any way?:

Does mom have any exposures to toxins (heavy metals, chemicals at job or hobbies)?:

Does anyone else do anything that would bring toxins into the home?:

Do you suspect any toxicities in the home or in previous environments?:

Do you use iodized salt?: **If not you should make sure that you are using iodized salt at home.**

What sort of diet does your family follow?:

Does anyone smoke at home?:

FAMILY HISTORY

Please give the name and age of all siblings:

Please state if anyone in the family (parent, sibling, grandparent, aunt, uncle, or first cousin) has problems with any of these medical issues, identify the person and describe the problem:

Known metabolic or genetic disorders:

Autistic spectrum disorder:

Attentional problems:

Depression:

Anxiety:

Unusual personality:

Learning disabilities:

Substance abuse issues:

Other psychiatric issues:

Allergic rhinitis:

Eczema:

Food allergies or sensitivities:

Asthma or breathing problems:

Obesity:

Difficulty growing:

Diabetes:

Cholesterol:

Heart disease:

High blood pressure:

Abnormal heart rhythms:

Sudden unexpected death:

Fatigue:

Constipation:

Stomach or intestinal disorders:

Headaches:

Seizures:

Other neurologic disease:

Thyroid or other hormonal problems:

Bedwetting:

Urination problems:

Dental disease:

Chronic unexplained symptoms:

Is anyone else in the family who has a medical problem that might be relevant?:

Is anyone else in the family on a special diet or taking supplements?:

SOCIAL HISTORY

Who lives at home?:

Who cares for the child during the day?:

Do you get any extra help or need any extra help to care for your child

What is the child's father's occupation?:

What is the child's mother's occupation?:

Has either parent had to change occupations to care for the child?:

Are you currently experiencing financial distress?:

Are there any other stressors?:

How are people getting along?:

Does the child play video games?:

Is there anything else you would like me to know?:

Please bring copies of any laboratory or developmental testing or previous letters from evaluations.

CHILD/ADOLESCENT SYMPTOM CHECKLIST

Name of Child:_____ Date of Birth: _____ Age:_____ Date:_____

Name of person completing this form:_____ Relationship to child: _____

Please circle the symptoms that apply to this child in the past few weeks:

	Never	Rarely	Sometimes			Always
Hyperactive	0	1	2	3	4	5
Fidgety	0	1	2	3	4	5
Difficulty sitting still	0	1	2	3	4	5
Short attention span	0	1	2	3	4	5
Easily distracted	0	1	2	3	4	5
Forgets easily	0	1	2	3	4	5
Does not turn in assignments	0	1	2	3	4	5
Disorganized	0	1	2	3	4	5
Poor grades	0	1	2	3	4	5
Academically behind	0	1	2	3	4	5
Learning difficulties	0	1	2	3	4	5
Speech problems	0	1	2	3	4	5
Reading difficulty	0	1	2	3	4	5
Math difficulty	0	1	2	3	4	5
Defies authority	0	1	2	3	4	5
Loses Temper	0	1	2	3	4	5
Argumentative	0	1	2	3	4	5
Gets angry easily	0	1	2	3	4	5
Gets into fights	0	1	2	3	4	5
Throws or breaks objects	0	1	2	3	4	5
Problems with temper	0	1	2	3	4	5
Homicidal thoughts	0	1	2	3	4	5
Suicidal thoughts	0	1	2	3	4	5
Suicidal attempts, gestures	0	1	2	3	4	5
Hurts animals	0	1	2	3	4	5
Lies	0	1	2	3	4	5
Sets fires	0	1	2	3	4	5
Steals, shoplifts	0	1	2	3	4	5
Breaks curfew	0	1	2	3	4	5
Runs away form home	0	1	2	3	4	5
Skips school	0	1	2	3	4	5
Smokes	0	1	2	3	4	5
Uses alcohol	0	1	2	3	4	5
Uses drugs	0	1	2	3	4	5
Legal problems	0	1	2	3	4	5
Is or has been on probation	0	1	2	3	4	5
Is or was in juvenile detention	0	1	2	3	4	5
Problem making or keeping friends	0	1	2	3	4	5
Sleep disturbance	0	1	2	3	4	5
Trouble falling asleep	0	1	2	3	4	5

Interrupted sleep	0	1	2	3	4	5
Early morning wakening	0	1	2	3	4	5
Oversleeping	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Crying spells	0	1	2	3	4	5
Irritability, edginess	0	1	2	3	4	5
Excessive worry	0	1	2	3	4	5
Low energy, tired	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Overeating	0	1	2	3	4	5
Weight gain or loss	0	1	2	3	4	5
If so, how much in the last 3-6 months: Gained_____ Lost _____						
Lack of interest in usual things	0	1	2	3	4	5
Difficulty separating	0	1	2	3	4	5
Won't sleep in own bed	0	1	2	3	4	
Fears of ordinary things	0	1	2	3	4	5
For example, storms, crowds, doctor, germs, closed spaces, flying						
Excessive hand washing	0	1	2	3	4	5
Rituals that child must do	0	1	2	3	4	5
For example, need to check and recheck things in a certain order						
Counting behavior, thoughts	0	1	2	3	4	5
Need for organization, cleanliness	0	1	2	3	4	5
Anxiety, nervousness	0	1	2	3	4	5
Panic/anxiety attacks	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Stomachaches	0	1	2	3	4	5
Unexplained physical symptoms	0	1	2	3	4	5
Dizzy spells	0	1	2	3	4	5
Suspiciousness, paranoia	0	1	2	3	4	5
Hears voices (that others don't)	0	1	2	3	4	5
Sees things (that others don't)	0	1	2	3	4	5
Wets bed	0	1	2	3	4	5
Soils underclothing	0	1	2	3	4	5
Eating disorder	0	1	2	3	4	5
Picky eater	0	1	2	3	4	5
Binge-eating, purging	0	1	2	3	4	5
Anorexia	0	1	2	3	4	5
Trauma, other abuse	0	1	2	3	4	5

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Phone: (248)-327-7175, Fax: (248)-750-0698, Email: admin@shalvapsychiatry.com

Dear Client,

The Shalva team welcomes you to our clinic. We are excited to have you establish care with our practice. We have a wide range of services under one roof to serve you. Please take a moment to review our policies, your responsibilities and our payment requirements. Please feel free to contact us should you need additional guidance or have concerns.

Charges and Insurance

We require a credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Shalva will make every effort to check benefits and send claims to your insurance. You are ultimately responsible for all unpaid fees for services you receive that are not covered by your insurance.

You are responsible for calling your insurance company and understanding what your benefits are and what your responsibilities are for payment including co-pays, co-insurances and deductibles. You are responsible for ensuring that your financial obligations for health care received are fulfilled as promptly as possible.

Personal property

Shalva Psychiatry is not responsible for cash, valuables and personal items you bring. Please do not leave these things unattended at any time.

Cancellation Policy

We understand there may be times when you may miss an appointment due to unforeseen emergencies or obligations, including medical emergencies. However, the cost of the missed appointments and expensive equipment unused need to be shared. Insurance companies DO NOT PAY for missed appointments.

If you are late to your appointment and can only receive part of the appointment time that was reserved for you, you will have to pay for the rest of the missed session time, prorated on the $60-per-session fee detailed below. Therefore, we will have to charge you a part of this cost if we did not receive 48 hours advanced notice for neurofeedback and 24 hours advance notice on therapy and medical visits. The fee for **No Shows/No Calls** is $120 for a clinician; $60 for a tech. You must cancel appointments 24 hours beforehand or you will be charged a **cancellation fee of $60. Repeat no shows/no calls could be grounds for discharge. In addition, therapy clients who no show more than twice could lose their standing appointment and could be charged up to the full price of the visit. This also applies to phone and video consultations.**

Patients may be asked for random urine samples as part of their treatment plan. In addition, clinicians may recommend taking non-addictive medications or supplements to help in their care.

I, _____ agree and understand the above policy and acknowledge understanding of my obligations.

Signed, Dated,

_____ _____

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CONSENT FOR TREATMENT (GENERAL)

I hereby authorize **Dorit Ben-Ami, MD** /("**Physician**"), **Physician's associates** and **Physician's employees** to provide services to **me / my child** (*circle one*) and to perform any examinations, treatments, diagnostic tests or procedures which, in **Physician's** judgment, may be advisable.

Physician will explain the services and treatment I/my child will be receiving, including a description of the purpose, method, significant potential risks/complications, and alternatives. **Physician** will also explain the consequences of non-treatment. I understand that I have an opportunity to ask questions and understand that the **Physician**'s responses should be satisfactory to me prior to agreeing to treatment. **Informed Consent Agreements** will be presented as appropriate according to treatments suggested by **Physician.**

I understand that medicine is not an exact science and that all possible outcomes and/or complications cannot be anticipated and that no implied or expressed promises or guarantees will be made. I further understand that some of the treatments and medical therapies recommended by **Physician** may be innovative, not widely accepted and may not meet the established standard of care. These treatments may also not be supported by clinical research. In addition, some of these treatments may have side effects, including worsening symptoms and adverse changes in laboratory test results. Such side effects may be temporary or permanent.

I understand the importance of my participation in my treatment. I agree to abide by the medical plan prepared by **Physician** and to not make any changes in the medical plan without first consulting with **Physician**. I agree to maintain those records requested by **Physician** and to communicate any concerns about the treatment or side effects to **Physician**, as soon as possible.

I authorize **Physician** to retain the services of other professionals or health care providers, whose services are considered necessary by **Physician**, to assist **Physician**. I understand and agree that charges for services provided by these individuals are separate and distinct from those of the **Physician**.

In consideration for services rendered or to be rendered to me by **Physician**, I hereby assign to **Physician** and authorize payment directly to **Physician** of any insurance benefits or other payments by third parties otherwise payable to me. I understand I am financially responsible to **Physician** for charges not covered by any insurance.

I understand that medications can have side effects which will be reviewed by Dr Ben Ami at the time of prescribing. It is also my responsibility to review the clinical information provided by the pharmacy or with sample medications for all new prescriptions.

I specifically acknowledge that no guarantees of any kind have been made to me as to course, duration, or result of the treatment. I give this general consent to treatment and the use of complementary/alternative modalities voluntarily on my behalf and on behalf of my child, for whom I am the legal representative. I come to this arrangement as an informed consumer specifically seeking conventional, natural, and alternative approaches from **Dorit Ben-Ami, MD or an associate provider**

Consent for Treatment and Authorization to Release Information CONTINUED:

I hereby authorize **Dorit Ben-Ami, MD or associate provider** through its appropriate personnel, to perform appropriate assessment and treatment procedures on the above named patient.

I further authorize **Dorit Ben-Ami, MD or associate provider** to release any information required to effect treatment and continuation of care relating to the above named patient (this does not affect your HIPAA privacy rights).

Patient/Guarantor Signature _____ Date _____

Email Correspondence:

As Dr. Ben-Ami is a specialist and understands that occasionally there will be a question or a need for clarification, she or an associate provider is willing to engage in patient care to a limited extent via email with the following understanding.

I, (please print name) _____, hereby approve Email communication with Dr. Ben-Ami/associate provider. I understand as noted above that Email is not secure and that private health information might be revealed through Email. I do not hold Dr. Ben-Ami accountable for any breach in protected health information, accidental or otherwise. The information to be exchanged can include the results of Laboratory Testing, Billing information, and medical discussions with office staff. It is important to note that Dr. Ben-Ami or associate providers may not check her email daily and urgent questions or concerns should be communicated via telephone, not email. Also, sensitive and private medical issues are best dealt with face-to-face or via a phone consultation, not email.

Preferred E mail Address: _____

Signed: _____ Date: _____

Phone Consults: Whenever possible, a face-to-face encounter is the best way to evaluate progress and provide personal care. If needed, phone consultations will be scheduled and all copays, fees, deductible must be paid at time of service.

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CREDIT CARD ON FILE POLICY

At Ben-Ami Psychiatry and Psychotherapy, dba Shalva Adult and Child Psychiatry we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. We will use this card for missed appointments, copays and past due balances on your account. If you are using a Health Savings or Flexible Spending credit card, please ensure you fund the account before the date of service. Thank you for your cooperation.

I authorize Shalva Integrative Mental Health to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number _____ Exp. Date ____ / ____ / ____

Cardholder Name _____ Validation Code_____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Shalva Integrative Mental Health to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Shalva Integrative Mental Health. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Shalva Integrative Mental Health in writing and the account must be in good standing.

Patient Name (Print): _____

Responsible Party (Print): _____

Patient/Guardian Signature: _____ Date: ____ / ____ / ____