MICHIGAN STATE UNIVERSITY
HEALTHTEAM

Date _____ MRN _____ (For Office Use Only)

PATIENT INFORMATION

Patient Name _____ SS# _____
Last First M.I.

Age _____ Date of Birth _____ Male Female Marital Status _____ Email _____

Address _____
Street/Apt # City State Zip Code

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____

Employer's Address _____
Street City State Zip Code

MSU Student? Yes No If Yes, Student # _____ MSU Athlete? Yes No

Emergency Contact Person #1 _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Emergency Contact Person #2 _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Primary Care Physician _____ Telephone _____

Address _____
Street City State Zip Code

Referring Provider (if not PCP) _____ Telephone _____

Address _____
Street City State Zip Code

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Person Responsible for Payment _____
Last First M.I.

Date of Birth _____ SS# _____ Relationship to Patient _____

Address – **Same as Patient** ☐ _____
Street/Apt # City State Zip Code

Phone: Home _____ Work _____ Cell _____

Employer _____ Address _____
Street City State Zip Code

Other Parent's Name _____ Date of Birth _____
Last First M.I.

Other Parent's Address – **Same as Patient** ☐ _____
Street/Apt # City State Zip Code

Other Parent's Phone: Home _____ Work _____ Cell _____

INSURANCE INFORMATION

INSURANCE PLAN ______________________________ Effective Date ______________ Primary ___ Secondary ___

Insurance Plan Address ______________________________

Insurance Plan Phone# ___________________ Auth/Precert Phone# ___________________ Customer Service Phone# _________________

Name of Policyholder ______________________________ Date of Birth ______________ Gender ______

Employer & Address ______________________________

SSN _________________________ Relationship to Patient ______________________________

Policyholder Address/Phone # ______________________________

Contract/ID/Group # ______________________________ Service Plan # ____________ Coverage Type ________________

Primary Care Copay ___________ Specialty Copay ___________ Mental Health Copay ___________ PT/SP/OT Copay ___________

INSURANCE PLAN ______________________________ Effective Date ______________ Primary ___ Secondary ___

Insurance Plan Address ______________________________

Insurance Plan Phone# ___________________ Auth/Precert Phone# ___________________ Customer Service Phone# _________________

Name of Policyholder ______________________________ Date of Birth ______________ Gender ______

Employer & Address ______________________________

SSN _________________________ Relationship to Patient ______________________________

Policyholder Address/Phone # ______________________________

Contract/ID/Group # ______________________________ Service Plan # ____________ Coverage Type ________________

Primary Care Copay ___________ Specialty Copay ___________ Mental Health Copay ___________ PT/SP/OT Copay ___________

INSURANCE PLAN ______________________________ Effective Date ______________ Primary ___ Secondary ___

Insurance Plan Address ______________________________

Insurance Plan Phone# ___________________ Auth/Precert Phone# ___________________ Customer Service Phone# _________________

Name of Policyholder ______________________________ Date of Birth ______________ Gender ______

Employer & Address ______________________________

SSN _________________________ Relationship to Patient ______________________________

Policyholder Address/Phone # ______________________________

Contract/ID/Group # ______________________________ Service Plan # ____________ Coverage Type ________________

Primary Care Copay ___________ Specialty Copay ___________ Mental Health Copay ___________ PT/SP/OT Copay ___________

WORKERS COMPENSATION / AUTO LIABILITY _______ Primary _______ Secondary Authorization Required? Yes No

Carrier ______________________________ Case/Claim # ___________________________

Claims Address ______________________________

Phone # ____ Contact Person ______________________________

Date of Injury/Accident ______________________________

Office Use Only	MRN	BP	Wt	Ht

Michigan State University Department of Psychiatry
Child and Adolescent Consultation Clinic

Please help us become acquainted with your child & family by the answering the following questions as thoroughly as possible.

Child's Name __ Male __ Female	Child's Date of Birth	Age	School	Grade

Your Name	Home Address	Child's Pediatrician or Family Doctor
Relationship to Child		Doctor's Address & Phone Number
Telephone __ Home __ Cell		

How did you hear of our clinic? __ Pediatrician/Family Doctor __ Therapist __ School __ Insurance __Other: _____

BACKGROUND INFORMATION

Chief Complaint? Please provide a brief description of your concerns and/or the reason for your visit.

Does your child or has your child difficulty with any of the following? Check all that apply.

__ Sleep problems
__ Eating problems
__ Sadness/crying
__ Anger/irritability
__ Tantrums/rages
__ Feeling hopeless/guilty
__ Unable to enjoy activities
__ Harm to self
__ Harm to others or property
__ Inflated self confidence
__ Episodic increases in energy
__ Excessive worries or fears
__ Nervous habits
__ Repetitive thoughts or actions
__ Panic attacks
__ History of traumatic event(s)
__ Problems with friends
__ Problems in classroom
__ Frequent physical complaints
__ Attention/concentration
__ Repetitive movements or sounds
__ Defiance
__ School avoidance or truancy
__ Bullying others or being bullied
__ Tobacco, alcohol or drug use
__ Lying or theft
__ Excess concerns about weight
__ Bizarre ideas or experiences
__ Hallucinations
__ Special idiosyncrasies
__ Sensory issues
__ Delays in development
__ Bedwetting or toileting issues
__ Nightmares
__ Snoring
__ Speech problems

Has your child ever been prescribed medications for this problem or mental health reasons? __Yes __No If yes, please complete the following:

Name of Medication	Dates Taken	Prescribed by	Reason	Outcome

Has your child been seen by a counselor/therapist in the past? __ Yes __ No If yes, please complete the following:

Name	Dates Seen	Reason Seen	Type of Therapy

Has your child been seen a psychiatrist in the past? __ Yes __ No If yes, please complete the following:

Name	Dates Seen	Reasons and/or Diagnoses?

Has your child ever been psychiatrically hospitalized? __ Yes __ No If yes, please complete the following:

Name	Dates	Reasons and/or Diagnoses?

Does your child drink caffeine (tea, pop, coffee, energy drinks, etc)? __ Yes __ No If so, how much? _____

Do you have any concerns about your child using drugs and/or alcohol? __ Yes __ No

If yes, please explain: _____

Do you have guns or other weapons in your home? __ Yes __ No

MEDICAL HISTORY

When was child last seen by their doctor? _____ Reason? _____

Does your child have any health problems? __ Yes __ No If yes, please list:

_____

_____

Please circle if your child has had the following:
Chicken Pox Measles Mumps Rheumatic Fever
Scarlet Fever Whooping Cough Roseola Polio
Meningitis Encephalitis Tuberculosis

Has your child ever experienced any of the following?
Hospitalization? __ Yes __ No
Surgery? __ Yes __ No
Heart problems? __ Yes __ No
Any accidents? __ Yes __ No
Any head injuries? __ Yes __ No
Had a seizure(s)? __ Yes __ No

** If yes to any, please describe below:

_____

_____

Is child allergic to any medication(s)? __ Yes __ No If yes, please list: _____

Does child take any prescribed medication(s)? __ Yes __ No If yes, please list:

Medication	Dose	How often	Reason

Vaccinations up to date? __ Yes __ No __ Don't Know

Does child take vitamins, minerals or other non-prescription medications? __ Yes __ No Is so, list:

Name	How often	Reason

DEVELOPMENTAL HISTORY

Pregnancy Normal pregnancy? __ Yes __ No

If problems, please describe: _____

During pregnancy, did mother use any of the following? If yes, provide details regarding use, timing, amount, etc..

Medications? __ Yes __ No _____ Alcohol? __ Yes __ No _____

Tobacco? __ Yes __ No _____ Illicit drugs? __ Yes __ No _____

Labor & Delivery

Full Term? __ Yes __ No If no? __ Premature __ Overdue By how many weeks? _____

Labor __ Easy __ Difficult How many hours?_____ Baby's presentation? __ head first __ breech

Delivery? Vaginal __ C-section __ Induced? __ Yes __ No Birth Weight _____ lbs _____ oz

If C-section, why? _____

Following delivery, did your child…

Need supplemental oxygen? __ Yes __ No
Need blood transfusion? __ Yes __ No
Need X-rays, CT or MRI? __ Yes __ No
Show signs of birth trauma? __ Yes __ No
Have other complications? __ Yes __ No

Newborn Period

Did child exhibit the following? How long? How long?

__ Yes __ No Irritability _____
__ Yes __ No Vomiting _____
__ Yes __ No Convulsions/Seizures _____
__ Yes __ No Difficulty Breathing _____
__ Yes __No Breastfeeding _____
__ Yes __ No Normal weight gain _____

Develop-ment

Any concerns your child was delayed in development? __ Yes __ No If yes, circle area(s) of concern: Motor / Language / Social

	Age		Age		Age
Sitting without help		Spoke single words		Weaned	
Crawling		Spoke in sentences		Bladder Trained	
Walking		Puberty		Bowel Trained	

In relationships to siblings and peers? __ Plays individually __ Plays in groups __ Competitive __ Cooperative __ Leader __ Follower

Education

Types of Classes: __ Regular Education __ Resource Room __ Alternative Education __ Home Schooling
__ Special Education __ Learning Disabled __ Emotionally Impaired __ 504 plan
__ Other - Please describe any additional interventions including school accommodations, tutoring, etc:

_____

Has your child had specific learning difficulties? __ Yes __ No Has your child undergone testing to evaluate? __ Yes __ No
If yes, please describe in detail below and bring copy of any testing results to your visit:

_____

Has your child ever skipped a grade? __ Yes __ No Repeated a grade? __ Yes __ No If yes to either, please describe:

_____

Name / title / phone number of person at school familiar with your child's behavior and academic performance.

_____

	Name of School	City	Date Began	Date Ended	Grades completed at this school
Preschool					
Elementary					
Middle School					
High School					

Please complete the following for current family situation. Additional lines available for stepparents, guardians, etc.

Relation	Name	Age	DOB	Birthplace	Education	Occupation	Religion
Mother							
Father							

Parents: __ Married __ Separated __ Divorced If remarried or previously married, please provide dates:

Dates _____ _____ _____ Mother _____ Father _____

If parents not together, what is custody agreement? _____

__ Deceased M / F Date/Circumstances _____

Siblings – Please complete the following for all siblings.

Name	Age	Sex	School or Occupation	Grade	Relationship (full, half, step, etc.)	Living at Home	Any Mental Illness?	Uses drugs or alcohol?
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N
		__ M __F				__Y __ N	__Y __ N	__Y __ N

Sources of family income? _____

Sources of family stress? _____

Living Arrangements – Please list all individuals residing in the home & their relationship to child?

_____ _____

_____ _____

_____ _____

_____ _____

Number of moves _____

Location	Dates	House / Apt / Other	Rent / Own
	to		
	to		
	to		
	to		

Has child ever lived away from family? __ Yes __ No If yes, explain: _____

If child is adopted?

Adoption Source _____ Age of child when first in home _____ Date of legal adoption _____

Reason/circumstance _____

What has child been told? _____

LEGAL HISTORY

Has your child ever been: In trouble with the police? __ Yes __ No Charged with a crime? __ Yes __ No
Arrested? __ Yes __ No Convicted of a crime? __ Yes __ No
On probation? __ Yes __ No In juvenile detention or jail? __ Yes __ No

If yes to any of the above, describe: _____

FAMILY HISTORY

Any family history of cardiovascular disease before age 35 including arrhythmia, fainting, sudden death, etc? __ Yes __ No

Please indicate any mental health history in each of the child's biological or blood relatives with an X in the corresponding column.

			Paternal (father's) Family				Maternal (mother's) Family		
	Siblings	Father	Aunts / Uncles	Grand parents	Cousins / Other	Mother	Aunts / Uncles	Grand parents	Cousins / Other
Depression									
Anxiety									
Obsessions or Compulsions									
Mania or Bipolar Disorder									
Psychosis or Schizophrenia									
Attention or Concentration Problems									
Hyperactivity Problems									
Learning Problems									
Mental Retardation									
Alcohol Problems									
Drug Use Problems									
Legal Problems									
Abuse or Neglect									
History of suicide attempts									
History of harming self									
History of harming others									
History of psychiatric hospitalization									
Use of psychiatric medication									

REVIEW OF SYSTEMS: Please check box marked YES if your child has experienced any of the following. If not, leave blank.

YES GENERAL
- ☐ Fevers/chills?
- ☐ Weight loss?
- ☐ Changes to energy level?

YES HEENT
- ☐ Glasses?
- ☐ Hearing problems?
- ☐ Ear infections and/or ear pain?
- ☐ Seasonal/environmental allergies?
- ☐ Strep throat?
- ☐ Sinus problems?

YES NEURO
- ☐ Vision changes or problems?
- ☐ Head injury?
- ☐ Trouble walking?
- ☐ Seizures?
- ☐ Headaches?
- ☐ Numbness/tingling?
- ☐ Clumsiness/balance problems?

YES CV
- ☐ Chest pain?
- ☐ Fainting?
- ☐ Feeling heart beating or racing?
- ☐ Problems with blood pressure?
- ☐ Heart murmur?

YES PULM
- ☐ Wheezing or asthma?
- ☐ Trouble breathing at rest?

YES ENDO
- ☐ Intolerance to heat or cold?
- ☐ Unusual weight changes?
- ☐ Problems with blood sugar?
- ☐ History of diabetes?

YES HEME
- ☐ Bleeding problems?
- ☐ Abnormal bruising?

YES GI
- ☐ Frequent stomachaches?
- ☐ Nausea and/or vomiting?
- ☐ Diarrhea?
- ☐ Constipation?

YES GU
- ☐ Problems urinating?
- ☐ Bladder or kidney infections?
- ☐ Nighttime incontinence?

YES MSK
- ☐ Joint pains or swelling?
- ☐ Growing pains?
- ☐ Muscle weakness?

YES SKIN
- ☐ Rashes?
- ☐ Picking?
- ☐ Large or unusual birthmarks?

Patient	
MRN	

MSU Psychiatry Clinic

No-Show Policy

Quality care for our patients is our top priority. Please take a few minutes to review our No-Show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a No-Show Appointment

MSU Psychiatry Clinic defines a No-Show appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment.
- Cancels with less than 24 hours' notice.
- Arrives more than 10 minutes late and is consequently unable to be seen.

Impact of a No Show Appointment

No-show appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient fails to show up for a scheduled appointment it:

- Potentially jeopardizes the health of the patient.
- Is unfair (and frustrating) to other patients who would have taken the appointment slot.
- Is disrespectful of the provider's time.

How to Avoid Getting a No-Show

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation

MSU Psychiatry Clinic will attempt to contact you 2-3 business days before your scheduled appointment to confirm your visit. If our automated system is unable to confirm with you over the phone, we will leave a message with your appointment date and time.

2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our clinic 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions, and to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or reschedule an appointment, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care, as well as giving us the opportunity to rebook the vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call at 517-353-3070.

Consequences of No-Show Appointments

1. You will be charged a $50 no-show fee for each missed appointment.
2. If you miss 3 or more appointments within a year, you will be discharged from the clinic.
3. If you are discharged from the clinic, your remaining scheduled appointments will be cancelled.
4. Only emergency medical treatment will be offered within the first 30 days of discharge.

I have read and understand the MSU Psychiatry Clinic No Show policy as described above.

Patient/Guardian Signature _____ Date _____