MICHIGAN STATE UNIVERSITY
DEPARTMENT OF PSYCHIATRY

PSYCHIATRIC ASSESSMENT SERVICES FOR
CHILDREN AND ADOLESCENTS

Thank you for your interest in Michigan State University’s Psychiatric Assessment Services for Children and Adolescents, a service of the Department of Psychiatry and the MSU HealthCare.

The enclosed packet of material needs to be completed and returned to our office before an appointment can be scheduled. **NOTE** If this packet contains five Connors forms, they do not need to be returned with the packet, please bring them with you to the first appointment.

Obtaining as much information as possible regarding your child will assist us in performing an accurate and thorough assessment. Please complete the enclosed forms as accurately and completely as possible and return them in the enclosed envelope.

If your child has had any previous psychiatric or psychological assessments, or has been assessed for special services through school, please enclose copies of these reports as well.

We will ask you to sign a Patient Authorization for Disclosure of Health Information for your child’s primary care physician in order to coordinate care.

*Please note that your child will be seen for the purpose of assessment and treatment recommendations only. Decisions regarding continuing treatment will be made based on the assessment findings. Participation in the assessment does not mean that we are assuming ongoing care.*

The Department of Psychiatry is a training institution. You will be scheduled with a Resident who is supervised by a licensed Psychiatrist. Note that a medical student may be observing in your care.

Thank you for your prompt consideration. If you have any questions, please feel free to contact us at (517) 353-3070.

Nikki Peterson
Intake Coordinator
Department of Psychiatry
Michigan State University
Telephone: 517-353-3070  Fax: 517-884-1817

Michigan State University Health Care does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health program or activities.
Patient Registration

Last Name: ___________________________ First Name: ___________________________

First Name Used: ___________________ DOB: ___________________ SSN: ___________________

Legal Sex: __________________________ Assigned at birth: __________________________ Gender Identity: __________________________

Preferred Pronoun: □ he/him □ she/her □ they/them

Sexual Orientation: □ Lesbian or gay or homosexual □ Straight or heterosexual □ Bisexual □ Something else □ Don't know □ Choose not to disclose

Street Address: ____________________________________________________________

City: ___________________________ State: _______________ Zip: _______________

Phone Number: ___________________________ Secondary Number: ___________________

Email (Not parent email if minor): __________________________________________

Language Preference: ___________________________ Ethnicity: __________________________

Race: ___________________________ 

Marital Status: ___________________________

PRIMARY INSURANCE

Holder: ___________________________ Group #: ___________________________

Policy: ____________________________

EMERGENCY CONTACT

Name: ___________________________ Relation: ___________________________

Phone Number: ___________________________ Phone Number: ___________________________

Secondary Number: ___________________________

PARENT/GUARDIAN(S)

Parent/Guardian #1 Name: ___________________________ Email: ___________________________

Street Address (if different than patient): __________________________________________

City: ___________________________ State: _______________ Zip: ___________________________

Parent/Guardian #2 Name: ___________________________ Email: ___________________________

Phone: ___________________________ 

Street Address (if different than patient): __________________________________________

City: ___________________________ State: _______________ Zip: ___________________________

SECONDARY INSURANCE

Holder: ___________________________ Group #: ___________________________

Policy: ____________________________

NEXT OF KIN

Name: ___________________________ 

Relation: ___________________________

Phone Number: ___________________________ Phone Number: ___________________________

Secondary Number: ___________________________

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Michigan State University Department of Psychiatry
Psychiatric Assessment Services for Children and Adolescents

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

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Male</th>
<th>Female</th>
<th>Child's Date of Birth</th>
<th>Age</th>
<th>School</th>
<th>Grade</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Your Name</th>
<th>Home Address</th>
<th>Child's Pediatrician or Family Doctor</th>
<th>Doctor's Address &amp; Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relationship to Child</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone</th>
<th>Home</th>
<th>Cell</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How did you hear of our clinic?</th>
<th>Pediatrician/Family Doctor</th>
<th>Therapist</th>
<th>School</th>
<th>Insurance</th>
<th>Other</th>
</tr>
</thead>
</table>

**BACKGROUND INFORMATION**

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

<table>
<thead>
<tr>
<th>Does your child or has your child difficulty with any of the following? Check all that apply.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep problems</td>
</tr>
<tr>
<td>Eating problems</td>
</tr>
<tr>
<td>Sadness/crying</td>
</tr>
<tr>
<td>Anger/irritability</td>
</tr>
<tr>
<td>Tantrums/rages</td>
</tr>
<tr>
<td>Feeling hopeless/guilty</td>
</tr>
<tr>
<td>Unable to enjoy activities</td>
</tr>
<tr>
<td>Harm to self</td>
</tr>
<tr>
<td>Harm to others or property</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dates Taken</th>
<th>Prescribed by</th>
<th>Reason</th>
<th>Outcome</th>
</tr>
</thead>
</table>

Has your child been seen by a counselor/therapist in the past? _Yes _No if yes, please complete the following:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dates Seen</th>
<th>Reason Seen</th>
<th>Type of Therapy</th>
</tr>
</thead>
</table>
Has your child been seen a psychiatrist in the past?  __ Yes __ No  If yes, please complete the following:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dates Seen</th>
<th>Reasons and/or Diagnoses?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Dates</th>
<th>Reasons and/or Diagnoses?</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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  Any accidents?  __ Yes __ No
- Surgery?  __ Yes __ No  Any head injuries?  __ Yes __ No
- Heart problems?  __ 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:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Name</th>
<th>How often</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**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
Labor & Delivery

Tobacco? _Yes _No
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? _Yes _No
Irritability
Vomiting
Convulsions/Seizures

How long?

Development

Any concerns your child was delayed in development? _Yes _No
If yes, circle area(s) of concern:
Motor / Language / Social

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Age</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting without help</td>
<td>Spoke single words</td>
<td>Weaned</td>
<td></td>
</tr>
<tr>
<td>Crawling</td>
<td>Spoke in sentences</td>
<td>Bladder Trained</td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td>Puberty</td>
<td>Bowel Trained</td>
<td></td>
</tr>
</tbody>
</table>

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

Education

Types of Classes:
Regular Education
Resource Room
Special Education
Learning Disabled
Alternative Education
Emotionally impaired
Home Schooling
504 plan

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:

<table>
<thead>
<tr>
<th></th>
<th>Name of School</th>
<th>City</th>
<th>Date Began</th>
<th>Date Ended</th>
<th>Grades completed at this school</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool</td>
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<tr>
<td>Elementary</td>
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<tr>
<td>Middle School</td>
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<tr>
<td>High School</td>
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</tbody>
</table>
Please complete the following for current family situation. Additional lines available for stepparents, guardians, etc.

<table>
<thead>
<tr>
<th>Relation</th>
<th>Name</th>
<th>Age</th>
<th>DOB</th>
<th>Birthplace</th>
<th>Education</th>
<th>Occupation</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
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<td></td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>School or Occupation</th>
<th>Grade</th>
<th>Relationship (full, half, step, etc.)</th>
<th>Living at Home</th>
<th>Any Mental Illness?</th>
<th>Uses drugs or alcohol?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>M / F</td>
<td></td>
<td></td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
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<tr>
<td></td>
<td></td>
<td>M / F</td>
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<td>Y / N</td>
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<td>M / F</td>
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<td></td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
</tr>
</tbody>
</table>

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 ________

<table>
<thead>
<tr>
<th>Location</th>
<th>Dates</th>
<th>House / Apt / Other</th>
<th>Rent / Own</th>
</tr>
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<tbody>
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Has child ever lived away from family?  ___ Yes  ___ No  If yes, explain:

If child is adopted?  ___ Yes  ___ No  Age of child when first in home Date of legal adoption

Adoption Source

Reason/circumstance

What has child been told?
**LEGAL HISTORY**

Has your child ever been:  
- In trouble with the police?  Yes No  
- Arrested?  Yes No  
- Charged with a crime?  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:  

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**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.

<table>
<thead>
<tr>
<th>Depression</th>
<th>Anxiety</th>
<th>Obsessions or Compulsions</th>
<th>Mania or Bipolar Disorder</th>
<th>Psychosis or Schizophrenia</th>
<th>Attention or Concentration Problems</th>
<th>Hyperactivity Problems</th>
<th>Learning Problems</th>
<th>Mental Retardation</th>
<th>Alcohol Problems</th>
<th>Drug Use Problems</th>
<th>Legal Problems</th>
<th>Abuse or Neglect</th>
<th>History of suicide attempts</th>
<th>History of harming self</th>
<th>History of harming others</th>
<th>History of psychiatric hospitalization</th>
<th>Use of psychiatric medication</th>
</tr>
</thead>
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</tbody>
</table>

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**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? 
  - **HEENT:** 
    - Glasses? 
    - Hearing problems? 
    - Ear infections and/or ear pain? 
    - Seasonal/environmental allergies? 
    - Sinus throat? 
  - **NEURO:** 
    - Vision changes or problems? 
    - Head Injury? 
    - Trouble walking? 
    - Seizures? 
    - Headaches? 
    - Numbness/tingling? 
    - Clumsiness/balance problems?

- **CV:** 
  - Chest pain? 
  - Fainting? 
  - Feeling heart beating or racing? 
  - Problems with blood pressure? 
  - Heart murmur? 
  - Wheezing or asthma? 
  - Trouble breathing at rest?

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

- **HEME:** 
  - Bleeding problems? 
  - Abnormal bruising?

- **GI:** 
  - Frequent stomachaches? 
  - Nausea and/or vomiting? 
  - Diarrhea? 
  - Constipation? 
  - Problems urinating? 
  - Bladder or kidney infections? 
  - Nighttime incontinence?

- **MSK:** 
  - Joint pains or swelling? 
  - Growing pains? 
  - Muscle weakness?

- **SKIN:** 
  - Rashes? 
  - Picking? 
  - Large or unusual birthmarks?
PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name (Last, First, Middle) ________________________________

Date of Birth: ___________________________ Phone #: ___________________________

I authorize the disclosure of my protected health information between the parties below:

Department of Psychiatry

909 Wilson Rd, West Fee Hall Room B119
Address

East Lansing, MI 48824-6537
City, State, Zip Code

Phone: (517) 353-3070
Fax: (517) 884-1817
Phone/Fax Number

SEND RECORDS TO ________ REQUEST RECORDS FROM ________ (PLEASE MARK ONE)

SPECIFY THE INFORMATION TO BE DISCLOSED: Please specify date(s)

☐ All of my behavioral health information ___________________________

☐ Ongoing Communication, as needed, between the parties named above ___________________________

☐ Progress Notes / Encounters ___________________________ ☐ Treatment Summaries ___________________________

☐ Psychiatric / Psychological Assessments ___________________________

☐ Psychological Testing ___________________________ ☐ Psychotherapy Notes ___________________________

☐ Lab Reports ___________________________ ☐ Immunizations ___________________________

☐ Medications ___________________________ ☐ Consultations ___________________________

☐ Information from other healthcare providers/facilities (please specify) ___________________________

☐ Other (please specify) ___________________________

PURPOSE OF THIS DISCLOSURE:

☐ Continuing Care ☐ Insurance ☐ Legal ☐ Disability ☐ Patient Request ☐ Workers Comp

Other (please specify) ___________________________

I UNDERSTAND that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may not be protected from further disclosures.

I UNDERSTAND that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, except in very limited circumstances. I may inspect or receive a copy of the information disclosed in accordance with this Authorization.

I UNDERSTAND that I may revoke this Authorization at any time by contacting the Psychiatry Clinic except to the extent that action has been taken in reliance on this Authorization. This Authorization expires ________________ (or one year from the date signed).

Signature of Patient or Personal Representative (Required) ___________________________ Date (Required) ___________________________

Name of Personal Representative and Relationship to Patient (or description of authority to act on behalf of the patient) ___________________________
Thank you for choosing the Michigan State University Department of Psychiatry. We are committed to providing our patients with the best possible care and minimizing administrative costs. Please review the information below.

- Insurances vary in their coverage, and it is the patient's responsibility to understand his/her mental health benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsible for any co-payments and deductibles at the time of service. This is an insurance company policy. Payment for professional services can be made with cash, check, VISA, MasterCard, Discover, or American Express.

- We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for psychiatric care is a contract between you and the carrier. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

- Our staff is happy to help with insurance questions related to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by your insurance company. Please contact Customer Service at the number listed on your insurance card.

- You will be asked to review your information, including demographics and insurance information, every year. Out of date information can cause unnecessary delays in the payment of your claim.

- No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our billing office.

- Missed Appointments/Late Cancellations: Missed appointments (no-shows) or appointments not cancelled with 24 hours' notice will be charged a $50 no-show fee. Charges for missed appointments are not covered by insurance. The charge will be billed directly to you, and you will be required to pay this fee prior to your next appointment. Recurrent no-shows (more than 2 within 6 months) or cancellations (more than 3 in 6 months) will result in a discharge from care.

- Outstanding Balances: We urge you to keep your account current. Account balances past due over 120 days will be sent to an outside agency for collection, at which time you will be discharged from care. Payment arrangements can be made with our Billing Office at (517) 884-2998.

Again, thank you for choosing us as your healthcare provider.
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 ____________