INTEGRATED PSYCHIATRIC SERVICES
HEALTHY MIND, HEALTHY BODY

Sonali Bora M.D.
Child, Adolescent & Adult Psychiatrist
Ph: 678-335-6020

New Patient Form – Child and Adolescent

Personal Information

Name*_____

First Middle Last

Gender*_____ Date of Birth (MM/DD/YYYY) _____

Address _____City*_____State*_____Zip Code*_____

Parent's Name_____

Parent's Phone*_____ Home Phone_____

Parent's Primary Email*_____

Parent's Secondary Email_____

Family Members Living at Home (age and relationship with patient)

_____

_____

Emergency Contact: Name*_____

Emergency Contact: Phone*_____

Child's School _____Child's Grade_____

Guarantor Information

Guarantor's Name_____

First Last

Guarantor's Birthdate (MM/DD/YYYY) _____

Guarantor's Address_____

Guarantor's City_____Guarantor's State_____Zip Code_____

Guarantor's Cell Phone Number_____

Guarantor's Alternate Phone_____

Guarantor's Email- Id_____

Guarantor's Relationship with Patient_____

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Insurance Information

Subscriber Name (Primary on Insurance) _____

Subscriber's Relationship with Patient _____

Insurance Company Name_____

Insurance Company Address*_____

Insurance Company City*_____ _____Insurance Company State*_____

Insurance Company Zip Code*_____

Insurance Company Phone_____

Insurance Holder's ID Number*_____

Insurance Holder's Group Number_____

Secondary Insurance Information

Does the Insured have a Secondary Insurance? Yes No

(If No, please skip the secondary insurance section.) ☐ ☐

Subscriber (Primary on Insurance) _____

Relationship with Patient _____

Secondary Insurer's Name_____

Secondary Insurer's Address_____

Secondary Insurer's City_____Secondary Insurer's State_____Zip Code_____

Secondary Insurer's Phone Number_____

Secondary Insurance Holder's ID Number_____

Secondary Insurance Holder's Group Number_____

Pharmacy Information

Current Pharmacy*_____

Pharmacy's Address*_____

Pharmacy's Zip Code*_____Pharmacy's Phone number*_____

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Medical Information

Visit Information: Referred by: _____

Principal Reason(s) for Requesting a Treatment/Consultation*:

_____

_____

_____

Area of Concern (Academic/Work)

☐ Difficulty with peers ☐ Difficulty with authority ☐ Behavioural problems

☐ Learning disability ☐ Difficulty with focus and concentration

☐ Language / speech delay ☐ History of current academic/work problems

Areas of Concern (Personal)

☐ Unduly sad ☐ Suicidal thoughts/ behaviour ☐ Temper tantrums

☐ Withdrawn / shy ☐ Uncontrollable habits / mannerism ☐ Strange/bizarre behaviour

☐ Overly anxious ☐ Homicidal thought /behaviour ☐ Risk taking behaviour

☐ Perceptual/visual disturbance ☐ Problem with self-care (eating, bathing, toileting)

Areas of Concern (family)

☐ Parent child problem ☐ Sibling conflict ☐ Marital conflict or co-parenting problems

☐ Recent family changes ☐ Recent trauma/loss ☐ Domestic violence/abuse

* Elaborate (Family changes/trauma/loss/violence/abuse)

_____

_____

_____

Current Medical Illnesses* (Enter NA if none):

_____

Prior Psychiatric Diagnosis/Treatment:

_____

_____

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Medication Allergies and Reactions* (Enter NA if none)

_____
_____
_____

Prior/Current Primary Care Physician_____

Prior/Current Primary Care Therapist_____

Prior/Current Mental Health Provider Psychiatrist_____

Past Treatment History:

_____
_____
_____

Partial Hospitalisation

☐ Intensive Outpatient Programs ☐ Hospitalisation ☐ None

Month/Year and Reason for Hospitalization_____
_____

Has the Patient Ever had Psychological Testing? Yes ☐ No ☐

If yes, then please email test results to info@int-psy.com

Family Psychiatric History:

_____
_____
_____

List Past/Current Psychiatric Medications Including Maximum Dosages and Frequency:

_____
_____
_____
_____