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:

____

____

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:

____

____

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