Main Line Psychiatric

New Patient Registration

(Please print clearly and complete all pages)

Name:_____ Today's date:_____

Sex: M F

Date of birth:_____/_____/_____

Home address:_____Phone: _____

_____

Email address:_____

Primary care physician:_____ Phone:_____

Therapist:_____Phone:_____

Pharmacy:_____Phone:_____

School (children or adolescents):_____Phone:_____

School Counselor:_____Phone:_____

Grade:_____ Educational Testing Performed? Y N Date performed:_____

Mother's Name:_____ Phone:_____

Father's Name:_____Phone:_____

Marital status: S M D W Sep

Custody arrangement (if applicable): _____

Additional Home address:_____

_____

Sibling names and ages:_____

Parent's employer name:_____ Job title:_____

Parent's employer name:_____Job title:_____

_____

Insurance Company:_____Phone: _____

Who referred you to this office? _____

For what problem(s) do you seek help? _____

_____

Psychiatric History

Please circle Y (yes) or N (no) by each question.		
Y	N	Have you ever before consulted a psychiatrist for your child?
Y	N	Have you ever consulted a psychologist, social worker, or any other type of therapist for your child?
Y	N	Has your child ever been hospitalized for psychiatric reasons?
Y	N	Has your child ever received shock treatments (electroconvulsive therapy)?
Y	N	Has your child ever attempted to harm himself or herself on purpose without intending suicide, such as to get a sense of relief or someone's attention?
Y	N	Has your child ever attempted suicide?
Y	N	Has your child ever assaulted or tried to harm anyone else?
Y	N	Has your child had contact with the legal system such as arrests or juvenile detention?
Y	N	Has your child ever injected anything into his or her veins?
Y	N	When your child first started school, did he or she have trouble separating from his or her parent or discomfort at being away from home?
Y	N	In school, did your child have more difficulty sitting still or paying attention than other kids, or was ever diagnosed as being hyperactive or having attention-deficit disorder?
Y	N	Did your child have any specific learning problems, such as with spelling, reading, math, or speech; has he or she been labeled a slow learner; or placed in special classes?
Y	N	Was your child ever the victim of physical or sexual abuse; violent crime; sexual assault, molestation, or harassment; natural disaster; motor vehicle or industrial accident; other types of injury; discrimination or persecution based on gender, race, ethnicity, religion, sexual orientation, etc.? (If Yes, please circle which one(s)).
Y	N	Has your child frequently wet his or her bed after age 5?
Y	N	Is your child or have they ever been markedly overweight?
Y	N	Has your child tried to lose weight despite family or friends saying that he or she is not overweight?
Y	N	To lose weight, has your child ever made himself or herself vomit or taken laxatives, diuretics (water pills), or diet pills?
Y	N	Any excessive exercising or injuries from sports?
Y	N	Does your child binge eat?
Y	N	Does your child self-induce vomiting after eating?
Y	N	Have you ever observed that your child appeared sad or depressed almost every day for at least two weeks?
Y	N	Has your child ever had compulsions (repetitive seemingly purposeful but unnecessary behaviors such as checking the doors several times before leaving home, frequent hand-washing, counting things repeatedly, etc.?

Y	N	Has your child ever had sudden attacks of anxiety or nervousness?
Y	N	Has your child ever had phobias (fears of specific situations or things)?
Y	N	Has your child ever found himself or herself in places without knowing how he or she got there, or been unable to account for what he or she had been doing for some period of time? (Please circle which one)
Y	N	While fully awake, has your child ever heard voices talking to him or her or about him or her that did not come from anyone near them?
Y	N	Has your child ever seen things, such as faces, animals, or ghosts, that other people could not see?
Y	N	Has your child ever tasted or smelled things or felt things touching them or crawling on them when nothing was there?
Y	N	When your child is in public, do they often feel that people are watching them, following them, talking about them, reading their mind, putting thoughts into their mind, trying to hurt or control
		them in some way, or plotting against them?
Y	N	Has it often happened that things your child has seen appeared larger, smaller, closer, or farther away than you knew them to be?
Y	N	In unfamiliar places, has your child often felt that they've been there before, or have familiar places often seemed strange, different, or unfamiliar to them?
Y	N	Has your child ever had a period of time lasting days to weeks when they seemed to feel clearly different than his or her usual self: their mood was euphoric or irritable; they seemed or felt more energetic, talkative, sociable, or creative; thoughts raced through their mind; they felt little need to sleep; they spoke very quickly; they ought things without considering whether they could afford them; they became sexually preoccupied and/or acted out sexually; they felt they had special powers?
Y	N	Has your child ever had a period of confusion, for example while hospitalized or ill, during which they became confused and lost track of where they were or what day it was or could not recognize people they knew?
Y	N	Does your child often forget where they put things, have trouble finding their way home, or forget what people tell them unless they write it down?
Y	N	Has your child ever had any abnormal movements, involuntary or voluntary?
Y	N	Has your child ever had any difficulties with movement or motor skills in general?

Medication History

Allergies to medication:

Please list any medications your child is now taking:

List only psychotropic medications that they have taken in the past. Please list dosage, length of medication trial, and effects (if known):

Please circle each of the following that your child ever took, even once:

Stimulants/ ADHD Medications

Adderall/**Adderall XR**
Focalin/dexmethylphenidate
Strattera/atomoxetine
Cylert/pemoline
Ritalin/**Concerta**/**Metadate**/**Methylin**/methylphenidate
Provigil/modafinil

Antidepressants/Anti-Anxiety Agents

Prozac/**Sarafem**/fluoxetine
Luvox/fluvoxamine
Effexor/venlafaxine
Remeron/mirtazapine
Sinequan/Adapin/doxepin
Vivactil/protriptyline
Anafranil/clomipramine
Desyrel/trazodone
Parnate/tranylcypromine
Moclobemide
Zoloft/sertraline
Celexa/citalopram
Effexor/venlafaxine
Cymbalta/duloxetine
Elavil/**Endep**/amitriptyline
Tofranil/imipramine
Triavil/**Etrafon** Limbitrol
Asendin/amoxapine
Serzone/nefazodone
Marplan/isocarboxazid
Paxil/**Pexeva**/paroxetine
Lexapro/escitalopram
Wellbutrin/**Zyban**/bupropion
Pamelor/**Aventyl**/nortriptyline
Norpramin/desipramine
Symbyax Surmontil/trimipramine
Ludiomil/maprotiline
Nardil/phenelzine
Eldepryl/deprenyl/selegiline

Mood Stabilizers & Anticonvulsants

Lithium/**Eskalith**/**Lithobid**
Lamictal/lamotrigine
Trileptal/oxcarbazepine
Lyrica/pregabalin
Depakote/**Depakene**/valproic acid
Tegretol/**Epitol**/**Equetro**/carbamazepine
Neurontin/gabapentin
Topamax/topiramate

Anti-anxiety medications/ Tranquilizers/ Sleeping Medications

Valium/diazepam
Paxipam/halazepam
Ativan/lorazepam
Dalmane/flurazepam
Halcion/triazolam
Sonata/zaleplon
BuSpar/buspirone
Librium/chlordiazepoxide
Centrax/prazepam
Xanax/alprazolam
Restoril/temazepam
ProSom/estazolam
Lunesta/eszopiclone
Tenex/guanfacine
Tranxene/clorazepate
Serax/oxazepam
Klonopin/clonazepam
Doral/quazepam
Ambien/zolpidem
Rozerem/ramelteon
Catapres/Clonidine

Antipsychotics/neuroleptics/major tranquilizers/anti-Parkinsonians (brand names in bold)

Risperdal/risperidone
Seroquel/quetiapine
Clozaril/clozapine
Geodon/ziprasidone
Zyprexa/olanzapine
Abilify/aripiprazole

Artane/trihexyphenidyl
Thorazine/chlorpromazine
Trilafon/perphenazine
Compazine/prochlorperazine
Orap/pimozide
Moban/molindone

Cogentin/benztropine
Mellaril/thioridazine
Stelazine/trifluoperazine
Torecan/**Norzine**/thiethylperazine
Navane/thiothixene
Loxitane/loxapine

Symmetrel/amantadine
Serentil/mesoridazine
Prolixin/fluphenazine
Haldol/haloperidol
Taractan/chlorprothixene

Others
Aricept/donepezil
Namenda/memantine

Exelon/rivastigmine

Reminyl/galantamine

Substance Use

Please circle each of the following that your child ever took, even once:

Alcohol	Ecstasy/MDMA/X	Marijuana/grass/pot/weed/hash/reefer
LSD	Mescaline	Peyote
Psilocybin/mushrooms	DMT	STP
PCP	Amphetamines/speed/diet pills	Non-prescribed stimulants (Ritalin, Adderall)
Cocaine/crack	Tobacco	Freon/Glue/other inhalants
Heroin/other opiates	Quaaludes	Barbiturates
Other downers	GHB/blue nitro	Abuse of prescription drugs of any kind

Family Psychiatric History

Please list any blood relative and their relationship to you if they have been treated or hospitalized for any mental/behavioral problems including depression, anxiety, psychosis, suicide attempt, alcoholism, drug abuse. If any family member has been prescribed psychotropic medications, please list the name of the medication, the reason it was prescribed, and the effect (if known).

Medical History

Has your child ever had a seizure?	Y	N
Has your child ever had a head injury?	Y	N
Has your child ever lost consciousness/blacked out/fainted?	Y	N
Has there ever been a sudden, unexplained death in a family member who was under 50 years old?	Y	N
Does your child have any heart problems or abnormalities?	Y	N
Does your child have a heart murmur?	Y	N
Has your child ever been medically hospitalized? (If yes, please list below)	Y	N
Has your child ever had surgery (tonsils, appendix, gallbladder, hernia, abdominal, heart)? (If yes, please list below)	Y	N

Please list all your child's current medical problems:

_____

_____

_____

_____

_____

Last Physical Exam:_____

Immunizations: _____

Last vision examination: _____

Last hearing examination::_____

First day of last menstrual period (girls): _____

MEDICAL HISTORY/REVIEW OF SYSTEMS CHECKLIST
Please circle each item your child has had:

Premature birth (specific how many weeks premature)
Birth trauma/injury
Hospitalized after birth
Mother used substances or had medical illness during gestation

Neurological Disorders:
Stroke Recurrent headache Encephalitis Meningitis Dizziness
Weakness Numbness Tingling
Glaucoma Cataract Loss of vision Retina/macular disease
Hearing loss Tinnitus/persistent ringing in the ears
B12: Folate:
Other neurological disorder (specify):

Dermatologic Disorders:
Itching Hives Psoriasis Eczema Severe acne Severe skin reaction to any medication
Other dermatologic disorder (specify):

Auto-immune Disorders:
Juvenile rheumatoid arthritis Lupus Fibromyalgia Multiple sclerosis Sarcoidosis
Other auto-immune disease (specify):

Respiratory Disorders:
Asthma Emphysema Chronic bronchitis Pulmonary embolus
Wheezing Shortness of breath Other lung disease (specify):

Cardiovascular Disorders:
High blood pressure Low blood pressure Fainting spells Rheumatic fever
Heart murmur Mitral valve prolapse Congestive heart failure Prolonged QT syndrome
Angina/chest pain Heart attack Endocarditis (heart valve infection)
Abnormal heart beat/arrhythmia Pacemaker insertion High cholesterol/triglycerides
Other heart problem (specify):

Gastrointestinal Disorders:
Esophageal reflux Peptic/duodenal ulcer Irritable bowel Persistent constipation/diarrhea
Crohn's disease Ulcerative colitis Diverticulosis Diverticulitis
Pancreatitis Hepatitis Jaundice Gallstones Encopresis (soiling)

Abdominal pains Persistent nausea/vomiting
Other stomach or intestinal problem (specify):

Urinary tract Disorders:
Kidney failure Kidney stones Recurrent urinary infections
Urinary blockage Incontinence Enuresis
Other bladder or kidney problem (specify):

Endocrine Disorders:
Diabetes Hypoglycemia Thyroid problems Growth delay/problems Infertility
Hormone supplementation TSH: T4: Other endocrine disorders:

Other Disorders:
Anemia Bleeding tendency Porphyria
Cancer (type?)
Positive HIV test Herpes Syphilis Mononucleosis
Malaria TB Lyme disease
Other infectious disease:
Poisoning Traumatic injury
Women only: ovarian cysts irregular periods hirsutism
Ovary removed Breast surgery Hormone replacement Birth Control Pill
Men only: priapism erectile dysfunction testosterone supplementation

Treatment Consent

1. I consent to psychiatric evaluation and treatment of my child, _____, by Taliba M. Foster, M. D. I understand that she does not, and cannot, guarantee any specific results. I understand that her ability to help my child depends on the completeness and accuracy of the information provided to her.

2. I consent to the exchange of information, such as diagnoses, medications prescribed, and diagnostic test results, between Dr. Foster, schools and other treating professionals when necessary to facilitate treatment. Otherwise, I understand that psychiatric records are confidential and privileged and will not be released to anyone without proper written authorization, unless legally required.

3. I consent specifically to the exchange of information, both for Taliba M. Foster, M.D. to provide and to receive information including diagnoses, medications prescribed, medical records, and diagnostic test results, from the following individuals and providers:

Y N Spouse/Partner/Significant Other: _____Phone:_____

Y N Therapist: _____Phone:_____

Y N School counselor: _____Phone:_____

Y N Primary Care Physician: _____Phone:_____

Y N Other Medical Specialists: _____Phone:_____

Y N Other Medical Specialists: _____Phone:_____

Y N Other (please specify):_____Phone:_____

Y N Other (please specify):_____Phone:_____

Y N Other (please specify):_____Phone:_____

4. I consent to the release to any third party payer or its agents any information necessary for the processing of a claim for services rendered. Should hospitalization be required, I consent to the release of any information needed for utilization review. Should prior authorization of outpatient treatment or prescription drugs be required, I consent to the release of any information needed.

5. I have read and agree to the terms of Dr. Foster's Office and Payment Policies. I understand that I am financially responsible for all charges, and that payments are due at the end of each session. In particular, I understand that I personally must pay her regular fee for the time reserved for any appointment which I miss without 24 hours notice.

6. The undersigned agrees, whether he or she signs as guardian, agent or as patient, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates himself or herself to pay the account of the physician. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

7. This consent is subject to revocation at any time, by written request, except to the extent that action has been taken in reliance thereon.

Patient's name:_____ Signature of patient:_____

Date:_____ Signature of parent/guardian:_____