Cinco Ranch
PSYCHIATRY
NICOLE STAHL, MD

Dear New Patient,

We are so glad you have chosen Cinco Ranch Psychiatry to provide this very important part of your child's health care. Our staff is committed to providing your family with the most caring, professional and confidential services possible. We want you and your child to feel comfortable and at ease in our office. This letter will provide details on what to expect at your first visit.

Your first appointment is a complete Psychiatric Evaluation. When you arrive, our patient service specialist will have you complete some initial paperwork. This will take approximately 15-20 minutes. After this is complete, Dr. Stahl will call your child's name and invite you and your child into her office where she will spend a few minutes getting to know some basic information about your family. Then, Dr. Stahl will spend approximately the next 30-40 minutes meeting with the parent alone to discuss the current problems that prompted you to seek treatment. We will also review the patient's complete medical history, psychiatric history, developmental history, educational history, social history and family history. If your child can not be left alone in the waiting room or play room during the parent interview, then another adult will need to be present to watch the child. Please do not bring siblings or other children to the initial appointment. The next 20-30 minutes will consist of an interview with the child or adolescent. The last 15 minutes will be spent with the parent and the child to discuss diagnostic impressions and treatment recommendations.

**Important Issues:**

1) INITIAL PAPERWORK

The Child Intake Questionnaire is required to be completed **prior** to your appointment. The estimated time to complete the initial paperwork is 30 to 60 minutes. The doctor needs ALL the requested information in order to make an accurate differential diagnosis. Please bring the **completed** paperwork with you to your first appointment. We will have some additional paperwork for you to complete when you arrive for your appointment. Please plan on arriving 15-20 minutes prior to your scheduled initial appointment time to take care of paperwork. If you arrive at your appointment time, the time for the evaluation may have to be abbreviated in order to stay on schedule and not delay the next patient's appointment. If we do not have enough time to complete the evaluation, you may have to schedule an additional appointment to complete the initial evaluation. We try our best to stay on schedule for our patients so you are not waiting to see the doctor!

**2)** OFFICE LOCATION **Please do not rely on your GPS as our location is new!!**

FROM I-10:

Travel west on I-10. Take Grand Parkway South Exit 743B and merge onto TX-99 S. Take exit for Cinco Ranch Blvd. Turn Right onto Cinco Ranch Blvd. In 5.4 miles, turn left on FM 1463. In approximately 0.8 miles (immediately after you pass Fry Rd), take a right into the driveway of Well Pet Center. Continue straight over

the speed bumps until you come to the third building on your right after passing by the Well Pet Center. Turn right to get to our office parking lot and we are the fourth office on your right, Suite 304. The address is: *5757 Flewellen Oaks Lane, Suite 304, Fulshear TX 77441.*

FROM WESTPARK TOLLWAY:

Travel west on Westpark Tollway/FM1093 until you reach FM 1463. Take a right onto FM 1463. Immediately before you reach Fry Rd, take a left into the driveway of the Well Pet Center Veterinary Hospital. Continue straight over the speed bumps until you come to the third building on your right after passing by the Well Pet Center. Turn right to get to our office parking lot and we are the fourth office on your right, Suite 304. The address is: *5757 Flewellen Oaks Lane, Suite 304, Fulshear TX 77441.*

Please call our office at (713) 332-4388 if you get lost or have any additional questions.

**3)** FINANCIAL POLICY

Payment information is taken when you make your initial appointment. For the first appointment, a credit card must be left on file to be charged 2 business days prior to your initial appointment. If this card declines, you will be taken off the schedule if we are unable to reach you to obtain an alternative payment method. For all follow up appointments, we accept CASH, CHECKS, and all major CREDIT CARDS.

The following is a brief list of services:

Initial Evaluation $350.00
Medication Therapy $160.00

**Regarding Insurance**

We will provide you with all the documentation necessary to file an insurance claim on your own. Your insurance plan will reimburse you directly. Please contact your insurance company to find out what your benefit amount is. Dr. Stahl does not accept assignment of benefits and does not participate in any network. She will be considered an out of network provider by your insurance plan. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We have no agreements to offer discounts for specific plans.

**Missed Appointments**

Unless canceled at least 2 business days in advance, our policy is to charge the credit card left on file for missed appointments at the full fee. Dr. Stahl does not double book appointments. Your appointment time is reserved for you. Please help us to serve you better by keeping scheduled appointments.

I have read and acknowledge the above financial policies regarding service fees and missed appointments.

_____ _____ _____

Name Signature Date

# Child Intake Questionnaire

Thank you for taking the time to answer the following questions. Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child write, N/A. If you need additional space, please feel free to write on the back of the sheet. This information is very helpful in making an accurate diagnosis.

Date _____ Referred by _____

Person completing this form _____ Relationship to child _____

What is the reason that you have sought an appointment at this time**?**

_____

_____

_____

**A. General Information**

Child's Name _____ DOB _____ Age _____

Sex _____ Address of child (including city, state and zip code) _____

_____

Child currently lives with: (check all that apply)

__ Biological Father __ Adoptive Father __ Grandfather

__ Biological Mother __ Adoptive Mother __ Grandmother

__ Stepfather __ Foster Father __ Other (Specify) _____

__ Stepmother __ Foster Mother

*(A **copy of legal custodianship** needs to be provided if child is cared for by persons other than living biological or adoptive parents.)*

Marital Status of Parents

___Married (for ____ years) __ Never Married __ Separated __Divorced __Widowed

If applicable, age of child when parents divorced _____

If applicable, what is current custody arrangement _____

(*Please bring **divorce decree** to the appointment)*

Mother's Information

Mother's Name _____ DOB _____ Best Contact Phone # _____

Address _____

Email Address_____

Currently employed __No __ Yes (Job Title _____ Employer_____)

Highest education completed _____

Father's Information

Father's Name _____ DOB _____ Best Contact Phone # _____

Address _____

Email Address_____

Currently employed __No __ Yes (Job Title _____ Employer_____)

Highest education completed _____

Other Residents in the Home

| Name | Age | Gender | Relationship to Patient |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**B. Residencies: Please** provide the following information if your child has had more than one residence: For type of residence please signify home, foster home, institution, other.

| Type of Residence | Dates from/ to | Reason for Placement | Results | Reason for Leaving |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**C. Education**

Current School _____ School District _____ Grade _____

Type of classroom placement (Regular, ED, LD, Resource, GT)

_____

_____

Has this child ever repeated a grade? _____ If yes, which ones, and what was the reason for repeating that particular grade? _____

School Educational Testing? __ No __ Yes, if yes what was the date? _____

Intelligence (IQ) __ Below Normal __ Normal __ Above Normal

Learning Disabilities (LD) __ No __ Yes, if yes in? _____

Emotional __ No __ Yes

Does this child currently receive any special education services? __ No __ Yes, if yes specify what type _____

Please list any other school related problems _____

_____

D-Hall's __ No __Yes Specify: _____

Suspended from bus __ No __Yes Specify: _____

ISS's __ No __Yes Specify: _____

Alternative School __ No __Yes Specify: _____

School/ Legal __ No __Yes Specify: _____

Tickets/ Warnings Numbers _____ When _____ For_____

Charges Numbers _____ When _____ For_____

***(Please bring copies of school testing/ behavior referrals, report cards, progress reports, etc.)***

**D. Social History**

How well does your child get along with:

Siblings _____

Parents _____

Teachers _____

Peers _____

Authority Figures _____

Does your child have close friendships? __ No __ Yes

What extracurricular activities is your child involved in? _____

_____

What are your child's interests/ hobbies? _____

_____

Has the child experienced any of the following stressors (check all that apply)

__ recent move __ change in schools

__ job change __ financial problems

__ personal/ family health problems __ marriage

__ divorce __ death

__ violence __ exposure to substance abuse

What is your religious affiliation?_____

Where do you attend services?_____

For how long?_____ Do you attend regularly?_____

Please rate the importance of your religious/spiritual beliefs.

__All Important __ Very Important __Somewhat Important ___Not Important

**E. Previous Mental Health History**

Has the child been seen by any of the professionals listed below for emotional/ behavioral problems such as ADHD, depression, anxiety, bipolar disorder, school refusal, substance abuse, etc.

Check all that apply

__ School Counselor

__ Pediatrician

__ Psychiatrist

__ Psychologist

__ Licensed Professional Counselor

__ Social Worker

For any blanks checked yes, please provide the following information. (Please list current or most recent treatments first)

| By Whom | When | Duration | For What | Results |
|---|---|---|---|---|
| | | From:<br>To: | | |
| | | From:<br>To: | | |
| | | From:<br>To: | | |
| | | From:<br>To: | | |

Has the child ever been placed on medication for treatment of emotional/ behavioral problems?

__ No __ Yes, please list below

| Name of Medication | Dose | Length of Trial | Effects (improvement) | | | Side Effects (Please specify) |
|---|---|---|---|---|---|---|
| | | | None | Slight | Much | |
| Past | | From:<br>To: | | | | |
| | | From:<br>To: | | | | |
| | | From:<br>To: | | | | |
| | | From:<br>To: | | | | |
| | | From:<br>To: | | | | |
| | | From:<br>To: | | | | |
| Current | | From:<br>To: | | | | |
| | | From:<br>To: | | | | |
| | | From:<br>To: | | | | |
| | | From:<br>To: | | | | |
| | | From:<br>To: | | | | |

Has your child ever been admitted to an inpatient psychiatric hospital, a residential treatment program, or a rehabilitation facility? __ No __ Yes, please list below.

| Name of hospital/ Facility | Date of admission | Duration of stay | Reason for admission |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Has your child ever attempted suicide? __No __ Yes, please explain method and date of attempt

_____

_____

**F. Substance Abuse History**

| Chemical | Last Use | Amount | How Often Used | How Long Used |
|---|---|---|---|---|
| Alcohol | | | | |
| Marijuana | | | | |
| Cocaine/ Crack | | | | |
| Inhalants | | | | |
| LSD | | | | |
| Prescribed Pills | | | | |
| Heroin | | | | |
| Other (specify) | | | | |

Has your child experienced any of these due to alcohol and/or illegal substance use:

__ Blackouts __ Withdrawal symptoms __ Cravings __ Overdoses

Has your child ever experienced legal problems (including arrest) due to alcohol and/or illegal substances.

__ No __ Yes, please explain _____

_____

**G. Medical Information and History**

Primary Care Physician

Name _____ Phone # _____ Address _____

Date of last physical exam _____

Is your primary care physician aware of this appointment? Y N

Preferred Pharmacy

Name _____ Phone # _____ Nearest Intersection _____

Specialist

Has your child ever seen a specialist such as a neurologist or cardiologist? __ No __ Yes, please list below

| Name | Date | Reason for Consultation |
|---|---|---|
| | | |
| | | |

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? Y N

Has your child ever had any heart problems? Y N
*(Including murmur, arrhythmias, high blood pressure, prolonged QT syndrome, high cholesterol/ triglycerides, other heart problems)* Please specify _____
_____

Does your child have any thyroid abnormalities? Y N

Does your child have any genetic syndromes? Y N

Has your child ever had diabetes? Y N

Has your child ever had any vision difficulties? Y N

Has your child ever had any hearing difficulties? Y N

Has your child ever passed out while exercising? Y N

Please list any other medical illnesses your child has (such as asthma, anemia, etc.)

_____

Has your child ever been medically hospitalized or had surgery? __ No __Yes, list below

_____

Any Recent Lab work Y N Please specify_____

Immunizations up to date Y N

Allergies/Sensitivities (drugs, foods, etc.)
_____

Current non-psychiatric medications (please include current dose and reason for medication)

_____

_____

Current supplements and/or Vitamins

_____

**H. Developmental History**

Pregnancy

Length in months (or weeks) if known _____

Were any medications used during pregnancy? __ No __ Yes, please specify.

_____

Did the mother use any of the following during pregnancy?

Cigarettes N Y If yes please specify quantity per day. _____

Alcohol N Y If yes please specify quantity per day. _____

Drugs N Y If yes please specify types and quantity. _____

_____

Do the current caretakers currently use alcohol or any types of drugs? N Y

If yes, how much alcohol? _____

If yes, what types of drugs and frequency? _____

Pregnancy complications (check all that apply)

__ bleeding __ high blood pressure

__ excessive vomiting __ sonograms

__ excessive weight gain __ rash

__ infections __ swelling

__ weight loss __ fever

__ kidney trouble __ toxemia

__ diabetes __ other, please specify _____

Delivery

Type of labor __spontaneous __ induced If labor was induced, please specify reason for induction.

_____

Type of birth delivery : __ normal __ breech __ cesarean section

Were there any problems with labor and delivery? __ No __ Yes, please specify.

_____

_____

Prenatal History

Baby's birth weight: __ pounds __ ounces

Baby's length at birth: __ inches

Number of days baby stayed in the hospital following his/her birth: __ days

APGAR score, if known: At birth ___ At 5 minutes ___

Any birth defects __ No __ Yes, please specify _____

_____

Any other problems or comments regarding this child when he/she was a newborn?

__ No __ Yes, please specify _____

_____

Any other problems or difficulties around the birth? __ No __ Yes, please specify _____

_____

How worried were your doctors about the overall health of the baby within the first few days?

_____

Infancy and Early Childhood

Are there any problems or comments regarding this child's infancy and early childhood development?

__ No __ Yes, please explain _____

_____

Child's approximate age when he/she began:

walking: ___ months

talking: (single words) ___ years

talking: (short sentences 2+words) ___ years

toilet training: daytime ___ years nighttime ___ years

**I. Abuse History**

Has the child been abused? __ No __ Yes

If yes, please provide the following information using these letters for the Abuse Type

P = Physical such as beating, slapping, pushing

S = Sexual such as touching, molesting, fondling, or intercourse

N = Neglect such as failure to feed, shelter, protect, provide medical treatment

V = Verbal such as name calling , shaming, belittling

| Child's Age | Abuse Type | By Whom | Effects | Who was told | Consequences of telling |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**J. Family Mental Health History (please notate whether on maternal or paternal side)**

Please list any blood relatives that have been treated or hospitalized for any mental/ behavioral problems.

| | Relationship to patient | Outpatient Treatment (specify) | Medications (specify) | Hospitalizations (specify number) |
|---|---|---|---|---|
| Depression | | | | |
| Bipolar disorder | | | | |
| Anxiety disorder | | | | |
| Eating disorder | | | | |
| Learning disorder | | | | |
| Substance Abuse<br>___ Alcohol<br>___ Drugs | | | | |
| ADHD | | | | |
| Suicide or suicide attempt | | | | |
| Schizophrenia | | | | |
| Legal problems | | | | |
| Other (please specify) | | | | |

**K. Family Medical History**

| | Relationship to patient |
|---|---|
| Cardiac disease (including arrhythmias, QT prolongation, hypertension) | |
| Diabetes (specify Type 1 or 2) | |
| Thyroid disease | |
| Seizures | |
| High Cholesterol/ Triglycerides | |
| Early cardiac death of family member (under the age of 40) | |

**L. Current Symptom Checklist** (Please check all symptoms that your child is currently experiencing)

__sad mood

__irritable mood

__abnormally elevated mood (feeling "on top of the world")

__sleep difficulties (falling or staying asleep) Please specify_____

__problems with appetite (eating too much or too little) Please specify_____

__low energy

__excessive problems separating from parents/guardians or leaving home

__excessive fear of something in particular (please note specifically)_____

__excessive fear of social situations

__excessive worries

__recurrent and persistent thoughts Please specify_____

__repetitive behaviors Please specify_____

__ reading skills substantially below what is expected

__ mathematics skills substantially below what is expected

__ writing skills substantially below what is expected

__ poor motor coordination

__ poor eye contact/uses few gestures

__failure to develop appropriate peer relationships/difficulty relating to others

__failure to share interests with others (ex. pointing out objects of interest)

__failure to respond to other's kind actions (responding kindly to someone who has treated them kindly)

__makes careless mistakes

__has difficulty staying focused on what needs to be done

__does not seem to listen when spoken directly to

__does not follow through when given instructions or fails to finish activities (not due to refusal)

__difficulty organizing tasks

__avoids/dislikes tasks that require ongoing mental effort

__loses things necessary for tasks

__is easily distracted

__is forgetful in daily activities

__fidgety

__leaves seat when expected to remain seated

__runs/ climbs about excessively

__has difficulty playing quiet activities

__is "on the go"

__talks too much

__Blurts out answers before questions have been finished

__difficulty waiting their turn

__interrupts or intrudes on others

__hearing voices

__delusional thoughts

__Tics or other abnormal movements  Please specify_____

__problems with bowel movements (Please specify)_____

__food cravings (such as dairy or carbohydrates)  Please specify_____

__sensitivities to sounds, textures, or smells  Please specify_____

__excessive time on electronics  Please specify amount of time per day_____

How many hours does your child sleep each night?_____ Any naps?  Y  N

Please describe a typical diet for your child.

Breakfast_____

Lunch_____

Dinner_____

**Please remember to bring any of the following paperwork to your appointment if applicable: Divorce Decree, Legal Custodianship, School Records, Testing Records, Previous Psychiatric/ Therapy Records.**

**Please complete this form and bring it with you to your initial appointment.**

Cinco Ranch
PSYCHIATRY
NICOLE STAHL, MD

# Credit Card Authorization

I understand that payment is expected at the time of service by either cash, check, or credit card. I understand that the financial responsibility for services provided is mine, and that insurance is for my reimbursement if I choose to do so. I understand that I must file the insurance claim and that the physician will not file it for me.

**I understand that the credit card listed below will be charged for missed appointments and cancellations with less than 2 business days notice.** I am aware that insurance will not cover charges for missed or cancelled appointments. With appropriate notice, appointment slots can almost always be used to serve another patient.

I understand that if this credit card declines for a charge, that I will be billed for the missed appointment. No further appointments may be scheduled until the outstanding balance is paid.

I agree to notify the receptionist when I become aware of any changes in my address, phone number, marital status or responsible party that has occurred since my last appointment.

I, _____, hereby authorize Nicole Stahl, M.D., P.A. to charge my credit card for services rendered and time allotted for treatment at a rate of $350 for an initial appointment or $160 for a follow up appointment. If I am leaving this credit card on file for someone other than myself, I understand that my credit card can be charged for the patient's **appointments, unpaid fees, missed appointments or cancellations with less than 2 business days notice.**

Credit card # _____ Security Code_____ Exp. date _____

Name as printed on card_____

Billing Address: _____City: _____ State: _____

Zip_____ (Note: zip code must be for where the credit card statement is sent to.)

By signing below I am authorizing Nicole Stahl M.D. P.A. or Cinco Ranch Psychiatry to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this page and can thereby authorize this card to be charged:

_____ _____
Patient's Name Date

_____ _____
Responsible Party's Name Date

_____ _____
Responsible Party's Signature Date