Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

Name: _____ **DOB:** _____

Gender: MALE FEMALE **Social Security #:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Numbers:

Home: ( ) _____ Can we call you at Home? Yes No

Cell: ( ) _____

Work: ( ) _____ Can we call you at Work? Yes No

Email: _____

Marital Status (circle one): Single Married Divorced Separated

Race (circle one):

American Indian or Alaska Native	Black/African American	Chinese
Filipino	Guamanian or Chamorro	Korean
Hispanic White	Japanese	Other Asian
Native Hawaiian	Other Pacific Islander	Samoan
White/Caucasian	Other Race	

Ethnicity (circle one):

Cuban	Mexican/Mexican American	Not Hispanic or Latino
Other Hispanic or Latino	Puerto Rican	

Preferred Language (circle one):

English Spanish Chinese Italian Polish Russian French Turkish Other

Known Allergies: _____

Employer: _____ **Occupation:** _____

Are you a Student? Yes No **If yes, Name of School:** _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

Primary Care Physician: _____ **Phone #:** _____

Address: _____

Therapist Name: _____ **Phone #:** _____

Discipline: _____

Preferred Pharmacy Name: _____ **Phone #:** _____

Pharmacy Address: _____

EMERGENCY CONTACT:

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

PRIMARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

SECONDARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

For Partial Hospitalization Clients Only

Will you be driving to the program? _____

Make/Model/Plate #: _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

PH5623

ALLERGIES:_____ SPECIAL DIET:_____

1. CURRENT PROVIDER OF MEDICAL CARE (Include name and address of regular health care providers).

Physician/Program Name Address Phone Number

_____

_____

2. BIRTH AND DEVELOPMENT HISTORY (Check all that apply. Note complications in any areas in the comments section).

A. Pregnancy

Prenatal Care	❑ Yes	❑ No
Drugs/Alcohol/Cigarettes	❑ Yes	❑ No
Illness/Medications	❑ Yes	❑ No

B. Condition at Birth

Normal	❑ Yes	❑ No
Birth Weight	❑ Low	❑ Normal

C. Delivery

Full Term	❑ Yes	❑ No
Premature	❑ Yes	❑ No
C-Section	❑ Yes	❑ No

D. Infancy - Any Problems

Feeding	❑ Yes	❑ No
Sleeping	❑ Yes	❑ No
Responding to Environment	❑ Yes	❑ No

E. Milestones - Age at which child:

Walked without support_____ Spoke first word_____

Spoke first 3 word sentence_____

Toilet Trained - Urine_____ Bowel_____

Comments:_____

_____

3. FAMILY HISTORY (For each blood relative, provide the information requested. Note additional siblings under "Other").

A. Biological Family (Include current age, age at death (if deceased), cause of death).

Patient_____

Mother_____

Father_____

Sibling_____

Sibling_____

Sibling_____

Other_____

B. Illnesses (Indicate if biological family has had any of the following and include relationship to patient).

Tuberculosis_____
Diabetes_____
High Blood Pressure_____
Heart Problems_____
Cancer_____
Epilepsy_____
Blood Disease_____
Mental Illness_____
Alcohol Use/Abuse_____
Drug Use/Abuse_____
HIV/AIDS_____
Other_____

4. PATIENT HISTORY (Provide the information requested, as appropriate).

A. Immunization History

Are all required Immunizations up to date? ❑ Yes ❑ No

If no, what required Immunizations need to be completed?

_____

_____

B. Allergies

Specify_____

C. Medical History

Date of Last Physical _____ By whom _____

Significant Findings_____

_____

Ear Infections ❑ Yes ❑ No

Comments_____

_____

Head Injury ❑ Yes ❑ No

Comments (Include if ever unconscious after an injury or ever vomited after an injury)

_____

_____

Seizure Disorder ❑ Yes ❑ No

Comments_____

_____

D. Eating Disorder (Include history of purging, bingeing, food restriction, excessive exercise, laxative or diuretic abuse, pre-occupation with body weight, distorted body image and history of eating disorder treatment).

_____

_____

_____

_____

E. Dental History

Date of Last Exam_____ Cavities ❑ Yes ❑ No

Under Treatment (Specify)_____

Family Dentist (Name, Address, Phone Number)

_____

F. Other

Accident Prone ❑ Yes ❑ No

Comments _____

Last Vision Screening (Date and Findings)_____

Last Hearing Screening (Date and Findings)_____

Onset of Menses _____ Last Menstrual Period _____ Sexually Active ❑ Yes ❑ No

Comments (Include type of protection used) _____

_____

_____

_____

5. EVALUATION (To be completed by a Nurse Practitioner, Physician, Physician's Assistant or Registered Nurse).

T_____ P_____ R_____ B/P_____ Ht._____ Wt._____

Do you have current pain? ❑ Yes ❑ No

Do you have chronic or re-occurring pain? ❑ Yes ❑ No

*****If YES for either question, completed a Pain Assessment Form*****

Date of last physical within 1 year? ❑ Yes ❑ No

If No, Parent/Patient agrees to obtain history and physical by primary care physician? ❑ Yes

Does Patient require nutritional referral? ❑ Yes ❑ No

Patient is able to self administer medication while at Partial Hospital as per prescription? ❑ Yes ❑ No

_____

_____

_____

_____

Staff Signature _____ **Title** _____ **Date**_____

PH5617

PH5617

Patient Name: _____ Date of Birth: _____

Please list below the current medications that you are taking for your psychiatric illness (please include any herbal remedies or dietary supplements).

Name	Dose	Route	Frequency	Reason

Are you prescribed any medications for your medical illness? ❑ Yes ❑ No

Do you take any medication including over the counter medications or herbal remedies or any dietary supplements for any other reason? ❑ Yes ❑ No

If you answered "Yes" please enter those medications on the additional medical medication form.

Form completed by: _____ Date: _____

I have reviewed the patient's Home Medication List and compared it to the medications being prescribed.

_____ _____ _____

Physician / NP Signature ID# Date

PATIENT/FAMILY SELF REPORTED HOME MEDICATION LIST
PSYCHIATRIC MEDICATIONS LIST

Patient Name: _____ Date of Birth: _____

Please list any of the medications that you are currently taking for your medical illnesses, or any other reason, and the name of the practitioner who prescribes them. Please include any over the counter medications or herbal remedies or dietary supplements. Please update this list when medications are discontinued, doses are changed, or new medications (including over the counter products) are added.

Name	Dose	Route	Frequency	Reason	Prescriber Name

Form completed by: _____ Date: _____


PH5609

FAMILY

Name:	Age:	Occupation:	Check if Estranged:	Check if Resides w/ Client
(bio) Mother				
(bio) Father				
(step) Mother				
(step) Father				
Sibling				
Sibling				
Sibling				
(step) Sibling				
(Significant relationship with extended family member)				
Grandmothers				
Grandfathers				
Aunts				
Uncles				
Cousins				

FINANCIAL

If not applicable list N/A

Financial Problems

Difficulty meeting basic needs: i.e. food, shelter

Parent Job Change

Loss Employment

Assistance Received

EATING DISORDER

Changes in eating patterns?

Significant weight loss or gain?

Preoccupation with weight/body?

Excessive exercise?

Has child been diagnosed/treated for Anorexia, Bulimia, or Binge - Eating Disorder?

SEXUALITY

Patient "Dating" History_____

Sexually Active_____

Promiscuity_____

Pregnancy, Miscarriage, Abortions_____

Does client have children?_____

Conflict Re: Homosexuality_____

Has sexuality been discussed within the home?_____

Prostitution_____

CHILDHOOD HISTORY

	Yes / No	Age	Explain
Delayed Speech Development			
Poor Coordination			
Can't Sit Still			
Talk Too Much / Too Loudly			
Can't Tolerate Delay			
Impulsive			
Can't Accept Corrections			
Temper Tantrums			
Self Mutilation			
Wets the Bed			
Feeling Left Out			
Rocking			
Lying			
Stealing			
Vandalism			
Fights			
Accident Prone			
Easily Frustrated			
Constantly Touching Others			
Responds to Structure			
Doesn't Follow Directions			
Daydreams			
Short Attention Span			
Unresponsive to Discipline			

PARENT DISCIPLINE

Please explain parent discipline style/consequences to behavior_____

ADOLESCENT STRENGTHS

MENTAL HEALTH

Describe child prior to onset of illness_____

What changes in mood/behavior have you noticed since onset of illness?_____

What observed/reported symptoms on mental illness have you noticed?_____

When was onset of illness?_____

History of mental illness in the family_____

LEGAL

Order of Protection_____

PINS_____

Client Arrests/Criminal Record_____

Parent/Sibling Arrests/Criminal Record_____

Probation_____

EDUCATION

Attendance_____

Truancy_____

Classified ED or LD_____

Tutoring_____

Attends BOCES Program_____

Speech/Language Therapy_____

Extracurricular Activities (spots, music, etc.)_____

Summer School_____

Difficulty with Reading, Writing, Math_____

Adjustment Difficulty to Kindergarten/1st Grade_____

Poor Task Completion_____

Overall Academic Performance_____

INTERPERSONAL RELATIONSHIPS

Observation of Peer Relationships_____

Duration/Quality of Peer Group_____

Changes in Peer Group_____

Interest Level in Socialization_____

Isolation/Withdrawn from Peers_____

Role Models_____

Relationships with Adults Other than Family (i.e. Teachers, Clergy, Coaches, etc.)

_____

Aggressive Behavior_____

Physical Confrontations_____

Gang Memberships_____

Communication Skills_____

HISTORY OF ABUSE/TRAUMA

Physical Abuse_____

Sexual Abuse_____

Incest_____

Emotional/Verbal Abuse_____

Client Witnessing Physical, Sexual, Emotional, Abuse of Sibling or Parent

_____

CPS Involvement_____

Other_____

DRUG/ALCOHOL

	Drug Type	Currently Uses Yes / No	Past Use (How Long Ago)	Treatment Received
Client History				
Family History of Drug/Alcohol Abuse				
Name				

SIGNIFICANT FAMILY EVENTS

Name(s)	Client Age	Explain Events and Client Change in Functioning Following Event
Death of Relative		
Death of Friend		
Parent Separation		
Parent Divorce		
Parent Remarriage		
Parent/Marital Discord		
Separation from Siblings		
Moving Residence		
Change in School District		
Friend Moving Away		
Adoption		
Foster Care		

CULTURAL

Ethnic Background _____

Languages Spoken by Child/Parents _____

Religion _____

Mather Hospital
Northwell Health®

Patient Label

CS4414

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

Telehealth involves the use of electronic information and communication technologies to enable healthcare providers to remotely provide healthcare services to patients.

Services Provided:
Telehealth services offered by Northwell Health, Inc. (Northwell) through its providers may include consultation, diagnosis, assessment, treatment, education, care management and/or self-management (Services).

The information you provide may be used for:

- A review of health records, images, and/or test results
- Live two-way interactive audio and video; and/or
- Reviewing output data from medical devices

The electronic communication systems we use will incorporate security protocols to protect your privacy and will include measures to protect your data against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care by allowing you to remain in your home or at a doctor's office while another provider consults on your care.
- More efficient evaluation and care management.
- Obtaining expertise of a specialist, as appropriate.

Possible Risks:

- Delays in evaluation and treatment could occur due to failures of the equipment and technologies.
- A telehealth provider may decide that the transmitted information is of poor quality. If this is the case, you may need to reschedule the telehealth consult or meet with your local primary care doctor.
- Although unlikely, security protocols could fail, causing a breach of privacy of personal medical information.

Service Limitations:

- Our providers do not address medical emergencies. If you believe you are experiencing a medical emergency, you should dial 9-1-1 and/or go to the nearest urgent care center or emergency room.

By checking the box below, you acknowledge that you understand and agree with the following:

1. I hereby consent to receiving the Services via telehealth. I understand that it is up to the Northwell telehealth provider to determine whether my specific clinical needs are appropriate for a telehealth encounter.
2. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Northwell will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners who may be located in other areas, including out of state.

Patient Label

CS4414

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of Northwell. I agree to hold Northwell harmless for delays in evaluation or for information lost due to such technical failures.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth Services at any time for any reason or for no reason.
5. I understand that I will be directed to contact emergency medical services or dial 9-1-1 immediately in the event of a medical emergency.
6. I understand that alternatives to the telehealth Services, such as in-person Services are available to me, and in choosing to participate in the telehealth Services, I understand that some parts of the telehealth Services involving tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Northwell provider (e.g., labs or blood work).
7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Persons, other than the Northwell telehealth provider, may be present during the telehealth Services in order to operate the telehealth technologies.
9. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.
10. I understand that I will be responsible for all copays and deductibles associated with the telehealth Services that I receive. To the extent that I do not have insurance or to the extent that I have insurance that does not cover the telehealth Services, I acknowledge and agree that I will be responsible for the costs of the telehealth encounter. I have been able to ask questions regarding any costs that I may incur and my questions have been answered to my reasonable satisfaction.
11. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.
12. To the extent that I receive group therapy Services via telehealth, I understand and agree that (a) I must participate in a private location, (b) I am not to record the telehealth encounter, (c) I am not to invite or allow others who are not participants in the group to view or listen to the encounter, and (d) I must keep the ID, password and link to the virtual group encounter confidential. Upon the conclusion of a group therapy session or if I need to leave a group therapy session before it concludes, I agree to promptly logoff of the electronic communications technology platform used to conduct the Services. To the extent that I violate the terms of this Section 11, I understand and acknowledge that my participation in the session may be terminated, and I may no longer be able to participate in the group therapy Services via telehealth.

Mather Hospital
Northwell Health®

Patient Label

CS4414

CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES

Patient Consent:

I have read this document carefully, I understand the risks and benefits of the telehealth Services, I have had my questions regarding the procedure explained, and give my consent to participate in the telehealth Services under the terms described herein.

❑ **ACCEPT.** By checking the Box for this **"CONSENT FOR AMBULATORY-BASED TELEHEALTH SERVICES"** I hereby state that I have read, understood, and agree to the terms of this document.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name (Relationship if other than patient)
Telephonic Interpreter's ID#	Date	Time	

OR

Interpreter (Signature)	Date	Time	Interpreter's Name and Relationship to Patient (Print)
Witness to Signature (Signature)	Date	Time	Witness Name (Print)

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.