The Northshore Group

Date: _____ Clinician: _____

Child Information

Name _____ Age _____ Birth date _____ Sex ☐ M ☐ F

Address _____
(STREET) (APT #) (CITY & STATE) (ZIP CODE)

School _____ Grade _____ Social Security No. _____-____-_____

Parent and/or Guardian Information

*** Please list below only phone numbers our staff can use to call or text about appointments and the account.**

Father _____ Age _____ Birth date _____

Home Phone* _____ Work Phone* _____ Cell* _____

Address _____
(STREET) (APT #) (CITY & STATE) (ZIP CODE)

Social Security No. _____-____-_____ Religion _____ Education _____

Occupation _____ Employer _____

Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Sep Date: _____ Previous Marriages _____

Mother _____ Age _____ Birth date _____

Home Phone* _____ Work Phone* _____ Cell* _____

Address _____
(STREET) (APT #) (CITY & STATE) (ZIP CODE)

Social Security No. _____-____-_____ Religion _____ Education _____

Occupation _____ Employer _____

Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Sep Date: _____ Previous Marriages _____

Other _____ Relationship _____

Home Phone* _____ Work Phone* _____ Cell* _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Siblings and Relatives

Name	Relationship	Age/DOB	Education	Occupation	Residence

Referral Information

Source of Referral _____

Previous Psychiatric Sources Used _____

Family Physician _____ Office Phone _____

Would you like us to bill your insurance for you? ☐ Yes ☐ No If yes, please present card.

Have you called your insurance company for authorization (if required)? ☐ Yes ☐ No

OFFICE USE ONLY:
DX:_____

THE NORTHSHORE GROUP
1111 NORTHSHORE DRIVE – SUITE SOUTH 490
KNOXVILLE, TN 37919-4054
VOICE – (865)584-0171 FAX – (865)584-0174

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

_____
(Name of PCP, Therapist, Psychiatrist)

_____
(Phone number of above PCP, Therapist, Psychiatrist)

_____ City _____ State _____ Zip _____
(Address of above PCP, Therapist, Psychiatrist)

I, the above named patient, authorize my provider at The Northshore Group, and the clinician listed above to exchange information regarding my mental health / substance abuse treatment and medical healthcare for coordination of care purposes, including information relating to diagnosis, testing or treatment. I understand that this authorization shall remain in effect for the duration of my treatment and that I may revoke this authorization at any time by written notice.

Please select one: _____ I authorize communication with my PCP and or other healthcare provider
_____ I do NOT authorize communication with my PCP and or other healthcare provider

Signature of Patient / Personal Representative: _____ Date: _____

INFORMATION TO BE COMPLETED BY PROVIDER

Date of Initial Consult: _____ **Date of Next Appointment:** _____

Type of Service:
_____ **Individual Therapy**
_____ **Group Therapy**
_____ **Family Therapy**
_____ **Medication Management**
_____ **Other:** _____

Diagnostic Impressions: _____

_____

Treatment Recommendations / Medications: _____

_____

_____

Please call if further information would be helpful.

Provider: _____ Date: _____

Date Sent: _____

The Northshore Group

Child/Adolescent Developmental History

Patient Name: _____ **Age:** _____ **Sex:** _____

Date of Birth: _____ **Date:** _____

What was your child's birth weight?
_____ lbs. _____ oz. ❑ Unknown

Was delivery normal?
❑ Yes ❑ Unknown
❑ No; specify _____

Did the birth mother experience any physical or emotional problems during pregnancy?
❑ Yes; specify _____
_____
❑ No ❑ Unknown

Were medications taken during pregnancy?
❑ Yes; specify _____
❑ No ❑ Unknown

Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?
❑ Yes; specify _____
❑ No ❑ Unknown

Did the baby experience any problems immediately after birth?
❑ Yes; specify _____
_____
❑ No ❑ Unknown

Has your child ever required hospitalization?
❑ Yes; specify _____
_____
❑ No ❑ Unknown

Is there any history of physical, sexual or emotional abuse?
❑ Yes; specify _____
_____
❑ No ❑ Unknown

Is there a history of prolonged separations or traumatic events?
❑ Yes; specify _____
_____
❑ No ❑ Unknown

At what age did your child do the following?
(Italicized areas reflect normal development)
_____ smiled *(6 mths)*
_____ sat alone *(6 to 10 mths)*
_____ talked in sentences *(30 to 36 mths*)
_____ walked by self *(12 mths)*
_____ held head up (*3 to 4 mths)*
_____ fed self *(2yrs)*
_____ crawled *(6 to 10 mths)*
_____ rode a bike *(6 yrs)*
_____ rolled over *(6 mths)*
_____ talked in single words *(18 to 24 mths*)
_____ pulled up *(6 to 10 mths)*
_____ established toilet training *(2 ½ to 4 yrs)*

How would you describe your child's approach to new situations?
❑ Positive, jumps right in
❑ Withdrawn, tends not to participate
❑ Slow to warm up; cautious

How would you generally describe your child's overall mood?
❑ Positive (happy, laughing, upbeat, hopeful)
❑ Negative (depressed, cranky, angry, hostile)
❑ Mixed but more positive, than negative
❑ Mixed but more negative than positive

Which school is your child currently attending?
_____

Is your child currently receiving special services in this school?
❑ Yes; specify _____
_____
❑ No

Has your child ever failed a class or been held back for academic reasons?
❑ Yes; specify grade: _____
❑ No

Is your child expected to pass this school year?
❑ Yes
❑ No

THE NORTHSHORE GROUP

An Association of Independent Practitioners

Patient's Rights and Responsibilities Statement

Statement of Patient's Rights

Patients have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Patient's Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decision about their care made without regard to financial incentives.

Statement of Patient's Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and the provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon as they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of the care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Patient Signature Date

_____

Provider Signature Date