PATIENT INFORMATION AND REGISTRATION

Patient Name:_____ Nickname:_____
Last First MI

Social Security #_____-_____-_____ Date of Birth _____/_____/_____ Age_____

Gender: _____ Preferred Phone #: (_____) _____-_____

Mom's Cell Phone #:(_____) _____-_____ Dad's Cell Phone #: (_____) _____-_____

Email address: _____

Address:_____ City/State: _____ Zip Code: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact Person:_____ Phone #: _____

Siblings' Names: 1.) _____ Age:_____ 2.)_____ Age:____

3.)_____ Age:_____ 4.)_____ Age:____

Pharmacy:_____

Party Responsible for Payment (If other than Patient)

Name:_____ D. O. B.:_____

Address:_____ Phone #:_____

_____ Drivers License #:_____

Insurance Information

Primary Insurance Comp._____ Phone # :_____

Policy Holder's Name:_____ D. O. B.:_____

Policy I. D. # _____ Group # _____

I certify the information provided is correct and irrevocably authorize services be provided to the above named patient.

_____ Date_____
Signature of Patient/Parent or Guardian

Dear Parent,

In order to make the best use of time during the initial evaluation, I ask that you fill out the following questionnaire. It helps focus the evaluation on the important issues.

The first section addresses behaviors and emotions, the second section addresses health concerns (medical history and family history) and the third section addresses questions regarding development.

Thank you!
Caroline C. Batenburg, M.D.

Child's Name: _____ Sex: _____ Age: _____
Informant's Name: _____ Date: _____/_____/_____
Relationship to Child: _____

I notice the following things in my son/daughter:

Inattention	NO	SOME	YES
1. Fails to pay attention to details or makes careless errors.	_____	_____	_____
2. Doesn't stay on task.	_____	_____	_____
3. Doesn't listen when spoken to directly.	_____	_____	_____
4. Doesn't follow through on instructions.	_____	_____	_____
5. Has difficulty organizing tasks.	_____	_____	_____
6. Often avoids or dislikes repetitive activities.	_____	_____	_____
7. Often loses things necessary for tasks.	_____	_____	_____
8. Is often easily distracted by things around him/her.	_____	_____	_____
9. Is often forgetful in daily activities.	_____	_____	_____
		TOTAL YES:	_____

Impulsivity/ Hyperactivity	NO	SOME	YES
1. Often fidgets or squirms in seats.	_____	_____	_____
2. Often leaves seat when remaining seated is required.	_____	_____	_____
3. Often runs about or climbs excessively in situations in which it is inappropriate.	_____	_____	_____
4. Has difficulty playing or engaging in leisure activities quietly.	_____	_____	_____
5. Is often "on the go" or acts as if "driven by a motor."	_____	_____	_____
6. Often talks excessively.	_____	_____	_____
7. Often blurts out answers to questions before the question is completed.	_____	_____	_____
8. Often has difficulty awaiting turn.	_____	_____	_____
9. Often interrupts or intrudes on others.	_____	_____	_____
		TOTAL YES:	_____

At what age did these symptoms start? : _____
Have they been regularly present since that time? : _____

Oppositional Behavior	NO	SOME	YES
1. Often loses temper.	_____	_____	_____
2. Often argues with adults.	_____	_____	_____
3. Often actively defies adult requests or rules.	_____	_____	_____
4. Often deliberately annoys people. Peers refuse to play because he/she does silly/mean things.	_____	_____	_____
5. Often blames others for mistakes.	_____	_____	_____
6. Is often touch or easily annoyed.	_____	_____	_____
7. Is often angry/ resentful for long periods.	_____	_____	_____
8. Often does mean or spiteful things to others.	_____	_____	_____
		TOTAL YES:	_____

My son/ daughter…	NO	SOME	YES
1. Often bullies or threatens others.	_____	_____	_____
2. Often starts physical fights.	_____	_____	_____
3. Has used a weapon in a fight.	_____	_____	_____
4. Has been physically cruel to others.	_____	_____	_____
5. Has been physically cruel to animals.	_____	_____	_____
6. Has stolen while confronting a victim.	_____	_____	_____
7. Has forced another into sexual activity.	_____	_____	_____
8. Has set fires with intent to damage.	_____	_____	_____
9. Has deliberately destroyed property.	_____	_____	_____
10. Has broken into a house or building.	_____	_____	_____
11. Often tries to "con" others out of things.	_____	_____	_____
12. Has stolen things without confronting the victim (money from home/shoplifting)	_____	_____	_____
13. Stays out late without permission (beginning before age 13).	_____	_____	_____
14. Has run away from home at least twice.	_____	_____	_____
15. Is truant from school.	_____	_____	_____
		TOTAL YES:	_____

Substance Abuse	NONE	1-3 TIMES	MONTHLY	WEEKLY
1. Drinks alcohol.	_____	_____	_____	_____
2. Gets intoxicated.	_____	_____	_____	_____
3. Uses marijuana.	_____	_____	_____	_____
4. Uses amphetamines (speed).	_____	_____	_____	_____
5. Uses cocaine.	_____	_____	_____	_____
6. Uses IV or other drugs.	_____	_____	_____	_____
7. Uses nicotine (smoke/vape/oral)	_____	_____	_____	_____

Depression

Does your child ever get sad or depressed or irritable for no reason? What things make him/her grouchy?

_____

_____

_____

How often does your child feel sad or grouchy?

[ ] Never [ ] 1-3 times a month [ ] Weekly [ ] Daily

How long does the sadness last?

[ ] Minutes [ ] An hour [ ] Several hours [ ] All day, constant

Is your child sad or grouchy today?

[ ] No [ ] Yes

If yes, how long has this episode of sadness/irritability lasted?

[ ] Less than 2 weeks [ ] 2-4 weeks [ ] Months [ ] Longer than a year

In the past, has he/she ever been sad for six months in a row?

[ ] No [ ] Yes

If yes, when? _____

In the past, has he/ she ever been sad for two straight weeks at a time?

[ ] No [ ] Yes

If yes, when? _____

Has your child lost interest in things he/she used to think were a lot of fun (other than outgrowing them)?

[ ] No [ ] Yes

Has he/she lost the ability to get pleasure out of activities (parties, being with Friends, etc.)? [ ] No [ ] Yes

If yes, for how long? [ ] Less than 2 weeks [ ] 2-4 weeks [ ] Months [ ] Longer than a year

Has your child experienced the following associated with ongoing sadness/irritability?:

	NO	SOME	YES
1. Weight loss or loss of appetite.	____	____	____
2. Trouble falling asleep.	____	____	____
3. Trouble waking up in the middle of the night.	____	____	____
4. Falling asleep during the day.	____	____	____
5. Very slow to move around or do things when sad.	____	____	____
6. Paces, jumpy, or increases in irritability or activity when sad.	____	____	____
7. Loss of energy.	____	____	____
8. Makes negative comments about self, blames self for things that are not his/her fault.	____	____	____
9. Sad thoughts keep him/her form concentrating.	____	____	____

Does your child talk about hurting him/herself or say he/she wishes he/she were dead? [ ] No [ ] Yes

Has your child ever tried to hurt him/herself? [ ] No [ ] Yes

Mania

Has your child had any times when he/she was unusually happy or over-excited for no reason?
Has he/she been happy or excited that you worried that something was wrong with him/her?
[ ] No [ ] Yes
If yes, how long has he/she been that way?
[ ] Less than 2 weeks [ ] 2-4 weeks [ ] Months [ ] Longer than a year

Does your child have mood swings? [ ] No [ ] Yes If so, how long do they last? _____

Does your child have excessive anger outbursts you are concerned about? [ ] No [ ] Yes
Is the mood between the outbursts normal? or is there continued irritability?

Anxiety

Does your child worry about the following:	NO	SOME	YES
1. Upcoming tests or grades?	____	____	____
2. Meeting new people?	____	____	____
3. How he/she will do in upcoming games or sports teams?	____	____	____
4. Bad things happening to family?	____	____	____
5. Kidnappers or burglars?	____	____	____
6. That other kids don't like him/her?	____	____	____
7. Scared of trying new things?	____	____	____
8. Worries excessively about bad things (storms, wars)?	____	____	____

If the above symptoms of anxiety are present, does the patient:

	NO	SOME	YES
1. Feel restless and keyed up?	_____	_____	_____
2. Feel and look tired?	_____	_____	_____
3. Say he/she can't concentrate because of worrying about a problem?	_____	_____	_____
4. Get irritable when worried?	_____	_____	_____
5. Get physically tense when worried?	_____	_____	_____
6. Worries keep him/her form sleeping?	_____	_____	_____

Separation Anxiety

Does your child:	NO	SOME	YES
1. Worry that you will be hurt or die if you are away from him/her?	_____	_____	_____
2. Worry that he/she will be hurt or die if you are away from him/her?	_____	_____	_____
3. Refuse to leave you to go to school?	_____	_____	_____
4. Refuse to go to sleep without you near?	_____	_____	_____
5. Physically cling to you in public?	_____	_____	_____
6. Have nightmares about parents dying?	_____	_____	_____
7. Get headaches/stomach aches when you leave him/her?	_____	_____	_____
8. Throw temper tantrums to keep you from leaving?	_____	_____	_____
9. When he/she is away from you , does he/she repeatedly call and beg you to come for him/her?	_____	_____	_____

Phobias

Are there things your child is very scared of, much more than other children his age?

[ ] No [ ] Yes

If yes, what are they?

_____

Odd Behaviors

Please describe odd or bizarre behaviors exhibited by your child.

_____

_____

_____

During pregnancy, did the mother have problems with:

	YES	NO
High Blood Pressure	____	____
Diabetes	____	____
Depression	____	____
Anemia	____	____
Smoking	____	____
Alcohol/Drug Abuse	____	____
Serious Illness	____	____

Other problems: _____

How did the mother feel about this pregnancy? _____

How did the father feel about this pregnancy? _____

How long did labor last? _____

	YES	NO
Was labor spontaneous?	____	____
Was the baby born head first?	____	____
Was delivery by Caesarian?	____	____
Was the baby in an incubator?	____	____
Was the baby full term?	____	____

If no, how early? _____

How much did the baby weigh at birth? _____

How many days did the baby stay in the hospital after birth? _____

How many days did the mother stay in the hospital after birth? _____

At what age did your child do the following things:
Smile: _____
Sit without help: _____
Crawl: _____
Walk without support: _____
Say first words: _____
Potty trained: _____
Completely weaned: _____
Speak in sentences: _____
List any significant fears or sleep problems:
_____
_____
_____

Date of last physical examination: _____

Name of physician: _____

ACUTE CHILDHOOD ILLNESSES:

(e.g. strep throat)

ILLNESS	DATE	LENGTH AND / OR COMPLICATIONS OF ILLNESS	TREATMENT
1.			
2.			
3.			

[ ] NONE

CHRONIC ILLNESSES:

(e.g. asthma, chronic ear infection)

ILLNESS	DATE	LENGTH OF ILLNESS OR CONDITION	TREATMENT
1.			
2.			
3.			

[ ] NONE

SURGERIES:

SURGERY	DATE	LENGTH OF TIME IN HOSPITAL	OUTPATIENT TREATMENT AFTER SURGEY
1.			
2.			

[ ] NONE

HOSPITALIZATIONS:

ILLNESSES	DATE	LENGTH OF TIME IN HOSPITAL	
1.			
2.			

[ ] NONE

ACCIDENTS	DATE	UNCONSCIOUS	DESCRIBE TREATMENT (i.e. hospitalization)
1.			
2.			
3.			

[ ] NONE

FAMILY HISTORY:

Are there people in your biological family with:

ILLNESS	YES	NO	WHO?
Alcoholism			
Depression			
Bipolar Disorder or Manic Depressive			
Heart Disease			
Sudden cardiac death			
Epilepsy or seizures			
Learning disabilities			
Memory problems/dementia			
Anxiety or nervousness			
High blood pressure			
Hyperactivity/attention problems			
Schizophrenia			
Substance Abuse			
Thyroid Disease			
Long QT Syndrome			
Arrythmias			

Practice Policies and Fees:

Please read carefully and feel free to bring up any questions you may have.

Scope of practice:

The aim of Caroline C. Batenburg, M.D. is to provide excellent psychiatric services to the community of New Braunfels and surrounding areas. In principle, she provides psychiatric care in person. In certain circumstances, she will allow televisits, as long as it does not interfere with the quality of care.

Treatment of Minors:

Treatment of patients under the age of 18 will be provided only with the consent of the parent or legal guardian. In cases of divorce, a copy of the custody agreement must be provided. By signing the consent form on page 3 of this document, the parent acknowledges that he or she is the guardian (as established by the state or the divorce decree) of any minor presented for treatment.

*** If the patient is a minor, he/she will not be seen without his/her legal guardian present.**

Financial Agreement:

All balances are due and payable in full at the time of treatment, unless other arrangements are made prior to appointment. We are required to notify you that certain services that may be deemed necessary by Dr. Batenburg may not be covered by your Private Insurance, Medicare or Medicaid.

Missed, late or cancelled appointments:

Your appointment time is a reservation for psychiatric services. Therefore, you will be billed for missed appointments or appointments canceled with less than 24 business hour notice. (Monday appointments will need to be canceled by noon on the preceding Friday.) Patients arriving 10 minutes late maybe asked to reschedule.
As a courtesy we send appointment reminders but ultimately you are responsible for keeping your appointments.

Refill Requests:

ALL MEDICATION REFILLS NEED TO BE REQUESTED 48 to 72 HOURS IN ADVANCE.
Please contact your pharmacy directly to request a refill. They will have all the information needed to properly contact us for your prescription. This is the most efficient way for you to obtain your medication refill. Please note that due to the high volume of requests, prescriptions take 48 – 72 hours to process. **Refills that need to be filled the same day or prior to the 48 to 72-hour notification may be assessed a fee up to $50 per prescription. Also, if a non-emergency refill is granted on a weekend, you will be charged a $50.00 fee.**
Please check with your pharmacy *before* calling our office to check on the status of your refill. Also, if Dr. Batenburg has sent a prescription during a visit, this may be taken by the pharmacy as a new prescription with a different prescription number. Please check with the pharmacy first to confirm this.
It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations may result in a denial of refills.
Prior Authorization for medications may take up to seven days and a charge of $50 will be assessed for this service.

CONTROLLED SUBSTANCES:

Controlled substance prescriptions are monitored via the Texas Prescription Monitoring Program. Stimulant medication (Adderall, Concerta, Vyvanse, Ritalin, Dexedrine, Focalin, Metadate, ect) refills **WILL NOT** be processed on weekend or after business hours. Keeping track of quantities and when prescriptions will be needed is critical to avoid going without medication.
Controlled substance prescriptions that are stolen require an appointment and a police report to be replaced or refilled.

Forms and Letters:

Patients frequently request letters/forms for school, work, special accommodations, and other matters during routine appointments. Please keep in mind that appointments are scheduled for the purpose of assessing progress in treatment and response to medication. If time permits, you may be able to make these requests but it will take time to process the request. Your fee will be determined by the length of time and level of complexity required to complete the letter/form.

Dr. Batenburg will not complete disability paperwork nor will she write letters for emotional support animals.

Phone calls/Emergency Phone calls:

In cases of emergency phone calls, or calls due to side effects of medications, there will be no fees. For non-emergency calls, there is no charge for phone calls of 5 minutes or less in duration, phone calls from 6-15 minutes will be billed as a medication check and phone calls from 16-30 minutes will be billed as a medication check/psychotherapy visit. Please see our published fee schedule for additional information

Termination of Care Policy:

1. Patient are free to terminate their care with Caroline C. Batenburg, M.D. at any time or for any reason by notifying our office directly.

2. Patient's being disrespectful, threatening, or verbally abusive towards the Doctor, Staff, or other patients and their families in the waiting room will not be tolerated. These behaviors will also result in termination of care and clinical services.

3. Caroline C. Batenburg, M.D. may exercise her right to terminate care after:

    - Three No call/No shows
    - Three cancellations that are not cancelled within 24 hours of appointment time.
    - Three rescheduled appointments

4. If you are still in need of mental health services, you may go to the nearest emergency room. You may also contact one of the following psychiatric hospitals that provides services for child and adolescents: Laurel Ridge (210) 491-9400, Methodist Hospital (210) 575-0500, and Nix Hospital (210) 341-2633, Clarity Mental Health (210) 616-3000. If you are without health insurance, you may contact The Center for Health Care Services (210) 261-1000, Comal County MH Center (830) 620-6221.

I understand the Practice Policies and Fees (updated January 2023).
I have read the policies and fees notice and understand that if I request any services that are not covered by any insurance plan, that I will be billed accordingly.

_____	_____
Please print patient's name	**Date of Birth**
_____	_____
Signature of Patient or Guardian	**Date**
_____	_____
Caroline C. Batenburg, M.D.	**Date**