Commit to Change

with Dr. Renee B Bonin & Associates
200 Beaullieu Dr. Bldg 9B-1
Lafayette, LA 70508
Phone: 337-504-3483
Fax: 337-504-3573

Please be advised:

Initial appointments must be kept in order to further services.

If you are unable to come to the scheduled appointment, please call the office at least 24 hours in advance.

Thank you!

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Patient Information

Please print

Today's Date: _____

Patient's Full Name: _____ Birthdate: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mother's Name: _____ Birthdate: _____

Father's Name: _____ Birthdate: _____

Best Phone Number: _____ **O** Home **O** Cell **O** Work

Alt Phone Number: _____ **O** Home **O** Cell **O** Work **O** Other: _____

E-mail: _____

Appointment Reminders will be sent via e-mail, 24 hours before scheduled appointment.
Who do we e-mail for appointments? Please list names, relation, & information:

_____

_____

SSN for Parent (s)/Guardian(s): _____

Patient Gender: __Male __Female Religion: _____

Race(s)/Ethnicity: _____

Native American: ___Yes ___No *If yes, tribe affiliation: _____

Primary Care Physician: _____
Phone: _____ *Fax:* _____

Pharmacy: _____
Phone: _____ *Fax:* _____

Emergency Contact Name: _____ Phone: _____

Reason for appointment: _____

Referred by: _____

Insurance Information

Primary Insurance: _____ Member ID#: _____

Policy Holder: _____ Birthdate: _____

SSN: _____ Company Phone #: _____

Secondary Insurance: _____ Member ID#: _____

Policy Holder: _____ Birthdate: _____

SSN: _____ Company Phone #: _____

Guarantor:

Name: _____ Birthdate: _____

Address: _____

City: _____ State: __ Zip: _____ Relation: _____

Phone Number: _____ SSN: _____

Billing Information

All professional services rendered are the responsibility of the patient/guarantor. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 60 days, then the patient must pay all fees to collection agency.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
I hereby authorize payment directly to the undersigned Provider for my charges.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the undersigned Provider to release any information acquired in the course of my treatment to my insurance company in writing or by fax.

Parent/Guarantor Signature: _____ Date: _____

No Show Statement

Late Cancellation/No Show appointments: Appointments must be cancelled or rescheduled at least 24 hours in advance, or a **$50 fee** will be charged to the patient/guarantor. *We will not schedule any future*

appointments and if the payment is not made within 48 hours, any future appointments will be cancelled.

Appointments are booked for an entire hour, unless for medication only, and we do not double-book.

Please initial, which is acknowledgement and commitment to pay this fee, if necessary: _____

Patient History

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 more space or wish to make additional comments, please write on the back or attach a separate page.

Form Completed by: _____ Relation to child: _____

Best Phone number: _____ **O** Home **O** Cell **O** Work

Address: _____

City: _____ State:_____ Zip Code: _____

Current Medications		
Name of Drug	Dose (Strength & # per day)	Prescriber
1.		
2.		
3.		
4.		
5.		

Will child continue to get their medication prescribed by current provider?

___ Yes ___ No

If not, are you looking for a different provider? Please explain:

_____

_____

Drug Allergies: __No __Yes to:_____

Extended Family and Caregivers					
Name	Relation	Age	Gender	Highest Grade	Living in Household?
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No

					Yes No

Personal History

- Why are you seeking help for your child? _____
  _____
  _____

- What kind of services are you seeking for your child? _____
  _____

- Services/Interventions sought previously:
  - Medical Evaluation
  - Medication
  - School Modification
  - Neuropsychological Assessment
  - Neurological Exam
  - Psychological Counseling/Therapy
  - Educational Testing
  - Speech language Service
  - Occupation/Physical Therapy
  - Psychiatric Exam
  - Special Education
  - Tutoring
  - Other (Specify):_____

- **Medical and Developmental History:**
  - Prenatal History:
    Please answer which of the following conditions may have occurred during this pregnancy and explain (month, amount, treatment) in the space below:
    - ☐ Edema (swelling of the hands and feet)
    - ☐ Vaginal Bleeding
    - ☐ Toxemia
    - ☐ Emotional Stress
    - ☐ High Blood Pressure
    - ☐ Infections (colds, flu, urinary tract)
    - ☐ Injuries
    - ☐ Preterm Labor
    - ☐ Smoked Cigarettes
    - ☐ Abnormal weight gain
    - ☐ Fever
    - ☐ Accidents
    - ☐ Medications Used
    - ☐ Forceps used
    - ☐ Breech Position
    - ☐ Induced Labor
    - ☐ Caesarean Delivery
    - ☐ Alcohol Used
    - ☐ Breathing Difficulties
    - ☐ Other (specify): _____
  - Birth History:
    - ☐ Place (City or county, and state): _____
    - ☐ Hours of Labor: _____
    - ☐ Was the baby on time? yes no
      - If no, was he/she: Early Late

- By how many weeks?_____

- Child's Post Delivery Period:
  Check which of the following problems may have occurred after the child's birth and explain the treatment in the space below.
  - ☐ Trouble Breathing
  - ☐ Cord Around the neck
  - ☐ Required a blood transfusion
  - ☐ Hemorrhage (bleeding) in head.
  - ☐ Hydrocephalus (water on the brain)
  - ☐ Cyanosis (Turned blue)
  - ☐ Need for ventilation
  - ☐ Jaundice
  - ☐ Poor Feeding
  - ☐ Vomiting
  - ☐ Floppy Muscle Tone
  - ☐ Incubator Care
  - ☐ Infection
  - ☐ Fever
  - ☐ Number of day's infant was hospitalized after delivery: _____
- Infancy:
  Were any of the following present in your baby to a significant degree during the first few years of life? If so, please describe:
  - ☐ Did not enjoy cuddling
  - ☐ Difficult to comfort
  - ☐ Excessive irritability
  - ☐ Difficult feeding
  - ☐ Extremely Passive
  - ☐ Was not calmed by being held or stroked
  - ☐ Excessive Restlessness
  - ☐ Frequent head banging
  - ☐ Sleeping Difficulties
- Developmental Milestones:
  Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.
  - ☐ Crawl Independently: _____
  - ☐ Walk Independently: _____
  - ☐ Put two words together: _____
  - ☐ Put 4 to 5 sentences together to relate an experience: _____
  - ☐ Knew primary colors: _____
  - ☐ Say the letters of the alphabet: _____
  - ☐ Print first and last name: _____
  - ☐ Tie shoes: _____
  - ☐ Snap, zip, button clothing: _____
  - ☐ Began to read: _____
  - ☐ Toilet trained: _____
- Health History:
  - ☐ When was your child's last physical exam? Date: _____
    Where? :_____

- Does your child have any:
  - Vision Problems? Yes No Date of last vision exam: _____
  - Hearing Problems? Yes No Date of last hearing exam: _____
- Please check which of the following your child has had and note age, complications, and frequency below:
  - _____ Hospitalizations: _____
    _____
    _____
  - _____ Surgery: _____
    _____
  - _____ Trauma (Stitches/ Broken Bones):_____
    _____
    _____
  - _____ Head Trauma: _____
  - _____ Loss of Consciousness: _____
  - _____ Coma: _____
  - _____ Seizures: _____
  - _____ Tics: _____
  - _____ Staring Spells: _____
  - _____ Tremor: _____
  - _____ Poor Muscle Tone: _____
  - _____ Falls Frequently: _____
  - _____ Anemia: _____
  - _____ Persistent High Fever: _____
  - _____ Headaches: _____
  - _____ Vision Problems: _____
  - _____ Hearing Problems: _____
  - _____ Asthma: _____
  - _____ Allergies: _____
  - _____ Stomach Aches: _____
  - _____ Excessive Vomiting: _____
  - _____ Pica (eating non-food items): _____
  - _____ Sleep Problems: _____
  - _____ Bed wetting: _____
  - _____ Stool Soiling: _____
  - _____ Bowel Problems: _____
  - _____ Ear Infections (how many?): _____
  - _____ Other Infections: _____
  - _____ Accidental Poisoning: _____
- Any other medical problems: _____
  _____

_____

- Family History:
  - Child currently lives with: (please check all that apply)
    - ☐ Natural Mother
    - ☐ Natural Father
    - ☐ Stepmother
    - ☐ Stepfather
    - ☐ Adoptive Mother
    - ☐ Adoptive Father
    - ☐ Foster Mother
    - ☐ Foster Father
    - ☐ Grandmother
    - ☐ Grandfather
    - ☐ Other (Specify): _____
  - **Mother's History**
    - ☐ Mother's name: _____ (*First* *Middle* *Last*)
    - ☐ Home Phone: _____ Cell Phone: _____
    - ☐ Address: _____
      City: _____ State: _____ Zip: _____
    - ☐ Place of Employment: _____
      Occupation: _____
      Work Phone: _____
    - ☐ School History: Highest grade completed: _____
      Learning problems? Yes No Attention Problems? Yes No
    - ☐ Does mother have any medical problems? Yes No
      If yes, please describe: _____
    - ☐ Are there problems similar to those of your child on the maternal side of the family? Yes No
      If yes, please describe: _____
  - **Father's History**
    - ☐ Father's name: _____ (*First* *Middle* *Last*)
    - ☐ Home Phone: _____ Cell Phone: _____
    - ☐ Address: _____
      City: _____ State: _____ Zip: _____
    - ☐ Place of Employment: _____
      Occupation: _____
      Work Phone: _____
    - ☐ School History: Highest grade completed: _____
      Learning problems? Yes No Attention Problems? Yes No
    - ☐ Does father have any medical problems? Yes No
      If yes, please describe: _____
    - ☐ Are there problems similar to those of your child on the paternal side of the family? Yes No

If yes, please describe: _____

- History of Family Stressors or Transitions:
  *Please check all that apply for the past **12** months.*
  - ☐ Family moved
  - ☐ Death in the family/loss
  - ☐ Changed school
  - ☐ Parent changed job
  - ☐ Family financial problems
  - ☐ Repeat a grade
  - ☐ Parental separations and/or divorce
  - ☐ Family accident or illness
  - ☐ History of abuse
  - ☐ Conflict in family
  - ☐ New baby at home
  - ☐ Other (Specify) : _____
    _____
- Family Psychiatric History:
  Has anyone in child's family been diagnosed with or treated for: (please state relation)
  - ☐ Bipolar Disorder: _____
  - ☐ Post-Traumatic Stress: _____
  - ☐ Schizophrenia: _____
  - ☐ Alcohol Abuse: _____
  - ☐ Depression: _____
  - ☐ Anxiety: _____
  - ☐ Violence: _____
  - ☐ Anger: _____
  - ☐ Suicide: _____
  - ☐ Other Substance Abuse: _____

- **Educational History**
  - School Experience:
    If your child does not yet attend school, write N/A on the marked "Name of Child's School" and move down to the section marked "Home Life."
    - ☐ Did your child attend preschool? Yes No
      If yes, at what age? _____
      - Name of Preschool: _____
      - Were you concerned about your child's ability to succeed in preschool? Yes No
    - ☐ Name of child's current school: _____
      - School District: _____
      - Grade: _____
      - Teacher: _____

- Phone:_____

- Present class placement:
  - __ Regular Class
  - __ ESL
  - __Bilingual
  - __ Special Class (specify): _____
- Has testing been completed by school? Yes No

  If yes, Date: _____
- Is your child absent from school? Often Seldom Never
  - Usual reason for absence? _____
- Has your child ever been retrained? Yes No
  - If yes, what grade? _____

    Why? _____
- At what level do you feel your child is functioning, compared to other children their age? _____
- Has your child ever been:
  - ___ Suspended from school Number of Suspensions: _____
  - ___ Expelled from School Number of Expulsions: _____

- **Home Life**
  - What are the child's favorite activities? _____
  - Is your child assigned regular chores to complete? _____
  - How often must you discipline your child & for what? _____
  - What forms of discipline are used? _____
  - Describe your child's typical mood: _____

  - Most of the time, are your child's interactions with other kids:
    - Poor
    - Fair
    - Great
  - Does your child play with other kids?
    - Never
    - Seldom
    - Sometimes
    - Always
  - Does your child get along best with:
    - Older
    - Same Age
    - Younger children

Other information:

Please list any other information you would like the provider to have that was not addressed in this information: _____

_____

_____

_____

_____