NEW PATIENT PANDAS/PANS INTAKE ASSESSMENT

DATE: _____

PATIENT NAME: _____ AGE: _____DOB: _____

IF MINOR, NAME OF PARENT COMPLETING FORM: _____

Mother's Name:_____ Mother's Date of Birth: _____

Father's Name: _____ Father's Date of Birth: _____

Parent's Marital Status (circle one) : Married/ Separated/Divorced/Other: _____

ADDRESS/CITY/STATE/ZIPCODE:_____

_____

H#: _____ C#: _____

Name of Cell Phone Carrier (REQUIRED): _____

OTHER PHONE NUMBERS (WORK, ETC): _____

_____

WHO WERE YOU REFERRED BY? _____

INSURANCE INFORMATION:

NAME OF INSURANCE: _____

POLICY HOLDER NAME: _____

POLICY HOLDER DOB: _____ EMPLOYER: _____

*****ARE YOU AWARE THAT THE DR. IS OUT OF NETWORK FOR ALL COMMERCIAL NSURANCE? YES/NO**

*****HAVE YOU CONTACTED YOUR INSURANCE COMPANY TO OBTAIN YOUR OUT OF NETWORK BENEFIT INFORMATION? YES/NO N/A**

*****IF YOU HAVE BLUE CROSS/BLUE SHIELD YOU ARE REQUIRED TO PUT A CREDIT CARD ON FILE WITH THE OFFICE FOR PAYMENT? YES/NO N/A**

ARE YOU CURRENTLY BEING SEEN BY:

-PSYCHIATRIST: YES/NO If yes, Name of Psychiatrist: _____

ARE YOU CURRENTLY BEING PRESCRIBED PSYCHIATRIC MEDICATION? YES/NO

LIST ALL MEDICATIONS, DOSAGE AND DIRECTIONS THE PATIENT IS TAKING (INCLUDING SUPPLMENTS):

_____

_____

_____

SYMPTOMS: _____

_____

_____

_____

When did you notice an onset of symptoms? _____

Has patient had lab work done? **YES/NO**: When? _____

Has patient been on antibiotics? **YES/NO**: What? _____

When? _____

Has patient had IVIG? **YES/NO**: When? _____ Where? _____

Has patient been hospitalized for PANS/PANDAS **YES/NO**: When? _____

Where? _____

Tonsils Removed? **YES/NO** When? _____ Ear Tubes: **YES/NO** When? _____

Does the patient have allergies? **YES/NO** (if Yes, describe what they are allergic to) _____

_____

Does the patient have asthma? **YES/NO** If yes, when were they diagnosed? _____

Has the patient ever had or do they currently have eczema? **YES/NO** _____

Has the patient ever done an Ibuprofen Test dose? YES/NO (If yes, list details of when, the strength and the outcome)

_____

_____

DESCRIBE SYMPTOMS (IF NONE, WRITE NONE)

OCD Symptoms: _____

Germ Phobias: _____

Motor/Vocal Tics: _____

Anxiety Symptoms: _____

Moodiness and/or depression: _____

Irritability and/or aggression: _____

Learning/cognitive issues or confusion: _____

Behavioral Regression: _____

Sensory Symptoms: _____

Hallucinations: _____

Other Motor Symptoms: _____

Urinary Symptoms: _____

Sleep Disturbance/Fatigue: _____

Dilated Pupils: _____

NAME & PHONE NUMBER OF ANY PROVIDERS YOU HAVE SEEN OR ARE SEEING

(If none, write none)

PCP/PEDIATRICIAN/PROVIDER: _____

NEUROLOGIST: _____

IMMUNOLOGIST: _____

NEUROPSYCH TESTING: _____

NATUROPATH: _____

THERAPIST: _____

OFFICE USE ONLY

DATE AND TIME OF APPOINTMENT: _____

REQUESTED RECORDS RECEIVED: _____

COMPLETED PAPERWORK/LAB RESULTS RECEIVED: _____