Jerad M. Dalton, DO / Ann Kledzik, MD / Michele Thorne, PhD, HSPP
Child, Adolescent, and Adult
Psychotherapy and Medication Management

Dear Parent,

Thank you for contacting Axon Health Associates. We look forward to meeting your family and discussing your questions and concerns. We recommend that you arrive fifteen minutes prior to your first scheduled appointment time so check in can be completed prior to the doctor meeting with you.

The forms below are to be completed by you and your child's teacher. Please complete this patient information packet prior to your visit and bring completed teacher forms to the appointment.

We recommend that you bring any pertinent records or information for review. This may include prior evaluations, developmental/psychological testing, and school reports.

Please be prepared to pay for your appointment at the time of service. We are happy to file with your insurance company if you would like us to do so, and they may reimburse you for a portion of the visit depending on your coverage.

If you cannot keep this appointment, please call the office as soon as possible.

Thank you,

Jerad Dalton, DO
Ann M. Kledzik, MD
Michele Thorne, PhD, HSPP

Registration Form

PATIENT INFORMATION

Patient's Name: ____ Birth Date: ____________
(Last) (First) (Middle Initial)

Home Address: ____
(Street / Box #) (City/State) (Zip)

Home Phone: __________________________ Cell Phone: _________________________________

Employer: _____________________________ Work Phone: ________________________________

Marital Status: ______________________ Male ______ Female ______

Primary Physician: _________________________ Phone: _________________________________

Primary Physician Address: ____

Source of Referral: ____

PARENT/GUARDIAN/EMERGENCY CONTACT INFORMATION

Mother's Name: _____________________ Home Phone: __________________________________

Address (if different from patient's): ____
(Street / Box #) (City/State) (Zip)

Mother's Employer: ___________________ Mother's Occupation: ___________________________

Mother's Work Phone: _________________ Mother's Cell Phone: ___________________________

Father's Name: _____________________ Home Phone: ___________________________________

Address (if different from patient's): ____
(Street / Box #) (City/State) (Zip)

Father's Employer: ________________________ Father's Occupation: _______________________

Father's Work Phone: ______________________ Father's Cell Phone: _______________________

INSURANCE INFORMATION

Primary Ins. Co. Name: ________________________________ Phone: ______________________________

Policy Holder's Name: _________________________________ DOB: ________________________________

Relationship to patient: _______________________________ EDI / Payer ID: ______________________

Policy Holder's ID#: __________________________________ Group #: ____________________________

Claims Address: ____

Dr. Jerad Dalton, DO / Dr. Ann Kledzik, MD / Dr. Michele Thorne, PhD, HSPP

9245 N. Meridian St. Suite 225
Indianapolis, IN 46260
(317) 818-9000 (Tel)
(317) 818-9009 (Fax)

Patient History Questionnaire

Child's Name____ Birth Date_______________
Person Completing Questionnaire/Relationship to Patient___________________________

Purpose of Evaluation

What are your questions or concerns regarding your child?

Pregnancy and Birth History

Is this your biological or adopted child? ____
If adopted, at what age did you adopt this child? _____________________________________
Is the child aware of the adoption?____

	Yes	No	Comments
Did you have any health problems during your pregnancy with this child? (If so, please described nature of these complications such as infection, bed rest, high blood pressure)			
Did you take any medications or use any drugs, alcohol or tobacco during pregnancy?			
Was your baby carried for a full nine months? If no, please indicate the length of pregnancy			
Did your baby need any special care after delivery?			
How much did your baby weigh at birth?	lbs		oz

Past Medical History

	Yes	No	Comments
Has your child ever been hospitalized? If so, please describe the reason and what age this occurred.			
Has your child ever had any serious accidents or head injuries? If yes, please describe and include your child's age.			
Has your child had any serious or chronic illnesses (asthma, allergies, diabetes, etc)? If yes, please describe and state if it has resolved.			
Has your child ever had a seizure? If yes, please state at what age.			
Has your child ever had any tics (repetitive facial movements, throat clearing, sniffing, eye blinking, etc.)?			
Is your child taking any medications? If yes, please list medication and dosage.			
Does your child have any allergies to medications?			
Do you have concerns about your child's eating habits? If yes, please describe.			
Do you have concerns about your child's sleep? If yes, please describe.			
Does your child complain of pain more than once a week (headaches, stomachaches)?			

Developmental History

	Yes	No	Comments
Did you have any concerns about your child's development? Please explain.			
At what age did your child…Roll over? Sit alone? Crawl? Walk?			
At what age did your child begin saying single words? Combine words?			
Did your child have any developmental therapies (OT, PT, Speech) and at what age?			
At what age did your child become toilet trained?			
Does your child currently have any daytime accidents and if so, how often?			
Does your child have any nighttime accidents and if so, how often?			

Past Mental Health Treatment

Please list any previous medications that your child has been prescribed for mood, anxiety, attention or behavior and any side effects he/she may have experienced.

____
____
____

Has your child ever had any behavior therapy or counseling? If so, please include your child's age at the time and the name of the therapist.

____
____
____

Educational History

Please list the schools your child has attended:

	Name of School	Dates attended
Preschool	___________________________	______________________
Elementary School	___________________________	______________________
Middle School	___________________________	______________________
High School	___________________________	______________________

Please describe any educational services or resources that are provided to your child (IEP, 504 plan, special education services, etc.)

____
____

Please describe any extracurricular activities in which your child participates.

____
____

Please describe your child's peer group and how he/she interacts with others.

____
____

Family History

Parents are:

		Date
Married	_____	______________________
Separated	_____	______________________
Divorced	_____	______________________
		If divorced, describe custody arrangement and visitation____
Unmarried	_____	______________________
Widowed	_____	______________________

Please list the persons presently living in your home.

Name	Sex	Birth Date	Relation to Child	Present or Highest Grade Completed

Family members who no longer live in the home with the child.

Name	Sex	Birth Date	Relation to Child	Present or Highest Grade Completed

During the past 12 months has your family experienced any of the following:

	Yes	No	Comments
Death of a Family Member			
Serious Illness			
Marital Problems			
Unemployment			
Other(please describe)			

Have any family members experienced any of the following? If so, please note how this person is related to the child.

	Yes	No	Comments
Depression			
Anxiety			
ADHD			
Autism			
Bipolar disorder			
Schizophrenia			
Other mental health diagnoses			
Heart or blood pressure problems (if yes, please describe)			
Other medical problems (if yes, please describe)			

Person completing questionnaire_______________________________________

Relationship to Child____

Date_________________

Teacher Form

My child, _______________________________, is currently undergoing evaluation and treatment at Axon Health Associates. It would be appreciated if you could provide information regarding your knowledge of my child. Please also complete the attached checklist, and return this information to me or directly to Axon Health Associates as soon as possible. Thank you very much for your input.

____

Parent/Legal Guardian's Signature   Date

What is your name and relationship to this student? How long have you known this student?

____

____

Please describe any special services this child is receiving and reasons for an IEP, if applicable.

____

____

Please list the current grades and results of any standardized testing.

____

____

Please describe any concerns with this student's school performance.

____

____

Please describe any concerns with this student's mood or anxiety.

____

____

Please describe any concerns with defiance, aggression, or anger.

____

____

Please comment on any social difficulties this student may have.

____

____

Please include any other concerns or comments about this student.

____

____

Vanderbilt ADHD Diagnostic Parent Rating Scale

Patient Name: ______________________ **Today's Date:** ______________________

Date of Birth: ______________________ **Age:** ______________________

Grade: ______________________

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

1.	Does not pay attention to details or makes careless mistakes, such as in homework	0	1	2	3
2.	Has difficulty sustaining attention to tasks or activities	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by extraneous stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat when remaining seated is expected	0	1	2	3
12.	Runs about or climbs excessively in situations when remaining seated is expected	0	1	2	3
13.	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks too much	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting his or her turn	0	1	2	3
18.	Interrupts or intrudes on others (butts into conversations or games)	0	1	2	3
19.	Argues with adults	0	1	2	3
20.	Loses temper	0	1	2	3
21.	Actively defies or refuses to comply with adults' requests or rules	0	1	2	3

Vanderbilt ADHD Diagnostic Parent Rating Scale

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and vindictive	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Initiates physical fights	0	1	2	3
29. Lies to obtain goods for favors or to avoid obligations (“cons” others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen items of nontrivial value	0	1	2	3
33. Deliberately destroys others’ property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else’s home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3

Vanderbilt ADHD Diagnostic Parent Rating Scale

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

45. Feels lonely, unwanted, or unloved; complains that "no one loves" him or her	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance

	Problematic		Average	Above Average	
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavior					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5

Vanderbilt ADHD Diagnostic Teacher Rating Scale

Patient Name: ______________________ **Today's Date:** ______________________

Date of Birth: ______________________ **Age:** ______________________

Grade: ______________________

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

1.	Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2.	Has difficulty sustaining attention to tasks or activities	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustaining mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by extraneous stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12.	Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13.	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks excessively	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting in line	0	1	2	3
18.	Interrupts or intrudes on others (eg, butts into conversations or games)	0	1	2	3
19.	Loses temper	0	1	2	3
20.	Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
21.	Is angry or resentful	0	1	2	3

Vanderbilt ADHD Diagnostic Teacher Rating Scale

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (ie, “cons” others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others’ property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems, feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that “no one loves” him or her	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance

	Problematic		Average	Above Average	
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavioral Performance					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5

CONSENT TO TREAT

I hereby authorize Axon Health Associates, LLC and its respective personnel to provide evaluation and treatment to ____. If I am unable to attend the appointment as a guardian, I hereby authorize the following people to attend the appointment in my place:

____

I understand that these services are not guaranteed as to results, that no guarantees have been provided by Axon Health Associates, LLC, and that there are certain risks involved with these services. I understand that I can terminate this consent for treatment by requesting termination in writing.

____ ____________________

Patient/Legal Guardian Signature Date signed

____

Relationship to patient

PRIVACY ACKNOWLEDGEMENT

I understand that the patient's health information is private and confidential. I understand that with this consent, I give permission for aspects of my/my child's private healthcare information to be shared with Axon Health Associates, LLC, as is necessary for services to be provided. I understand that Axon Health Associates, LLC may use and disclose the patient's personal health information to help provide care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. By law, Axon Health Associates, LLC must report actual or suspected child or elder abuse to the appropriate authorities. In addition, Axon Health Associates, LLC is legally bound to take appropriate action if my child or I threaten anyone with violence, harm, or dangerous actions. I understand that there is a detailed document titled "Notice of Privacy Practices" that contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this acknowledgement. I am aware that a copy of this notice will be given to me upon my request or that it may be found at axonhealth.org. Axon Health Associates, LLC has established procedures which help meet patient obligations. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs, etc. I will assist Axon Health Associates, LLC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices". My signature below indicates that I have been given the chance to review a current copy of the "Notice of Privacy Practices".

____ ____________________

Patient/Legal Guardian Signature Date signed

____

Relationship to patient

FINANCIAL AGREEMENT

I agree to pay in full, at the time of service, for all services rendered for myself or my child by Axon Health Associates, LLC, for any out-of-network services. I understand that there is a document available upon request or at axonhealth.org regarding the Fee Schedule and any financial obligations, and I have read and agree with the information in this document. For in-network services, I agree to pay for my co-pay at the time of service and understand that my insurance company will be billed for the remainder. I am aware that there is a document titled Insurance Tips that is available upon request or at axonhealth.org. This document will be helpful to understand what portion of the fees may be covered by my insurance plan. I understand that 24 hours notice of cancellation is required to avoid charges for missed appointments. I understand that in families where parents do not share the same household, payment for services is the responsibility of the parent who accompanies the child to the appointment.

I also understand and agree to pay for any services related to legal matters, including but not limited to depositions, attorney phone calls, and court testimony; these services may be a different pay rate.
I also understand and agree to pay for services including record retrieval, phone consultation, and email consultation as requested by the provider.

____ ______________________

Patient/Legal Guardian Signature Date signed

____

Relationship to patient

CONSENT TO USE EMAIL COMMUNICATIONS

I hereby agree to sending to and receiving from Axon Health Associates, LLC email communications as part of comprehensive treatment for my child. I understand the risks of sending PHI through email even with encryption, and with this agreement I am accepting these risks to my child's PHI. I accept that Axon Health Associates, LLC shall not be held responsible for any exposure of email communications at my home or place of employment, depending on the location of my email address. I also understand that email communications can fail in their transmission, and I agree to contact Axon Health Associates, LLC if I have not obtained a response from my email communication within three business days. I also agree to never use email communications for emergency situations, and to call the office directly with any emergencies. I understand that I can terminate this agreement at any time by informing in writing. With my signature, I believe that the benefits of using email communications for my child's healthcare outweigh the security risks.

____ ______________________

Patient/Legal Guardian Signature Date signed

____

Relationship to patient

Preferred email address: ____________________________________