Kahala Clinic for Children & Family

Changing Minds, Changing Lives.

Your Name: _____ Contact Number: _____

Evaluation requested for: _____ Relationship to You: _____

Referred by: ☐ Pediatrician: _____

☐ School: _____

☐ Other: _____

Birthdate: _____ Gender: _____

School: _____ Grade: _____

Pediatrician: _____ Aware of concern(s)? Yes No

Insurance Carrier: ☐ HMSA ☐ HMAA ☐ UHA

Insurance Subscriber Number: _____

Insurance Main Subscriber's Birthdate: _____

Parental Status: ☐ Married ☐ Single ☐ Divorced

Child Custody: Joint Sole _____

Primary reason for seeking services:

☐ Alcohol/drugs	☐ Depression	☐ Coping
☐ Behavior problems	☐ Fears/phobias	☐ Family concerns
☐ Anger management	☐ Sexual Concerns	☐ Marital/relationship problems
☐ Anxiety	☐ Sleeping problems	☐ Recent loss/death
☐ Hyperactivity/inattention	☐ Eating disorder	☐ Psychological evaluation
☐ ADHD	☐ OCD	☐ Suicidal thoughts

Has patient been hospitalized recently? Yes No

Reason: _____

Is individual currently seeing a psychiatrist/psychologist/therapist? Yes No

Name: _____

Requesting: ☐ Dr. Keifer ☐ Dr. Bell ☐ Dr. Horita

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