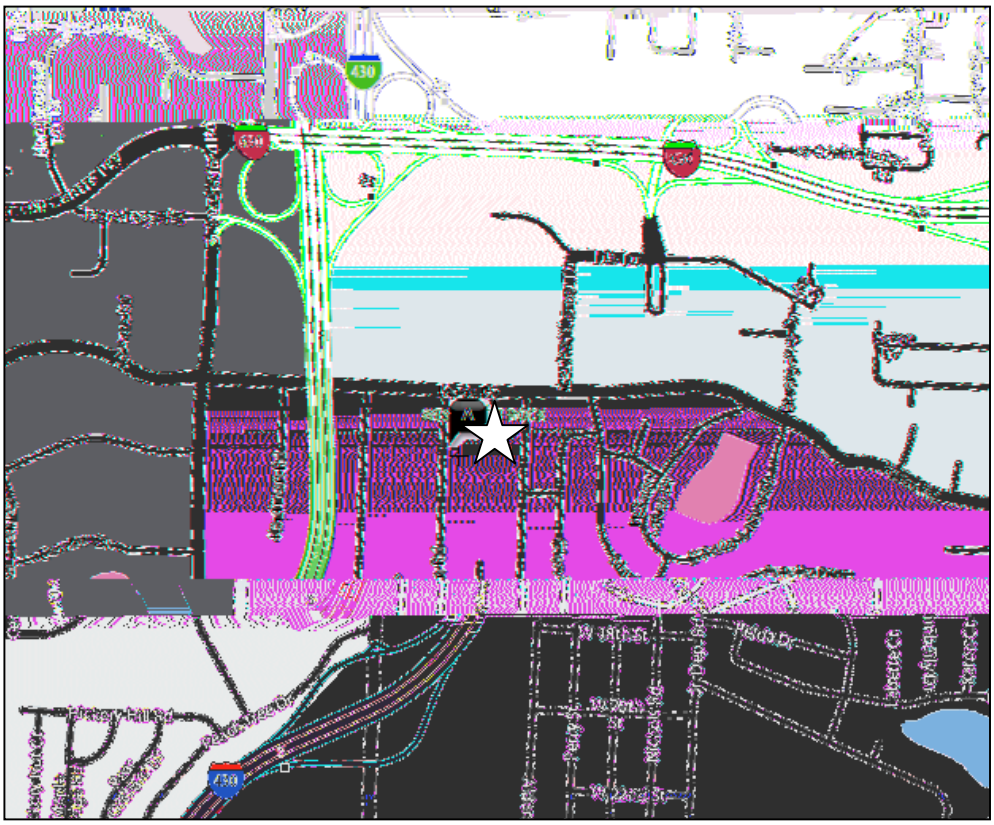
RICE CLINIC

eternal values for the body, mind & soul

Robert F Rice MD



Rice Clinic
1301 Wilson Road
Little Rock, AR 72205

From I-430

(#),

From I-630

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-

RICE CLINIC
CHILD & ADOLESCENT REGISTRATION

Child s Name _____ D B : A :

P N : S . S . #:

S A : H P :

C /S / :

P : C P :

E C ( ):

R C : P :

P /PCP: P /PCP P :

Guarantor of Account: SSN:

DOB G : C

A ( ):

E ( ): P :

Insurance Information

P I C : P :

S N : R C :

S D B : SSN:

I ID#: G N /N :

S I C : P :

S N : R C :

S D B : SSN:

I ID#: G N /N :

ALL FEES ARE DUE AT THE TIME OF THE APPOINTMENT - (24) .

IN CASE OF DIVORCE: T .

AUTHORIZATION: I R C /
. I R C . T
.

P : D : S : R :

PERMISSION FOR TREATMENT: I R C .

ACKNOWLEDGEMENT: I I , ,
R C .

S : D : R :

I give m permission for m child (ho is a licensed driver) to drive to and from the clinic for appointments.

S : D : R :

Child S mptom Checklist IV

C : D :

A : R :

Instructions: C (✓) . A .

Section 1a	**Never**	**Some-times**	**Often**	**Ver Often**
1. F , , .				
2. H .				
3. D .				
4. D ( ).				
5. H .				
6. A , ,))				
7. L (, , , , , ,).				
8. I .				
9. I .				

Section 1b

1. F .				
2. L .				
3. R .				
4. H .				
5. I .				
6. T .				
7. B .				
8. H .				
9. I (,).				

Section 2

	Never	Some-times	Often	Ver Often
1. L .				
2. A .				
3. A .				
4. D .				
5. B .				
6. I .				
7. I .				
8. I (,).				

Section 3

1. B , , .				
2. S .				
3. L (,)				
4. S .				
5. I				

For the items below, circle No or Yes

6. H (, , , ,)	N	
7. H .	N	
8. H .	N	
9. H (, , , ,).	N	
10. H .	N	
11. H .	N	
12. H ( ).	N	
13. H , , .	N	
14. H (, , ;)	N	
15. H ( ).	N	

Thank You!

Rice Clinic
Parent Questionnaire for Children and Adolescents

R

P N : D B : A

S G T

Briefl list problems ith hich ou ant help:

Famil Histor

M DOB O

D DOB O

M S ( ): M S D N M

C S ( ): J M D O :

S -P ( ):

S A :

Briefl list important medical information including an drug allergies:

Pri t and/or Evaluations (Check all that appl):

M P L D E (D :)

L S T O T :

EEG H CT/MRI

C H C

Do ou think ou s lost a previousl acquired skill? N (E)

Birth and Developmental histor

D C S (E : N)

P H S : C :

B (C): G F P B : O U ? N

, , ., ?

, ? D ?

(I)

SPEECH: N L D (: ,) A

MOTOR: N L D (: ,) A

SOCIAL: N L D (: ,) A

SELF-CARE: N L D (: ,) A

List an medical or ps chiatric histor of child that is important for us to kno :

Is there a famil histor of neurological, learning, ps chiatric, or developmental problems?

N (D):

Traits and Behaviors (Check all that appl)

S H P P P /

T H R /

S F O -
S M S
R J T
I C & T
K C P -
H R P , ,
O P , .
R A S

Interests

S B C /M C /
A B S P /A
M D R
M S

Mental Energ (___ Not Applicable)

T G & L
T P S
P

Attention (___ Not Applicable)

D T D
F F D
B B T
A C , C
I M
A

Work Production (___ Not Applicable)

T D A -
F C D
D P

Reading Problems (___ Not Applicable)

L O P
S T C
R R P

Writing Problems (___ Not Applicable)

H P
S O

Speech Problems (___ Not Applicable)

P P
P

Math Problems (___ Not Applicable)

P R C C

Mood Problems (___ Not Applicable)

S B N
H H
S H P
F L
H /

Ph sical Health Problems (___ Not Applicable)

H S D
D H ? H ?
C E M
T /T T
C P
H C

Social Problems (___ Not Applicable)

L G D
R I T
T R
T

School Information

S C S

H ?

D / ? N (E)

D IEP 504? N

D IEP/504? N (E)

Are An of the Follo ing Subjects Difficult for our Child?

Subject	Yes	No	Not Sure
A			
C			
E			
F L			
H			
M			
M			
N T			
R			
S			
S A			
S S /H			
S /D			
S /PE			
C			
R			

P P I /R C P S

CURRENT MEDICATIONS

Patient Name:	**Date of Birth:**
, , , ,	
( ) .	

Name	**Dosage**	**Frequency**	**By mouth, shot, patch, etc.**	**Reason**	**Doctor**

RICE CLINIC
Limits of Confidentiality

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RICE CLINIC
Consent to Specific Forms of Communication

***If you choose text or e-mail, your information may not be secure as the information will not be encrypted.**

confirm my appointments, treatment and billing information via:

☐ ☐ ☐ ☐ ☐ ☐

information about my health

☐ ☐ ☐ ☐ ☐ ☐

special services, events, fund raising efforts or new health information

☐ ☐ ☐ ☐ ☐ ☐

Print **Sign**

FEES FOR MISSED APPOINTMENTS*

- **Missed Appointments** ( ) → **$50**
  (. ., , ,)
- **Late Cancellations** ( ) → **$25**
  (- -), (- -),

**Policy effective 3/23/2009*