

DEVELOPMENTAL HISTORY

Was the pregnancy with this child: Planned _____ Unplanned _____ Child's birth weight: _____

Were there any difficulties in pregnancy/delivery? Yes No _____

Were there any health problems after birth? Yes No _____

Were the family relationships under stress during the pregnancy? Yes No _____

Please circle any symptoms that may have applied to the child during the first year of life (if known):

Crying excessively

Irritability

Unhappiness

Sleeping Problems

Eating Problems

Circle any symptoms that may have applied to the child during the Toddler/Preschool yrs (1-5 yrs old):

Irritability

Jealousy

Destructive

Stuttering

Overactive

Head Banging

Temper Tantrums

Bed wetting after 3

Breath Holding

Soiling after 3

Difficult w/transitions

Chewing clothes

Ate unusual items

Eating Problems

Nail Biting

Withdrawn

Compulsive actions

Hesitant

Other: _____

Circle any symptoms that may have applied to the child during Kindergarten-3rd Grade (5-9 yrs old):

Trouble Following Direction

Social Issues

Aggressive

Fearful

Clumsy

Eating Problems

Doesn't attempt what he/she could when appropriate

Lack of remorse

Lying

Stealing

Overactive

Other: _____

SCHOOL INFORMATION

Current grade in School: _____ School Name _____

Phone #: _____ Average Grades: A B C D F

Contact Person (teacher or school counselor): _____

Teacher/Counselor's comments about your child:

Has the child ever been held back a grade? Yes No If so, which grade _____

Circle any identified learning problems: ADD ADHD Reading Math Other
please explain: _____

Does your child currently have a learning plan at his/her school: IEP / 504 (Circle which apply)

Results of any testing (other than ISTEP) done by the school: _____

Any Behavioral problems at school: _____

Please list all schools your child has attended from kindergarten to present:

PERSONALITY

Circle any of the following words that best describe your child:

Active *Withdrawn* *Excitable* *Leader* *Likeable* *Reckless*
Ambitious *Submissive* *Sympathetic* *Lonely* *Violent*
Aggressive *Self-Confident* *Often Afraid* *Easy Going* *Impatient*
Bossy *Hard Working* *Impulsive* *Imaginative* *Introvert*
Sick Often *Depressed* *Nervous* *Self-Conscious* *Moody* *Calm*
Extrovert *Serious* *Worrier* *Persistent* *Often Sad* *Serious* *Shy*
Hyper *Caring* *Controlling* *Compulsive* *Sensitive* *Perspective* *Unremorseful*

Other: _____

SOCIAL FUNCTIONING

What do your child's friends say about him/her?

How many close friends does he/she have? 0 1 2 3 4 5+

Do friends come to visit at your house? Yes No

Please describe any recent changes in socialization/friends or loss of friends:

Do you have any dating concerns (if applicable)? Yes No Please explain:

Describe any school activities/sports/extracurriculars your child participates in:

Is religion an important part of your child's life? Yes No Undecided

Church attended: _____

PHYSICAL HEALTH

Please rate your child's physical health: Very good Good Average Declining Poor

List any severe illness, injuries and/or hospitalizations, including dates of treatment:

List any medications & dosages, including over the counter and herbal supplements the child takes:

MENTAL/EMOTIONAL HEALTH

Please explain what problem/s prompted you to seek help for your child, including when the problems started:

Has your child been involved with therapy or seen a counselor before: Yes / No

If you answered yes to the above, please explain: Date/How Long, Issues, Outpatient/Inpatient, Name of Counselor, Phone Number (if known) _____

Do you have concerns about your child in any of the following areas?

<i>Eating Disorder</i>	Yes	No	<i>Physical, Sexual or Emotional Abuse</i>	Yes	No
<i>Suicidal Thoughts/Attempts</i>	Yes	No	<i>Self Mutilation/Cutting</i>	Yes	No

If you answered Yes to any of the above, please explain:

LEGAL CONCERNS

Has your child ever been arrested or are there pending legal matters? Yes No

If yes, please explain: _____

Is your child on probation? Yes No

If yes, Probation officer: _____ Phone # : _____

ALCOHOL/DRUG USE

Please describe any present or past history of drug or alcohol use or concerns:

Has there ever been a family member with a drug/alcohol related problem? Yes No

If yes, please explain: _____

GENERAL INFORMATION

What are the main difficulties that are being experienced at school (if any)?

What are the main difficulties that are being experienced at home (if any)?

What behaviors would you like to see changed in your child?

Feel free to add any additional information below that might be helpful. All information is confidential and used only to benefit your child's therapy.

Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Patient Name

Patient Social Security #

Signature of Legal Guardian/Legal Representative

Date

Relationship to Patient

Benefit Plan Subscriber Name

Mental Health Benefit Plan

RIGHTS AND RESPONSIBILITIES

Experience has shown that when the contract terms of the psychotherapy relationship or evaluation process are clear and explicit from the beginning, some common misunderstandings are avoided. Please read carefully and sign at the bottom.

1. Since you are an integral part of your evaluation and therapy, you have the right to ask questions at any point. You may refuse to participate in any evaluation task; however, an accurate evaluation is better achieved with your cooperation.
2. Questions concerning your therapist's qualifications and experience will always be answered. As well, you may refuse to participate in any intervention, strategy, or behavior suggested by your therapist.
3. Therapy is an interactive, reciprocal experience. The therapist will always attempt to meet the client where they are emotionally. Your cooperation in the relationship is central to the success of therapy.
4. Within certain legal and ethical limits, information revealed by assessment or treatment will be kept strictly confidential and will not be disclosed to another person or agency without your written permission. The limits to this policy are as follows:
 - a. If a court of law issues a subpoena, we are required to provide the information required by the subpoena.
 - b. If a court of law has ordered you to participate in therapy or to be evaluated by our staff, the results of the treatment or assessment must be revealed to the court.
 - c. If you threaten physical injury or death to yourself or another person, we must take steps necessary to protect you or other involved individuals. (This includes disclosure to appropriate authorities or relevant individuals.)
 - d. If you or your child discloses emotional/physical/sexual abuse of a minor, we are required by law to report this to the Department of Child Services.
 - e. If you were sent here to be evaluated for an attorney, insurance agency, Social Security, or your employer, disclosure is required.
5. You have the right to be informed about policies regarding fees and services.
 - a. Co-payment or deductible will be due at the time of service.
 - b. Fees are based on the type and length of therapy you receive. You will also be responsible for charges incurred on your behalf with other professionals/agencies; court appearances; test scoring, interpretation or preparation.
 - c. We reserve the right to terminate treatment for non-payment of fees and services provided.
 - d. Any check that is returned for Non-Sufficient Funds (NSF) will be charged an additional \$25.00 above the amount of the check.
 - e. Unpaid accounts greater than one session will result in dismissal from the practice until payment is received.
6. You have the right to terminate therapy at any time.

7. If you cancel or do not show for a scheduled appointment and we do not hear from you for 30 days, then it will be assumed you are no longer under our care.
8. There will be an additional charge for processing forms other than medical insurance (i.e. court reports, reports for outside persons/agency).
9. It is your responsibility to become familiar with your own mental health benefits prior to entering into treatment with your therapist. Our staff may be able to provide you with some insurance information, but due to the various plans with each carrier and their confidentiality policies, we cannot guarantee the accuracy of information we receive from your carrier.
10. **APPOINTMENTS:** Your appointment time is set aside just for you. We look forward to meeting you at your reserved time. If you miss an appointment without notice, this means that another person is not able to use that appointment time. If you have an objection to being reminded of your appointment via text message please let your therapist know.

Unless there are circumstances your therapist and you would define as an emergency, it is our policy to charge a fee when it is not cancelled 24 hours in advance. Repeated “no-show” appointments could result in referring you back to the insurance company for reassignment to another practitioner. Your insurance company cannot be billed for fees associated with missed or canceled appointments. The fee for a missed appointment is \$100.

I have read and understand my rights and responsibilities:

Child/Adolescent Name	Child’s Signature (if age 14 or above)	Date
Signature of Parent or Guardian		Date