

Psychological and Consultation Services, P.C., P.C.

Mailing Address: PO Box 4455 East Lansing, MI 48826-4455

Office Address: 4123 Okemos Rd. Okemos, MI 48864

PATIENT'S ADDRESS AND PHONE NUMBERS			
Patient Name:	Social Security No:	DOB:	AGE:
Street Address:	City:	State:	Zip:
Home Ph. No:	Cell Ph. No:	Work Ph. No:	
Email:	Marital Status: S M W SEP D		
PATIENT'S EMPLOYER INFORMATION			
Employer:			
Employer's Street Address:			
City:	State:	Zip:	
Patient's Occupation:			
INSURANCE			
Primary Ins. Co. Name:	ID#	Group:	
Subscriber's Name:	Relationship to patient:		
Subscriber's DOB:	SS #		
Subscriber's Employer:			
Employer's Street Address:			
City:	State:	Zip:	
Secondary Ins. Co. Name:	ID#	Group:	
Subscriber's Name:	Relationship to patient:		
Subscriber's DOB: :	SS #		
Subscriber's Employer:			
Employer's Street Address:			
City:	State:	Zip:	

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Patient's Signature or Parent/Guardian

Date Signed

I hereby authorize Dr. Wade to apply for benefits on my behalf for covered services rendered by her, or by her order. I request payment from my insurance company be made directly to Dr. Wade or to the party who accepts assignment.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time, in writing. I have received the patient information booklet and understand the policies and procedures of the office. I certify the information I have reported, with regard to my insurance coverage, is correct.

Patient's Signature or Parent/Guardian

Date Signed

Signer's Relationship to Patient

Psychological and Consultation Services, P.C.
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We do not use or disclose your protected health information (PHI) for marketing purposes nor do we sell your protected health information (PHI) for marketing purposes.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, insurance auditing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

Other uses and disclosures not described in this Privacy Notice will be made only with authorization from you. You have the right to restrict certain disclosures of PHI to health plans/insurance companies if you pay out of pocket in full for the health care service. You have the right to be notified following a breach of unsecured protected health information.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect, Danger to Self and Others: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative location, you may advise us using the contact information listed on the first page of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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**Patient Consent and Acknowledgement Form for Use and
Disclosure of Protected Health Information**

With my consent, Psychological and Consultation Services, P.C. (PCS) may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). Please refer to PCS's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have received a copy of the Notice of Privacy Practices. I have the right to review the Notice of Privacy Practices prior to signing this consent. PCS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by a written request.

With my consent, PCS may call me, or other persons at my home or other designated locations, in reference to any items assisting the practice in carrying out TPO, such as appointment reminders, insurance items, and information pertaining to my clinical care, such as test results. If necessary, a message may be left on my voice mail or answering machine.

With my consent, PCS may mail to my home or other designated locations any items assisting the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request PCS restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to PCS's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, PCS may decline to provide treatment to me.

Signature of Patient

Print Name of Patient

Date

OR

Parent or Representative's Signature

Signer's Relationship to Patient

Date

Psychological and Consultation Services, P.C.

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Billing Responsibilities

I will accept responsibility for the co-payment, deductible, or account balances of any charges not covered by my insurance company for psychotherapy/testing, as needed. Overdue accounts will be sent to an agency for collection.

I also understand all payments are to be made at the time of each session. Consistent failure to do so will result in the termination of treatment. A list of referrals will be given to you if termination results. The referrals will be consistent with your insurance policy/benefits.

Management of Insurance Claim Rejections

If your insurance rejects a claim, for whatever reason, the balance due will immediately become your responsibility. Insurance companies have a relationship with their members, but not with the doctor's office. If you feel your insurance company should have paid charges for a service rendered, you will need to contact them directly so we can resolve any billing issues in a timely manner. Payment is expected from you until the insurance company resolves the payment issues. Once we are paid by your insurance company, we will refund you appropriately.

Patient's Signature

Date

OR

Parent or Representative's Signature

Date

Signer's Relationship to Patient

Psychological and Consultation Services, P.C.

Mailing Address: PO Box 4455 East Lansing, MI 48826-4455

Office Address: 4123 Okemos Rd. Okemos, MI 48864

CONSENT TO RELEASE INFORMATION

I authorize Psychological and Consultation Services, P.C. (PCS), 4123 Okemos Rd Ste 15, Okemos, MI 48864 to provide or receive only the following specific information:

PCS may leave messages on patient's phone answering machine or voice mail regarding changes of appointments and other appointment information, accounting information, and return messages left on PCS's answering machine.

Concerning _____
Patient's Name Birth date

To be used only for the following purpose(s): continuation of treatment.

The use of this consent to release information is effective from the date it was signed until the patient informs us, in writing, of any changes to this consent.

I understand this release may be revoked at any time by written notification to the organization holding the information, except after the release described above has taken place.

Patient's Signature

Date

OR

Parent or Representative's Signature

Date

Signer's Relationship to Patient

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CONSENT TO RELEASE INFORMATION

I authorize Psychological and Consultation Services, P.C., 4123 Okemos Rd Ste 15, Okemos, MI 48864 to provide or receive only the following specific information:

Fax, phone and /or letter correspondence relating to treatment such as diagnosis, treatment plan, progress notes, test scores, reports, and so forth.

To my primary care physician or other physician(s) indicated below:

Name, address, and contact information of individual/organization to receive information

Name, address, and contact information of individual/organization to receive information

Concerning: _____
Patient's Name Patient's DOB

To be used only for the following purpose(s): continuation of treatment.

Use of this consent to release information is effective from the date it was signed until:

The patient informs PCS, in writing, of any Medical Treatment Team changes.

I understand this release may be revoked at any time by written notification to the organization holding the information, except after the release described above has taken place.

Patient's Signature

Date

OR

Parent or Representative's Signature

Date

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CONSENT TO RELEASE INFORMATION FOR MEDICAL AUTHORIZATIONS

I understand, as a member of _____ (insurance company), my treatment will be periodically evaluated for continued payment for services. I am authorizing such disclosure.

Failure to authorize disclosure of treatment will result in unauthorized sessions by your insurance company, which could lead to higher co-payments or you being responsible for the payment of sessions.

Therefore, I authorize Psychological and Consultation Services, P.C. (PCS), 4123 Okemos Rd Ste 15, Okemos, MI 48864 to provide the above information to be used for the following purposes: payment of services by my insurance company.

Use of this consent to release information is effective from the date it was signed until the patient informs us, in writing, of any changes to this consent.

I understand this release may be revoked at any time by written notification to the organization holding the information, except after the release described above has taken place.

Patient's Signature

Date

OR

Parent or Representative's Signature

Date

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APPOINTMENT CANCELLATION POLICY

Thank you for choosing us to be part of your healthcare team. As our office is very busy and often has a wait-list, it is extremely important that you let us know 24 hours in advance if you are unable to keep your appointment.

Therefore, I understand any cancellations I make less than 24 hours before my scheduled appointment time will be charged to my account.

Thank you for your cooperation in this matter.

Patient's Signature

Date

OR

Parent or Representative's Signature

Date

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TELEPSYCHOLOGY INFORMED CONSENT

As a patient receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.

2. If a need for direct, face to face services arises, it is my responsibility to contact this office for a face to face appointment. I understand that an opening may not be immediately available.

3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.

4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.

5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

a. In emergency situations: Text messaging, Email, Phone, Video

b. Should service be disrupted: Text messaging, Email, Video

c. For other communication: Text Messaging, Email, Video

6. My psychologist may utilize alternative means of communication in the following circumstances:

When there is disruption of services during a session or by mutual agreement related to a specific situation discussed.

7. My psychologist will respond to communications and routine messages within 24 hours, and if you have not heard from your psychologist, please call the main office to speak to our front office staff.

8. It is my responsibility to maintain privacy on the patient/client end of communication. Insurance companies, those authorized by the patient/client, and those permitted by law may also have access to records or communications.

9. I will take the following precautions to ensure that my communications are directed only to my psychologist or other individuals: be sure I am in a space that protects confidentiality of session between myself and the psychologist. If someone else is in the room, I will share that information with my psychologist.

10. My communications exchanged with my psychologist will be stored in the following manner: with my medical records and on HIPAA compliant platforms.

11. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

Patient's Signature

Date

OR

Parent or Representative's Signature

Signer's Relationship to Patient

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PERMISSION TO TREAT MINOR

I, _____, Parent/Guardian, give my son/daughter
_____, permission to engage in psychotherapy and/or
psychological or neuropsychological testing, if needed, with Dr. Wade.

Parent or Representative's Signature

Printed Name

Signer's Relationship to Patient

Date

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Child and Adolescent Patient Questionnaire

Patient Information

Please complete the following questions. This form will help us know and understand as much as possible about you and your situation in order to develop and provide treatment to meet your specific needs.

Today's Date: _____

Person Completing Questionnaire: _____ Relationship to Patient: _____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Business Phone: (____) _____ - _____

Patient Name: _____

Sex: ☐ Male ☐ Female ☐ Other: _____ Social Security Number: _____

Child/Adolescent is presently living with:

☐ Biological Mother ☐ Biological Father ☐ Stepmother ☐ Stepfather
☐ Adoptive Mother ☐ Adoptive Father ☐ Foster Mother ☐ Foster Father

☐ Other (specify): _____

Non-residential adults involved with this child/adolescent on a regular basis:

Ethnic Group:

☐ Native American – Tribe: _____ ☐ Asian – Ethnic Group: _____
☐ Hispanic – Ethnic Group: _____ ☐ Black – Ethnic Group: _____
☐ White – Ethnic Group: _____ ☐ Other: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Country: _____

Cell Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Business Phone: (____) _____ - _____

Email: _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____

Hand Preference: ☐ Right ☐ Left

School: _____ Grade: _____

Special Placement (if any): _____

Parents:

Mother: _____ **Phone#:** _____

D.O.B.: _____ **Age:** _____ **Age at time of pregnancy with patient:** _____

Occupation: _____

Highest grade completed

- ☐ 8th grade or less ☐ Some High School
☐ High School Graduate/GED ☐ Some College/Specialized Training: _____
☐ College Graduate – University & Degree: _____
☐ Graduate of Professional School: Degree: _____
☐ Unknown

Learning Problems: _____

Attention Problems: _____

Behavior Problems: _____

Medical Problems: _____

Have any of your blood relatives experienced problems similar to those our child/adolescent is experiencing?

☐ No ☐ Yes If so, please explain: _____

Father: _____ **Phone#:** _____

D.O.B.: _____ **Age:** _____

Occupation: _____

Highest grade completed

- ☐ 8th grade or less ☐ Some High School
☐ High School Graduate/GED ☐ Some College/Specialized Training: _____
☐ College Graduate – University & Degree: _____
☐ Graduate of Professional School: Degree: _____
☐ Unknown

Learning Problems: _____

Attention Problems: _____

Behavior Problems: _____

Medical Problems: _____

Have any of your blood relatives experienced problems similar to those our child/adolescent is experiencing?

☐ No ☐ Yes If so, please explain: _____

Current Marital Status of Parents: ☐ Married ☐ Widowed ☐ Separated
☐ Divorced ☐ Never Married ☐ Permanent Partner

Siblings:

Name	Age	Medical, Social, or School Problems
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Pregnancy:

Complications

Excessive vomiting: ☐ No ☐ Yes

Hospitalization required? ☐ No ☐ Yes

Excessive staining/blood loss: ☐No ☐Yes Threatened miscarriage? ☐No ☐Yes
Infection(s): ☐No ☐Yes (Specify): _____
Toxemia: ☐No ☐Yes Operation(s) required? ☐No ☐Yes
Smoking during pregnancy? ☐No ☐Yes If so, number of cigarettes per day: _____
Alcohol during pregnancy? ☐No ☐Yes If so, describe if beyond occasional drink: _____

Other illness(es): ☐No ☐Yes (Specify): _____
Medications taken during pregnancy: _____
Duration of pregnancy (weeks): _____

Delivery

Type of Labor: ☐Spontaneous ☐Induced Duration (hours): _____
Type of Delivery: ☐Normal ☐Breech ☐Caesarean
Complications: ☐Cord around neck ☐Hemorrhage ☐Infant injured during delivery
☐Other (specify): _____

Birth Weight: _____

Post Delivery Period

☐Jaundice ☐Cyanosis (turned blue) ☐Incubator Care
☐Infection (specify): _____
Number of days infant was in the hospital after delivery: _____

Infancy Period

Were any of the following present (to a significant degree) during the first few year of life? If so, please describe.

Did not enjoy cuddling ☐No ☐Yes _____
Was not calmed by being held or stroked ☐No ☐Yes _____
Difficult to comfort ☐No ☐Yes _____
Colic ☐No ☐Yes _____
Excessive restlessness ☐No ☐Yes _____
Excessive irritability ☐No ☐Yes _____
Diminished sleep ☐No ☐Yes _____
Frequent head banging ☐No ☐Yes _____
Difficulty nursing ☐No ☐Yes _____
Constantly into everything ☐No ☐Yes _____

Temperament

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity Level – How active has your child been from an early age? _____

Distractibility – How well did your child pay attention? _____

Adaptability – How well did your child deal with transitions and change? _____

Approach/Withdrawal – How well did your child respond to new things (i.e. places, people, food, etc.)? _____

Intensity – Whether happy or unhappy, how aware are others of your child's feelings? _____

Mood – What was your child's basic mood? _____

Regularity – How predictable was your child in patterns of sleep, appetite, etc.? _____

Medical History:

If your child/adolescent's medical history includes any of the following, please note the age when the incident or illness occurred, as well as any other pertinent information:

Childhood diseases (ages and complications) ☐ No ☐ Yes _____

Operations ☐ No ☐ Yes _____

Hospitalizations for illness(es) ☐ No ☐ Yes _____

Head injuries ☐ No ☐ Yes _____

Convulsions (with or without fever?) ☐ No ☐ Yes _____

Coma(s) ☐ No ☐ Yes _____

Persistent high fevers ☐ No ☐ Yes _____

Eye problems ☐ No ☐ Yes _____

Tics (i.e. eye blinking, sniffing, any repetitive, non-purposeful movements, etc.) ☐ No ☐ Yes _____

Ear problems ☐ No ☐ Yes _____

Allergies or Asthma ☐ No ☐ Yes _____

Poisoning ☐ No ☐ Yes _____

Sleep

Does your child/adolescent:

Settle down to sleep? ☐ No ☐ Yes _____

Sleep through the night without disruption? ☐ No ☐ Yes _____

Experience nightmares, night terrors, sleep walking, or sleep talking? ☐ No ☐ Yes _____

Experience restless sleep? ☐ No ☐ Yes _____

Snore? ☐ No ☐ Yes _____

Appetite

Please describe your child/adolescent's appetite: _____

Present Medical Status:

Height: _____ Weight: _____

Physical Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Emotional Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Present illness/struggles for which child/adolescent is being treated: _____

List any medications your child/adolescent is now taking, even only occasionally:

Name of Medication	Dosage	Reason for Taking
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Allergies:

List any allergies related to medications:

Name of Medication:

Reaction:

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |

3. _____

Is your child allergic to dogs? ☐ No ☐ Yes

(*Therapy dogs are available)

Developmental Milestones:

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall exactly, check an item to the right.

	Age	Early	Normal	Late
Smiled	_____	☐	☐	☐
Sat without support	_____	☐	☐	☐
Crawled	_____	☐	☐	☐
Stood without support	_____	☐	☐	☐
Walked without assistance	_____	☐	☐	☐
Spoke first words	_____	☐	☐	☐
Said phrases	_____	☐	☐	☐
Said sentences	_____	☐	☐	☐
Bladder trained (day)	_____	☐	☐	☐
Bladder trained (night)	_____	☐	☐	☐
Bowel trained (day)	_____	☐	☐	☐
Bowel trained (night)	_____	☐	☐	☐
Rode tricycle	_____	☐	☐	☐
Rode bicycle				
(without training wheels)	_____	☐	☐	☐
Buttoned clothing	_____	☐	☐	☐
Tied shoelaces	_____	☐	☐	☐
Named colors	_____	☐	☐	☐
Named coins	_____	☐	☐	☐
Said alphabet in order	_____	☐	☐	☐
Began to read	_____	☐	☐	☐

Coordination:

	Good	Average	Poor
Rate your child/adolescent on the following skills:	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Throwing	☐	☐	☐
Catching	☐	☐	☐
Shoelace tying	☐	☐	☐
Buttoning	☐	☐	☐
Writing	☐	☐	☐
Athletic ability	☐	☐	☐
Excessive number of accidents	☐	☐	☐

(Compared to other children/adolescents)

Comprehension and Understanding:

Do you consider your child/adolescent able to understand directions and situations as well as other children their age?

☐ No ☐ Yes If not, why? _____

How would you rate your child/adolescent's overall level of intelligence compared to other children?

☐Below Average ☐Average ☐Above Average

School History:

Were you concerned about your child's ability to succeed in kindergarten? ☐No ☐Yes If so, please explain: _____

Rate your child's school experiences related to academic learning:

	Good	Average	Poor	N/A
Nursery school	☐	☐	☐	
Kindergarten	☐	☐	☐	
Grade school	☐	☐	☐	☐
Middle school	☐	☐	☐	☐
High school	☐	☐	☐	☐
Current grade	☐	☐	☐	☐

To the best of your knowledge, at what grade level is your child/adolescent functioning in the following subjects:

Reading? _____

Spelling? _____

Arithmetic? _____

Has your child/adolescent ever had to repeat a grade? ☐No ☐Yes If so, please explain: _____

Present class placement: ☐Regular Class(es) ☐Special Class(es) (specify): _____

Is your child/adolescent currently receiving any kind of special social counseling or remedial work?

☐No ☐Yes If so, please explain: _____

Please describe any academic problems your child/adolescent is having: _____

Rate your child's school experiences related to behavior:

	Good	Average	Poor	N/A
Nursery school	☐	☐	☐	
Kindergarten	☐	☐	☐	
Grade school	☐	☐	☐	☐
Middle school	☐	☐	☐	☐
High school	☐	☐	☐	☐
Current grade	☐	☐	☐	☐

Does your child/adolescent's teacher(s) describe any of the following as significant classroom problems?

Doesn't sit still in their seat ☐No ☐Yes

Frequently gets up and walks around the classroom ☐No ☐Yes

Shouts out (doesn't wait to be called on) ☐No ☐Yes

Typically does better in a one-to-one relationship ☐No ☐Yes

Won't wait their turn ☐No ☐Yes

Doesn't cooperate well in group activities ☐No ☐Yes

Doesn't respect the rights of others ☐No ☐Yes

Doesn't pay attention during storytelling or show-and-tell ☐No ☐Yes

Please describe any other classroom behavioral problems: _____

As best as you can recall, please use the following space to provide a general description of your child/adolescent's school progress in each grade: _____

Peer Relationships:

Does your child seek friendships with their peers? ☐ No ☐ Yes _____

Is your child sought by their peers for friendships? ☐ No ☐ Yes _____

Does your child play with kids primarily: ☐ Their own age? ☐ Younger? ☐ Older?

Describe any problems your child may have with their peers: _____

Home Behavior:

All children exhibit, to some degree, the behaviors listed below. Please check those you believe your child exhibits to an excessive or exaggerated degree, when compared to other children their age:

- ☐ Fidgets with hands, feet, or squirms in their seat
- ☐ Has difficulty remaining seated when required to do so
- ☐ Has difficulty waiting their turn in games or group activities
- ☐ Blurts out answers to questions before they have been completed
- ☐ Has problems following through with instructions (usually not due to opposition or failure to comprehend)
- ☐ Is easily distracted by extraneous stimulation
- ☐ Has difficulty paying attention during tasks or play activities
- ☐ Shifts from one uncompleted activity to another
- ☐ Interrupts or intrudes on others (often not purposeful or planned, but impulsive)
- ☐ Experiences sudden outbursts of physical abuse of other children
- ☐ Does not appear to listen to what is being said
- ☐ Loses things necessary for tasks or activities at home
- ☐ Has difficulty playing quietly
- ☐ Experiences boundless energy and poor judgement
- ☐ Experiences impulsivity (poor self-control)
- ☐ Acts like they are driven by a motor
- ☐ Wears out shoes more frequently than siblings
- ☐ Is considered to be a "different child"
- ☐ Frustrates easily
- ☐ Has sloppy table manners
- ☐ Often talks excessively
- ☐ Has a history of temper tantrums
- ☐ Experiences Temper outbursts

☐ Has excessive number of accidents

☐ Has poor memory

How well does your child work for a short-term reward? _____

How well does your child work for a long-term reward? _____

Does your child create more problems, either purposeful or non-purposeful, within the home setting than their siblings? ☐ No

☐ Yes _____

Does your child have difficulty benefiting from their experiences? ☐ No ☐ Yes _____

Please explain the types of discipline you use with your child: _____

Is there a particular form of discipline that has proven effective for your child? ☐ No ☐ Yes _____

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? ☐ No ☐ Yes _____

Interests and Accomplishments:

What are your child's main hobbies and interests? _____

What are your child's areas of greatest accomplishment? _____

What does your child enjoy doing most? _____

What does your child dislike doing most? _____

What do you like about your child? _____

List names and contact information of any other professionals consulted (including family doctor):

1. _____

2. _____

3. _____

4. _____

5. _____

Additional Remarks:

Please write any additional remarks you wish to make regarding your child:

By: Sam Goldstein, Ph.D. & Michael Goldstein, Ph.D.

Listed below are a number of categories in which people commonly find some difficulties. Please indicate how you are affected in each area by circling the appropriate number (please circle only one number for each item).

Not a Problem	Somewhat a Problem	Moderate Problem	Serious Problem	Severe Problem
1	2	3	4	5

Your Physical Functions

Sleep Pattern	1	2	3	4	5
Eating Problem	1	2	3	4	5
Bladder Control	1	2	3	4	5
Bowel Control	1	2	3	4	5
Seizures, Convulsions	1	2	3	4	5
Speech (stuttering or stammering)	1	2	3	4	5
Weight Problem	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Balance	1	2	3	4	5

Your Experience at Work

General Performance	1	2	3	4	5
General Satisfaction	1	2	3	4	5
Lateness	1	2	3	4	5
Absenteeism	1	2	3	4	5
Negative Feelings about Work	1	2	3	4	5
Relating to Supervisors	1	2	3	4	5
Relating to Co-workers	1	2	3	4	5
Relating to Subordinates	1	2	3	4	5

Your Inner Thoughts and Ideas

Thoughts about Hurting Yourself	1	2	3	4	5
Thoughts about Hurting Others	1	2	3	4	5
Unwanted Thoughts	1	2	3	4	5
Worrying about Health	1	2	3	4	5
Feeling Inferior	1	2	3	4	5
Seeing Things without Apparent Cause	1	2	3	4	5
Hearing Things without Apparent Cause	1	2	3	4	5
Experiencing Confusion	1	2	3	4	5
Problems with Memory	1	2	3	4	5

Your Feelings and Moods

Depression	1	2	3	4	5
Euphoria	1	2	3	4	5
Sudden Mood Swings (feeling high)	1	2	3	4	5
Nervousness	1	2	3	4	5
Lack of Energy	1	2	3	4	5
Not Liking Self	1	2	3	4	5
Not Liking Others	1	2	3	4	5

Your Behavior

Difficulty with Daily Routine	1	2	3	4	5
Letting Others Take Advantage of You	1	2	3	4	5
Hyperactivity (can't sit still)	1	2	3	4	5
Repeating Certain Acts	1	2	3	4	5
Physically Abusing Others	1	2	3	4	5
Using Alcohol to Cope with Problems	1	2	3	4	5
Lying	1	2	3	4	5
Stealing	1	2	3	4	5
Withdrawal from Others	1	2	3	4	5
Overly Dependent	1	2	3	4	5
Overly Suspicious	1	2	3	4	5
Hostility	1	2	3	4	5
Problems with Spouse	1	2	3	4	5
Problems with Children	1	2	3	4	5
Problems with Friends	1	2	3	4	5

Have you ever been physically abused?	☐ Yes	☐ No
Have you ever been sexually abused?	☐ Yes	☐ No
Have you ever thought about committing suicide?	☐ Yes	☐ No
Have you ever told anyone you would commit suicide?	☐ Yes	☐ No
Have you ever been so angry that you felt you might kill someone?	☐ Yes	☐ No

If you have responded yes to any of the above questions, please explain: _____

Prior Mental Health Services

Have you ever received counseling or psychiatric treatment in the past? ☐Yes ☐No

(If no, skip the questions in this section and go on to the next section.)

If yes, please answer the following questions:

In all, how much time have you spent in counseling?

☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-18 months ☐ 18-24 months ☐ More than 2 years

How long ago were you in counseling or treatment?

☐ In treatment now ☐ Less than 3 months ago ☐ 3-6 months ago ☐ 6 months - 1 year ago ☐ More than 1 year ago
☐ Other: _____

List psychiatric hospitals, treatment centers, or medical hospitals with psychiatric units you have been in:

Dates of Hospitalization

Problems/Diagnosis/Reason

Satisfied with treatment

1. _____
2. _____
3. _____

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

List other day treatment or partial hospital programs you were in:

Dates of Treatment

Problems/ Diagnosis/ Reason

Satisfied with treatment

1. _____
2. _____
3. _____

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

List name(s) of outpatient therapists you have received treatment from:

Dates of Treatment

Problems/Diagnosis/Reason

Satisfied with treatment

1. _____
2. _____
3. _____

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

Type of Outpatient you received:

☐ Individual Counseling ☐ Group Counseling ☐ Family Counseling ☐ Intensive Counseling (2-3 years)

☐ Other: _____

If in outpatient therapy, how many sessions did you attend?

☐ 1 or 2 sessions ☐ 3-10 sessions ☐ More than 10 sessions

How often did you miss scheduled sessions?

☐ Never ☐ Less than ½ of the time ☐ More than ½ of the time ☐ Almost all the time

Please list any medications that you have been treated with in the past for anxiety, mood, or behavioral problems:

Medication	Duration	Response/Side Effects
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Chemical Use History**Caffeine: Cups per day?**

Coffee	☐ None	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ More
Tea	☐ None	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ More
Cola	☐ None	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ More

Cigarettes:

Do you smoke? ☐ No ☐ Yes If so, how many packs a day, week, month, or year? _____

Cigars:

Do you smoke? ☐ No ☐ Yes If so, how many a day, week, month, or year? _____

If you currently use drugs or have used drugs in the past, please fill in the following blanks:

Substance	No	Yes	Amount	How Often	Age/Date First Used	Date Last Used
Alcohol	☐	☐	_____	_____	_____	_____

Marijuana	☐	☐	_____	_____	_____	_____
Speed/Amphetamines	☐	☐	_____	_____	_____	_____
Cocaine	☐	☐	_____	_____	_____	_____
LSD	☐	☐	_____	_____	_____	_____
Prescription	☐	☐	_____	_____	_____	_____
Other: _____	☐	☐	_____	_____	_____	_____

Number per week of: Beers: _____ Wine: _____ Mixed Drinks: _____

Number of times for Marijuana use: Per Day: _____ Per Week: _____ Per Month: _____

Which of the following reactions have you had as a result of substance use/abuse?

☐ Anger/Violence	☐ Guilt/Self-Respect	☐ Conflict with Family or Friends
☐ Legal Problems	☐ Job/School Problems	☐ Financial Problems
☐ Health Problems	☐ DUI	☐ Blackouts
☐ Seizures	☐ Withdrawal	☐ Depression
☐ Other: _____		

Have you sought treatment for drug abuse? ☐ No ☐ Yes

If yes, please explain and give the results: _____

Do you consider the drug abuse a problem? ☐ No ☐ Yes

Are you addicted to the substance? ☐ No ☐ Yes

How motivated are you to change? ☐ None ☐ A Little ☐ Somewhat ☐ A Lot

Legal History

Have you ever been arrested? ☐ No ☐ Yes If yes, please explain: _____

Were charges filed? ☐ No ☐ Yes If yes, what charges? _____

Are you pending court now? ☐ No ☐ Yes

Disposition of Charges: _____

Are you currently on probation? ☐ No ☐ Yes

If so, give the name of the probation/parole officer: _____

Health History

Are you currently experiencing any of the following?

☐ Abdominal Pain	☐ Backache
☐ Chest Pain	☐ Colitis
☐ Difficulty Sleeping	☐ Eye Problems
☐ Hearing Problems	☐ Hypertension
☐ Palpitations	☐ Problems with Skin
☐ Ulcers	☐ Vomiting
☐ Shortness of Breath	☐ Hypoglycemia
☐ Change in Menstrual Cycle	☐ Change in Urinary Pattern
☐ Gastrointestinal Problems	☐ Loss of Sexual Interest
☐ Change in Bowel Habits	☐ Loss or Increase in Appetite
☐ Cough	☐ Headache
☐ Problems with Muscles, Joints, Bones	☐ Other: _____

Primary Care Physician: _____

His/Her Address: _____ Phone #: _____

Hospital/Location:

Nature of Problem:

1. _____

2. _____

3. _____

Brothers: _____

Step Brothers: _____

Half Brothers: _____

Sisters: _____

Step Sisters: _____

Half Sisters: _____

None: ☐

Age(s) of Brothers: _____ Age(s) of Sisters: _____

How many children do you have? None: ☐ Boys: _____ Girls: _____

Age(s) of sons: _____ Age(s) of daughters: _____

☐ Spouse☐ Mother

☐ Father

☐ Mother-In-Law☐ Father-In-Law☐ Sister

□ Brother

☐ Friend☐ Permanent Partner

☐ Other: _____

(It may be easier to fill out the following table if you write the name of the relative in the areas below each category)

[illegible]

Been Involved In Criminal Behavior									
Sleeping Disturbances that were Ongoing									
Victim of Sexual Abuse									
Sexual Abuser									
Spent Time in Prison									
Convicted of a Sexual Offense									
Eating Disorder									

Describe any other relevant family issues: _____

Level of Functioning

Have you experienced any difficulties at work? ☐ No ☐ Yes

If yes, please explain: _____

Have you experienced any difficulties at home? ☐ No ☐ Yes

If yes, please explain: _____

Have you experienced any difficulties in your relationship with your spouse?

☐ No ☐ Yes

Have you experienced any difficulties in your relationships with your children?

☐ No ☐ Yes

Have you experienced any difficulties in your relationships with your friends?

☐ No ☐ Yes

If you answered yes to any of the questions above, please explain: _____

Is there any additional information that you feel would be helpful in understanding your current problem(s) and/or concerns? _____

Do you have any concerns regarding the scheduling of your first appointment? _____

THANK YOU FOR YOUR HELP IN COORDINATING YOUR CARE!