COMMANDER
COUNSELING & WELLNESS

CLIENT INFORMATION

Name _____ Date of Birth _____/_____/_____

Email _____ Phone (_____)_____-_____

Gender _____ Ethnicity _____

Address _____

City and State_____ Zip Code _____

Parent/Guardian name (if under 18 years old): _____

Emergency Contact Name _____ Phone (_____)_____-_____

Who referred you here? _____

INSURANCE

Insurance Name _____ Member ID # _____

Insured Name _____ Insured DOB _____

BILLING & PAYMENT INFO

For non-Medicaid patients, we require you keep a credit, debit, or health card on file in case of a no-show in which we charge a $65 fee.

Card number: _____ Exp. Date: _____/_____

3-digit Security Number: _____ Zip Code: _____

Clients are now able to take advantage of easier pay options, with automatic payments. A credit card is stored in a HIPAA secured format and automatically processes copays and deductibles at the end of the day. This adds convenience of not having to pay at the time of the session, and the ability to pay online through the client portal.
I authorize Commander Counseling & Wellness (CCW) to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that CCW will charge my card for $65 as a late cancel or no show if I do not show up for the appointment.
I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Signature:_____Date:_____/_____/_____

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Payment/copayments are due at the time of service. If you do not have your copayment you may be asked to reschedule your appointment. We accept cash, check, and credit/debit cards. Payment is determined by the following:

- Medicaid (Soonercare) insures you and the treatment are covered under the age of 18: No payment is due for services.
- You are insured by a Managed Care plan with which your provider is contracted, it is your responsibility to make sure that we are contracted with your particular plan. The amount due at the time of service will depend on the specifics of your plan. Co-pay and deductible are due at the time of service.
- If you are unable to provide insurance information at the time of the appointment you will be required to make payment in full or reschedule your appointment. You will be given an itemized receipt that you can file with your insurance company for reimbursement.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

RELEASE OF INFORMATION

I authorize Commander Counseling & Wellness (CCW) to furnish information to insurance carriers concerning my diagnosis and treatments and I hereby assign to the provider all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also authorize the release of all or part of the client's record, for incident of care to any person liable for any part of provider charges. I also acknowledge the responsible party is liable for payment in full for the services provided. I also understand the responsible party is liable for all attorneys' fees necessary in the collection of my delinquent amount. All appointments require 24-hour notice for cancellation. If 24-hour notice is not provided, the responsible party will be charged **$65** for the charge of the session. I also authorize my provider to consult with other CCW mental health care providers on an as needed basis.

Signature _____ Date _____/_____/_____

Relationship to Client if Minor _____

CONSENT FOR TREATMENT

I consent to medical treatment for myself or for the patient/client for whom I am the parent or legally authorized representative. I understand that Commander Counseling & Wellness will share patient/client health information according to federal and state law for treatment and operations. Further, I understand that the information discussed in the counseling setting is held confidential and will not be shared without written permission except under the following conditions:

1. The patient/client threatens suicide.
2. The patient/client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The patient/client reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The patient/client reports abuse of the elderly.
5. The patient/client reports sexual exploitation by a therapist.
6. The psychologist is required by court order to reveal privileged information.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies. Communication between the clinician and patient/client will otherwise be deemed confidential as stated under the laws of this state.

Having read and understood the above, I agree to these limits of confidentiality.

_____

Name of Patient Signature of Patient or Guardian Date

PSYCHOLOGIST-PATIENT SERVICES AGREEMENT

Welcome to Commander Counseling and Wellness. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy
Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement and can be found at CommanderCounselingandWellness.com, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a physician visit. Instead, it calls for very active effort on your part. In order for therapy to be most successful, you will have to work on issues discussed, both during our sessions and at home.
Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits.
Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

Sessions are typically 45-50 minutes, once per week at a time agreed on, although some sessions may be longer or more/less frequent. **Once an appointment hour is scheduled, you will be expected to pay the $65 no show fee unless you provide at least 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If it is possible, we will try to find another time to reschedule the appointment.

Our providers make every effort possible to schedule clients at the earliest possible opportunity. One business day prior to your appointment you will receive a text message reminder (if you have not opted out of this service). The text message will request that you reply to confirm, reschedule, or cancel your scheduled appointment. Should you need to reschedule or cancel, we ask that you notify us 24 hours prior to your appointment, as we have individuals on the cancellation list that would appreciate an earlier appointment. On the occasion that you miss an appointment, you will receive a notice of the "No Show." Should this occur a second and future times, you will be responsible for a $65 fee that cannot be billed to your insurance. This fee can be collected either by charging a card on file or if you choose not to have a card on file must be paid in office or over the phone prior to scheduling your next appointment. If you are more than 15 minutes late for your appointment, your provider may ask that you reschedule.

TELEHEALTH

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.

- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

EMAIL & TEXTING

Our office may only use email and texting only to schedule or modify appointments. Please do not email/text your provider any content related to your therapy sessions, as it is not secure or confidential. If you choose to communicate with us through email/texting, be aware that unencrypted emails may be intercepted and read by third parties. Also, all email/texts are retained in the logs of the internet and telephone service providers. While it is unlikely that someone will look at these logs, they are able to be read by the system administrator(s). Also, please be aware that any emails or texts received by your service provider and sent from your provider become a part of your client file. Note that University of Oklahoma emails are considered open records and can be requested by outside sources.

SOCIAL MEDIA POLICY

Our office does not accept friend or contact requests from current or former clients on any social networking site (i.e. Facebook, LinkedIn, Twitter, etc.). Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective policy. It may also blur the boundaries of a therapeutic relationship.

PROFESSIONAL FEES

Hourly fees range from $80-$150 for 45-50-minute individual psychotherapy sessions. In addition to weekly appointments, we may charge $150 per hour for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. We charge $150 per hour for preparation and $350 per hour for attendance at any legal proceeding; the latter is charged from the time we leave the office until we return.

CONTACTING US

Due to our work schedule, we are often not immediately available by telephone. While we are usually in the office between 9 AM and 5 PM, we will not answer the phone when we are with a patient. When we are unavailable, you may leave a message. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of times when you will be available. In emergencies or crises that you believe cannot wait for us to return your call, contact your family physician or go to the nearest emergency room and ask for the mental health professional on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only disclose information about your treatment to others if you sign a written authorization form that meets certain

legal requirements imposed by HIPAA. There are other situations that do not require your authorization, including the following:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that we may employ administrative staff to assist us with billing. These personnel need to have access to protected information in order to perform their duties. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without our permission.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. There are some other situations where we are permitted or can be required to disclose information without your consent or Authorization.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, we may disclose information relevant to that claim to the appropriate parties, including the Administrator of the Workers' Compensation Court. There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.
- If we have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that we report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation, the law requires that we report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, we may be required to provide additional information.
- If a patient communicates an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable victim and he/she has the apparent intent and ability to carry out the threat, or if a patient has a history of violence and we have reason to believe that there is a clear and imminent danger that the patient will attempt to kill or inflict serious bodily injury upon a reasonably identified person. We may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.
- If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and WE will limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. **EXCEPT** in circumstances that involve danger to yourself and/or others, where information has been supplied to us confidentially by others, or **if the information has been gathered in a reasonable anticipation of or specifically for use in litigation**, you may examine and/or receive a copy of your Clinical Record if you request it in

writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence or have them forwarded to another mental health professional, so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $1.00 for the first page and $.50 for each additional page (and for certain other expenses). If we refuse your request for access to your records, you have a right of review in some instances, which we will discuss with you upon request. In some instances, there is no right to have a review of the decision to refuse your request to inspect and/or copy the protected health information of your record.

Forms and Letters: Please allow for at minimum 3 business days for all forms and letters to be completed. Please allow for a minimum of 10 business days for Psychological Evaluation Reports to be completed after the date of feedback. If payment for Evaluations is not paid in full at date of feedback, please allow for a minimum of 10 business days for the report to be completed after payment is received.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is our policy to request an agreement from parents that they will give up their access to their child's records. If they agree, during treatment we will provide them with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have. We reserve the right to refuse to provide services to a child if a parent will not agree to accept these conditions. Parents should be aware that the agreement constitutes a binding contract.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company.

Sometimes insurance companies require additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report WE submit, if you request it. **If your insurance denies reimbursement, you will be responsible for payment of the provided services.**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____

Client Signature Date

USE OF EMAIL FOR DISTRIBUTION OF INFORMATION OR RECORD

With permission, you may be able to receive your medical records (e.g., psychological evaluation report) via email. We do not receive emails. Please read the following and chose an option.

- When we send you an email, the information that is sent may not be encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website.
- The guidelines state that if a patient/client has been made aware of the risks of unencrypted email, and that same patient/client provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

Option 1 – Allow Unencrypted Email

I understand the risks of unencrypted email and do hereby give permission to CCW to send me personal health information via unencrypted email

_____

Signature Printed Name Date

_____

Email address

Option 2 – Do Not Allow Unencrypted Email

I do not wish to receive personal health information via email

_____

Signature Printed Name Date

COMMANDER
COUNSELING & WELLNESS

PARENT BACKGROUND INFORMATION FORM

So that we can help you, please fill out the following information about **your child**. This information will be treated in a professional manner. Please fill this out to the best of your ability.

Today's Date: _______ Child's Name: __________ Ethnicity: _____

Gender: _____ Date of Birth: ____/_____/_____ Age: _____ Grade: _____

Parent/Guardian Name(s): _____ Phone: (____) ___-_____

How did you find us? _____

Presenting Problems or Concerns

In your own words, what are the problems or concerns that your child is experiencing?

When would you say these problems first began? _____

Family History

	Name	Living at home?	Age	Level of Education	Occupation
Father(s)					
Mother(s)					
Siblings(s)					
Other people in the home					

The child's parents are: Married _____ Divorced _____ Never Married _____
Was the child adopted/fostered? _____
What does the child get in trouble for at home?

Please circle any of the following which were problems for your child/adolescent:

Stealing	Tiredness/fatigue	Clumsiness	Lying	Eating problems
Over activity	School problems	Sex problems	Underactivity	Running away
Shyness	Easily upset	Extreme fears	Self-critical	temper tantrums

What are his/her strong points or favorable characteristics?

_____

_____

What games or particular interests does the child enjoy?

_____

_____

How does the child get along with teachers as compared with his/her parents?

_____

_____

How does he/she get along with others of the same age?

_____

_____

How many friends does the child have? _____

What people has the child felt close to in his/her life?

_____

What support system does the child have (family, church, clubs, friends, etc.)?

_____

_____

What troubles has the child's family had with the law?

_____

_____

Has Child Protective Services ever been involved with the family? If yes, why?

_____

_____

What religion does your family belong to? _____

Are there any aspects to the child's cultural identity or background that cause stress?

_____

School History

Name of School: _____ Grade: _____

Main teacher's email address:

_____

What grades did they repeat or skip? _____ GPA: _____ Any learning disabilities? _____

Do they have problems with (please circle):

Reading Writing Math Social Studies Science Languages

What type of special education or gifted services did they receive? _____

Did they receive speech and language therapy? _____

Do they have problems getting along with peers? _____ Teachers? _____

How many times have they received detention? _____ Suspended? _____ Expelled? _____

Circle what most describes the child's school achievement:

☐ Below Average (mostly D's & F's)
☐ Average (mostly C's)
☐ Above Average (mostly A's & B's)
☐ Low Average (mostly C's & D's)
☐ High Average (mostly B's & C's)

What is your impression of your child's learning potential?

Low Average Above Average Gifted

Is homework a problem? If so, please circle all that apply:

Can't get started Doesn't understand work Forgets to bring home materials Forgets assignments

No place to work Doesn't anticipate deadlines Easily distracted Argues about doing work

Takes too long The most stressful time of day Needs you there constantly Doesn't care

How often do they miss school? _____

How hard do they have to try in school to get good grades? _____

Is your child's work made more difficult by problems with:	Not at All	Somewhat	A Lot
Poor concentration	_____	_____	_____
Giving up too easily	_____	_____	_____
Inconsistent performance	_____	_____	_____
Poor motivation	_____	_____	_____
Disorganization	_____	_____	_____
Spacing out or daydreaming	_____	_____	_____
Not finishing things	_____	_____	_____

Having low frustration tolerance	_____	_____	_____
Anxiety/Sadness	_____	_____	_____
Rapidly shifting from one thing to another	_____	_____	_____
Being easily distracted	_____	_____	_____
Impulsiveness	_____	_____	_____

Biomedical and Developmental History

Pre-natal history (health and medical problems during pregnancy, mother's use of medications and/or substances: _____

_____

Was the pregnancy planned? _____ Welcomed? _____ Stressful? _____

Peri-natal history (details of labor/delivery, birth weight): _____

_____

Did the baby have any feeding problems?: _____

Was the child delayed in developing these areas:

Sit Alone: _____ Say first word: _____ Ride a tricycle: _____ Learn basic colors: _____

Walk alone: _____ Use two words together: _____ Become toilet trained: _____ Dress self: _____

Does your child have any of the following? (please circle all that apply)

a. Sleep problems (falling asleep, staying asleep, nightmares, sleepwalking, etc.)
b. Brain disorders (headaches, seizures, motor or vocal ticks, tremors, confusion, muscle weakness, coordination difficulties, head injury, staring spells, unexplained anger or sudden and unprovoked emotional outbursts, etc.)
c. Lung problems (shortness of breath, asthma, coughing, etc.)
d. Skin disorders (acne, hair loss, birthmarks, dermatitis, eczema, etc.)
e. Blood disorder (anemia, bleeding, bruising, etc.)
f. Heart problems (chest pain, surgery congenital heart disease, murmur, etc.)
g. Sexual problems (birth control, promiscuity, excessive masturbation, etc.)
h. Kidney problems (bedwetting, infections, etc.)
i. Muscle or bone problems (scoliosis, injuries, strains, spasticity, etc.)
j. History of poisoning (lead, chemicals, other)
k. Gland problems (obesity, slow or fast growth, early or delated puberty, thyroid problems, etc.)
l. Stomach or bowel problems (diarrhea, vomiting, constipation, stomach aches, stool soiling, etc.)
m. Genetic disorders (birth defects, inherited traits, chromosome abnormalities, etc.)

What have they been hospitalized for in the past? _____

What accidents has this child had? _____

Have they ever received a head injury where they lost consciousness (knocked out)? _____

If yes, approximately how many times? _____ How long? _____

Any problems with: Hearing _____ Vision _____ Motor coordination _____ Speech _____

What is the name of the physician who usually sees the child? _____

Any significant medical conditions (diabetes, allergies, hypertension, head traumas, cancer, etc.)? _____

When was their last medical examination? _____

Please list current and previously prescribed medications:

Name of Meds	Dosage	Started Taking	Stopped Taking

Who is the prescribing doctor? _____

Psychological History

What previous experiences has the child had with counseling or psychological testing?

Dates	Therapist or Institution	Nature of problem

What has the child been previously diagnosed with? _____

Has the child witnessed/experienced any abuse? _____

Does the child have any problems with eating? _____

Has the child ever been hospitalized for emotional or psychological reasons? _____

Has the child ever threatened or attempted suicide? If yes, please explain. _____

_____

What emotional troubles, nervous breakdowns, etc. have there been in the child's family or relatives?

_____

Please review each of the following lists of characteristics and check any item that applies to your child:

A. Does your child have any of the following attention related troubles?

___ Fidgets
___ Easily distracted
___ Difficulty playing quietly
___ Shifts from one activity to another
___ Often interrupts or intrudes on others
___ Often engages in dangerous activities
___ Blurts out answers before completed
___ Difficulty remaining seated
___ Difficulty awaiting turn
___ Difficulty sustaining attention
___ Often does not listen
___ Often loses things
___ Difficulty following instructions
___ Often talks excessively

B. Does your child have any of the following behavioral problems?

___ Often deliberately acts to annoy others
___ Is often touchy or annoyed by others
___ Often swears/use obscene language
___ Often blames others for own mistakes
___ Actively defies rules from adults
___ Often argues with adults
___ Is often angry or resentful
___ Is often spiteful or vindictive
___ Often loses temper
___ Takes other people's property

C. Does your child show any of the following anxious symptoms?

___ Unrealistic worry about future events
___ Persistent refusal to go to school
___ Bothersome thoughts
___ Unrealistic concerns about competence
___ Repeated nightmares about separation
___ Distress when separated from home
___ Unrealistic and persistent worry that something will happen to you
___ Avoidance of being alone
___ Physical aches and pains
___ Marked self-consciousness
___ Marked inability to relax
___ Ongoing refusal to sleep alone
___ Excessive need for reassurance

D. Does your child show any depressive symptoms?

___ Diminished pleasure in activities
___ Depressed or irritable mood every day
___ Poor appetite or overeating
___ Trouble sleeping or sleeping too much
___ Feelings of worthlessness or guilt
___ Suicidal thoughts or actions
___ Agitation or sluggish
___ Low self-esteem
___ Low energy or fatigue
___ Feelings of hopelessness

E. Does your child have any of the following symptoms?

___ Prefers to play by self
___ Poor social skills or awkwardness
___ Poor eye contact or social skills
___ Difficulty understanding sarcasm/metaphors
___ Overly fixates on interests/topics
___ Excessive need for routines
___ Sensory sensitivity

F. Does your child show any symptoms of trauma?

___ Has experienced unstable home life
___ Does not seek comfort when distressed
___ Does not have empathy for others
___ Unexplained irritability or sadness
___ Overly familiar boundaries with strangers
___ Would walk off with a stranger
___ Has trauma-themed play
___ Nightmares related to trauma
___ Stress when exposed to trauma reminders
___ Avoids talking/thinking about trauma
___ Feels guilty about trauma
___ Startles easily

G. Does your child show any of these symptoms?

___ Explosive temper with little provocation
___ Excessively monotonous or bland affect
___ Household member in jail/prison
___ Household member has problems with drugs/alcohol
___ Unusual fears
___ Substance abuse (drugs, alcohol)
___ Has more than 3 significant outbursts/week
___ Is generally irritable

What significant events have happened in the child's life (e.g., parents' divorce, removed from home, death or friend or family, abuse, moves, etc.): _____

_____

_____

Any other information that we need to know? _____

_____

_____