Sundstrom
CLINICAL SERVICES

Welcome to Sundstrom Clinical Services! We are grateful that you have reached out to us and we look forward to joining with you in your needs. To get the process started there is a set of forms you will need to complete:

1. Informed Consent
2. Client Registration
3. Financial Agreement
4. HIPAA Acknowledgement and Consent
5. Cancellation and No-Show Agreement
6. The Child & Adolescent Intake History Form

PLEASE NOTE: All of our forms are available as fillable PDF forms. To access, view, download, complete and print fillable forms you will need to use Adobe Acrobat Reader. Adobe Acrobat Reader is available for free and can be downloaded from the following web site: https://get.adobe.com/reader/. There are **two methods** you can use to complete the forms and ensured they are filled out:

Method 1

1. Right click on the form you need and select "Save link as." Give the file a name.
2. Go to your folder and open the file in Adobe Acrobat Reader.
3. Type/ fill in all grey boxes (All boxes outlined in red are required.) Save your file.
4. Please email your completed forms to info@sundstromclinic.com. Use **"New Client Registration"** as the subject line and make sure to attach your forms.

Method 2

1. Click on the form you need.
2. Once the form appears, download the forms and give it a name and save in a folder.
3. Go to your folder and open the file in Adobe Acrobat Reader.
4. Type/ fill in all grey boxes. (All boxes outlined in red are required.) Save your file.
5. Please email your completed forms to info@sundstromclinic.com. Use **"New Client Registration"** as the subject line and make sure to attach your forms.

Please email your completed forms to info@sundstromclinic.com. Use "New Client Registration" as the subject line and make sure to attach your forms.

Method 3: If you do not have access to filling in PDF forms you may also print the blank forms, handwrite in your answers, and mail them to:

Sundstrom Clinical Services
21900 Willamette Drive, Suite 202
West Linn, OR 97068

Please do not hesitate to call us if you have any questions. You may reach us at 503-653-0631. You can also access more information at www.sundstromclinic.com. We look forward to meeting you soon, and in the meantime wish you good health.

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INFORMED CONSENT

Welcome to Sundstrom Clinical Services. We are glad to join you in your needs. This signed document will constitute a binding agreement between us. Please read it carefully and discuss any questions you may have with your provider at the beginning of treatment.

PSYCHOLOGICAL SERVICES

Psychotherapy is an active process. We will work together with a variety of strategies to address your concerns and goals, based upon the theory, training and approach of your specific provider. We encourage you to be active in pursuing those goals outside of therapy as well.

Psychotherapy can have some risks, of which you should be aware, such as uncomfortable levels of feelings like sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires recalling unpleasant aspects of your history.

By the end of our initial evaluation, we will discuss impressions of what our work will include and our plans for treatment. You should also determine whether your provider is the right fit for your needs, and if you feel comfortable in continuing in the treatment relationship. We are happy to discuss any treatment question. If needed, you may request a referral or transfer to an alternative provider.

If you have not attended therapy within 120 days, you are no longer considered an active patient under the care of your provider. However, you are always welcome to restart care with your previous provider by attending additional sessions.

CONTACTING US

Most of the communication with your therapist should occur during scheduled sessions. Your therapist is not often immediately available by telephone or email. General questions regarding scheduling and billing should be directed to our central office during normal business hours. Confidential voice messages regarding therapeutic information may be left for your provider. In the event of emergencies outside of normal business hours, the office has a 24-hour phone service to address mental health crises and the on-call provider will respond. If you are in immediate danger, your first priority should be to call 911 or go to the nearest emergency room.

PROFESSIONAL RECORDS

We are required to keep appropriate records of our work together. It is our general policy that clients do not review medical records without their provider. However, if you request, we will provide you with a treatment summary unless we believe it would be emotionally damaging. If this is the case, we will be happy to forward the summary to another appropriate mental health professional who is working with you. You should be aware that this will be treated in the same manner as any other professional (clinical) service and you will be billed accordingly.

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LIMITATIONS TO PRIVACY AND CONFIDENTIALITY

In general, the law protects the privacy of personal health information between a client and a psychotherapist. We can only release information with your written permission. However, there are several exceptions.

If we believe that a child, an elderly person, or a disabled person is being abused, we are ethically bound to file a report with the appropriate state agency, which could require revealing confidential information. Master's level Therapists and Nurse Practitioners have a legal requirement to report.

If we believe that a client is threatening serious bodily harm to themselves or someone else, we may be required to take protective actions. These actions may include a transfer to a higher level of treatment (e.g., hospitalization) or notification of family members that can help protect, any potential victims, or the police. In these rare situations, we make every effort to discuss it with you prior and may seek professional consultation if we deem necessary.

In psychotherapy with couples, information on both is recorded in the same health record. If there is a need to release information, we will require written consent from both parties to release that information.

Often you have the right to prevent the release of information in legal matters. However, in some circumstances a judge may require our testimony. The scope of that testimony is limited only to the reporting of facts that occurred in the therapy office. We cannot provide professional opinions in court testimony as this is a conflict with the role of a therapist. Professional evaluators should be sought for psychological opinions.

_____ _____

Client's Name **Date**

☐ ***Checking this box indicates that you have READ the information in its entirety in this document and agree to abide by its terms during our professional relationship.***

_____ _____

Spouse's Name (if both participating) **Date**

☐ ***Checking this box indicates that you have READ the information in its entirety in this document and agree to abide by its terms during our professional relationship.***

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CLIENT REGISTRATION - Please complete this form in ink so it is legible for scanning

Client Name: _____ DOB: ____/____/____ Gender: _____
First MI Last

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email address: _____ *Primary Contact Method:* ☐ *Home* ☐ *Cell* ☐ *Work* ☐ *Email*

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Legally Separated*

Please include parent(s) / guardian(s), spouse / significant other, or emergency contact

Contact 1: _____ DOB: ____/____/____ Relationship to Patient: _____
First Last

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email address: _____ *Primary Contact Method:* ☐ *Home* ☐ *Cell* ☐ *Work* ☐ *Email*

Contact 2: _____ DOB: ____/____/____ Relationship to Patient: _____
First Last

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email address: _____ *Primary Contact Method:* ☐ *Home* ☐ *Cell* ☐ *Work* ☐ *Email*

Responsible Party

This is the person responsible for payment – it is not necessarily the insured.
Responsible party listed below must be the same person to sign the Financial Agreement.

Name: _____ DOB: ____/____/____ Relationship to Patient: _____
First Last

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email address: _____ *Primary Contact Method:* ☐ *Home* ☐ *Cell* ☐ *Work* ☐ *Email*

Insurance Information

PLEASE ENSURE ALL FIELDS BELOW ARE COMPLETE: Missing information may result in billing errors that may cause balances to be billed to the responsible party.

PRIMARY Insurance: _____ Provider Service # *(Listed on back of card)*: _____

Member ID #: _____ Group #: _____

Name of Insured: _____ DOB: ____/____/____ Relationship to Patient: _____

Insured's Address: _____ City: _____ State: ____ Zip: _____

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OUR FINANCIAL POLICY

Thank you for choosing Sundstrom Clinical Services (SCS). The following is a statement of our financial policy. All patients must accept our financial policy before receiving treatment. Full payment of your bill is considered part of your treatment.

Your Insurance

Accepted Insurance Policies: Our relationship is with you, not your insurance company. You are responsible for verifying if SCS providers are in-network with your insurance company. With constant changes in health insurance coverage, and plans merging and restructuring, we may not be enrolled as providers with your plan. If you change your insurance, you are responsible for notifying SCS prior to any services covered by your new policy. It is your responsibility to know your insurance benefits as it may not cover all the services provided to you. Any uncovered services are the responsibility of the patient.

Mental Health Benefits: Mental health benefits are often covered by a carrier other than your medical benefits. It is your responsibility to confirm your SCS provider is in network with your mental health carrier, and what your mental health benefits are.

Claims: Your insurance policy is a contract between you and your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you. We cannot bill your insurance company unless you give us your complete insurance information. Any balance after processing of our claim by your carrier is your responsibility. When there is a dispute over correct payment amount or covered services, our billing company makes every effort to work with your carrier to resolve it. Because the contract is between you and your carrier, if we are unable to resolve the dispute the balance will be transferred to patient responsibility.

Co-Payment: A fixed dollar amount set by your insurance contract that is required to be paid at the time of an office visit. All co-pays are due prior to treatment.

Deductible: An annual dollar amount established by your insurance plan that is deducted from insurance benefits. This amount is your obligation and you will be required to pay this at the time of service.

Co-Insurance: A percent set by your insurance plan that is deducted from your insurance benefits.

Prior Authorization: You are responsible for verifying if prior authorization is required for any services provided by SCS. As a courtesy to our patients, for certain types of testing we do request prior authorization from your insurance carrier. THIS IS NOT A GUARANTEE OF PAYMENT. Any unpaid charges will be your responsibility if they are not covered by your insurance.

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Other Services

Other services provided by SCS which are not covered by insurance, including but not limited to phone calls, follow-up correspondence, out-of-the-office consultation, completion of forms for disability, FMLA, etc., legal services, including court preparation, travel time and court testimony, cannot be billed to your insurance and are due at the time of service.

Late Arrival

If you arrive more than 10 minutes late for your appointment, you may be charged $25. This fee is not covered by your insurance.

Cancellation and No-Show Policy

Refer to SCS Cancellation and No-Show Agreement.

Past Due and Collection Accounts

Patients with past due accounts will be required to make payment in full before being seen at SCS. If your account is referred to an outside collection agency you will be required to pay any unpaid balance before further appointments can be scheduled. If your account has been sent to collections or you file for bankruptcy, for future appointments you will be required to pay cash in advance for any services which will not be covered your insurance. We reserve the right to forward your account to a collection agency if it is determined to be uncollectible.

Returned Checks

A $35.00 service fee will be charged for all checks returned for insufficient funds. If your check is returned, you will be required to prepay in full by cash or credit card for additional services.

Method of Payment

We accept cash, check, Visa, MasterCard and Discover.

Statements

Prefer electronic statements? Email: _____

Responsible party name below must match the responsible party information entered on the patient registration form under the "Responsible Party Information" section.

_____ _____
Responsible Party's Name **Relationship to patient**

_____ _____
Client's Name **Date**

☐ **Checking this box indicates that you have read and understand this office financial policy and agree to comply and accept responsibility for any payment that becomes due as outlined.**

*All fees are subject to change without prior notice

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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights:

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices:

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures:

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

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Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs./ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office.

If you have any questions about this notice, please contact:

Carol Lazrine, Practice Administrator
503/653-0631

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ACKNOWLEDGEMENT AND CONSENT

I understand that **Sundstrom Clinical Services, LLC** (SCS) will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that SCS may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how SCS will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of SCS, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of SCS's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that SCS is not required by law to agree to such requests.

☐ **By checking this box, I agree that I have reviewed and understand the information above and that I <u>been offered</u> a copy of the Notice of Privacy Practices.**

_____ _____
Client's Name **Date**

_____ _____
Parent/Guardian's Name **Description of Authority**

**Client's 14 years and older must also sign along with parent/guardian or authorized representative*

☐ **By checking this box, I agree that I have reviewed and understand the information above and that I <u>been offered</u> a copy of the Notice of Privacy Practices.**

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Cancellation and No-Show Agreement

Sundstrom Clinical Services is committed to providing our patients with exceptional care. We seek to honor your scheduled appointment times. When a patient cancels without giving notice, we are prevented from being able to provide service to others who desire an appointment.

If you need to cancel or change your appointment, it is your responsibility to call the office at 503-653-0631 at least **2 business days (48 hours)** prior to your scheduled appointment (Note: Monday appointments must be cancelled by Thursday).

You will be charged **$75** for appointments that are:
• Cancelled less than **48** hours before your scheduled appointment or
• You do not show for your scheduled appointment

This cancellation/no show fee is not covered by your insurance.

If you miss two (2) scheduled appointments without notifying the office, we will cancel the rest of your scheduled appointments. You will need to talk with your provider in order to schedule further appointments.

If you feel you have been wrongly charged for a missed appointment or late cancellation, please feel free to complete an appeals form, which will be reviewed by your provider.

☐ **I have read and understand this Cancellation and No-Show Agreement and agree to comply and accept responsibility for any payment that becomes due as outlined previously.**

_____
Client's Name

Responsible party name and signature below must match the responsible party information entered on the patient registration form under the "Responsible Party Information" section.

_____ _____
Responsible Party's Name **Relationship to patient**

_____
Date

**All fees are subject to change without prior notice.*

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CONFIDENTIAL INFORMATION – CPNP (Child/Adolescent)

1. PERSONAL INFORMATION

Person Completing Form: _____ Relationship: _____

Child/Adolescent's Name: _____ Date: _____

Gender: _____ Birth Date: _____ Age: _____

Grade In School: _____ School: _____ Phone: _____

Parents Names: _____

Parents Occupation: _____

Child lives with: ☐ Both parents ☐ Joint parenting(div) ☐ Mother ☐ Father ☐ Other: _____

Address: _____ _____
Street City/State/Zip Code

Phone: _____ _____ _____
Home Mother (work) Father (work)

May We Leave Messages For You At Home? Yes ☐ No ☐ At Work? Yes ☐ No ☐

Emergency Contact: _____ Relationship: _____ Phone: _____

How were you referred to Sundstrom Clinical Services? _____

Others Living In The Home: (names, ages, relationship to client) _____,

_____, _____,

_____, _____

Immediate Family Living Outside the Home: _____, _____
(name, relationship to client) (name, relationship to client)

2. COUNSELING ISSUES

Briefly describe the problem that brought you here today:

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Please check any of the symptoms that the child/adolescent has been having:

☐ Depressed mood	☐ Trouble concentrating	☐ Overwhelmed/Stressed
☐ Tearful/crying spells	☐ Memory problems	☐ Worried/Anxious
☐ Change in eating habits	☐ Difficulty following directions	☐ Feeling guilty
☐ Change in sleep habits	☐ Disorganization	☐ Feeling fearful
☐ Difficulty sleeping	☐ Difficulty getting started on tasks	☐ Panic Attacks
☐ Not enjoying usual activities	☐ Impulsive	☐ Stuttering
☐ Withdrawal from peers/family	☐ Decreased need for sleep	☐ Repetitive behaviors/tics
☐ Feeling hopeless	☐ Bouts of excessive energy	☐ Resistance to school
☐ Lack of energy	☐ Irritability	☐ Obsessions or compulsions
☐ Weight changes	☐ Problems getting along w/ family	☐ Security blanket/object/person
☐ Self Esteem problems	☐ Problems getting along w/ friends	☐ Fear of embarrassment
☐ Recurrent pain complaints	☐ Problems with anger/defiant	☐ Fear of bedtime
☐ Thoughts of killing self	☐ Acting violently	☐ Fire setting
☐ Has hurt or cut self	☐ Been pregnant/others pregnant	☐ Rule breaking

3. WHAT HAS BEEN DONE ABOUT THIS PROBLEM SO FAR?

HAVE YOU WORKED WITH THE CHILD'S TEACHER OR SCHOOL COUNSELOR? ☐ Yes ☐ No

If you have, please describe it below:

Name of teacher or counselor: _____

Date(s):

HAS THE CHILD BEEN IN COUNSELING BEFORE? Yes ☐ No ☐

HAS THE CHILD BEEN IN A PSYCHIATRIC HOSPITAL BEFORE? Yes ☐ No ☐

If yes, please describe it below. Start with most recent time first.

A. When did he/she have counseling? _____

Where did he/she go? _____ Name: _____

Explain what happened:

B. When did he/she have counseling? _____

Where did he/she go? _____ Name: _____

Explain what happened:

METHODS OF DISCIPLINE_____

4. MEDICAL INFORMATION

Who is the child's doctor?_____ Phone: _____

Has the child seen any medical provider (MD, NP, DO, Or specialest) within the past year? ☐ Yes ☐ No
What was it for?

Please list any **past** medications for this problem or related issues:

ARE THEY CURRENTLY TAKING ANY KIND OF MEDICATIONS (prescription or over-the-counter)?

Yes ☐ No ☐ Please list the medicines (and dosages) that he/she is currently taking:

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Please list any major problems that the child has had such as chronic illness, serious illness, operations, injuries or trauma to the head, etc.:

Does the child have allergies to anything? Yes ☐ No ☐ Please describe:

How many hours of sleep does your child get during a typical night? _____

Does your child have standard bedtime routines or rituals? Please explain:

What is your child's bedtime?

Does the child have problems with sleeping? Yes ☐ No ☐

☐ Difficulty falling asleep ☐ Frequent waking ☐ Can't sleep alone ☐ Nightmares
☐ Waking too early ☐ Sleepwalk ☐ Restless sleeper ☐ Snoring

Does the child have problems with pain? Yes ☐ No ☐

☐ Headaches ☐ Stomach Aches ☐ Other:

Does the child have problems with eating? Yes ☐ No ☐

☐ Eats too little ☐ Eats too much ☐ Excessively Picky ☐ Strong Aversion to textures

Does the child have problems with toileting? Yes ☐ No ☐

Urinary accidents: ☐ Nighttime ☐ Daytime Bowel Accidents: ☐ Nighttime ☐ Daytime

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Does the child use tobacco (any form)? ☐Current ☐Suspected ☐Past ☐No

Does the child use alcohol? ☐Current ☐Suspected ☐Past ☐No

Does the child frequently use caffeine (any form, including cola drinks)? ☐Current ☐Suspected ☐Past ☐No

Does the child use recreational drugs? ☐Current ☐Suspected ☐Past ☐No

Please list: _____

5. DEVELOPMENTAL/FAMILY HISTORY

Were there any problems with the pregnancy or the delivery of the child? ☐ Yes ☐ No

Was your child born on time? ☐ Yes ☐ No If not, how many weeks early _____ late _____

How much did your child weigh at time of delivery? _____

Were there any complications during the first few days/weeks of your child's life?

What was the mother's age at time of delivery _____ This was the mother's ___ pregnancy (1st, etc.)

Was there any substance (tobacco, alcohol, or drugs) use during the pregnancy of the child? Yes ☐No

If yes, please explain: _____

Did the mother use prescription medication or receive medical treatment during the pregnancy other than routine prenatal care? ☐ Yes ☐ No If yes, please explain:

Was your child delivered ☐vaginally or ☐c-section? Were there complications? ☐Yes ☐ No

If yes, please explain:

Any problems with eating, sleeping or crying spells (colic, nightmares, etc.)? ☐ Yes ☐No

Is your child right handed _____ or left handed _____ or uses both equally_____

Approximately when did the child first learn to sit? _____

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Approximately when did the child first learn to walk? _____

Approximately when did the child first learn to talk in single words? _____ In sentences? _____

Approximately when was the child toilet trained? _____

Describe any difficulties in the above:

Do you have any concerns about your child's ability or method of writing, coloring, tying shoes, use of fasteners, etc.?

Is there a family history of seizures, birth defects, heart rhythm problems?

Any hospitalizations? If yes, please describe:

Have there been any family crises such as separation, divorce, or death? ☐ Yes ☐ No
If yes, who?

Please list parent's occupations:

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Have any family members been diagnosed with the following:

Anxiety:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
Panic Attacks:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
Depression:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
Bipolar/Manic Depress:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
ADHD:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
Learning Disability:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
Reading disorder/Dyslexia:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
Schizophrenia:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
Autism/Asperger's/PDD:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
Tourette's/Tic Disorder:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None
Substance Use/Alcoholism:	☐ Mother	☐ Father	☐ Sib	☐ Grandparent	☐ Aunt, Uncle, Cousin	☐ None

Are there any important medical conditions that we should be aware of in the family?

Has the child been affected by any issues such as witnessing violence, having accidents, experiencing loss (including frequent moves of the family), or experiencing abuse (physical, sexual or emotional)?

☐ Yes ☐ No Please describe the relevant issue(s):

Briefly describe the child's relationship to parents:

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Briefly describe the child's relationship to siblings:

6. SCHOOL/SOCIAL HISTORY

When did the child start school? _____

Did your child receive early intervention services or attend Head Start? Please explain:

Were there any problems when the child started school? ☐ Yes ☐ No If yes, please describe:

What problems have come up in the recent school years?

Meltdowns or tantrums at school: ☐ Yes ☐ No

What grades is the child getting? _____

If there are poor grades, what do you see as the cause:

☐ Difficulty concentrating ☐ Not turning in completed work ☐ Not doing work ☐ Too anxious

☐ Skipping ☐ Not understanding/learning block ☐ Other: _____

Is your child on an IEP of 504 plan? ____Yes ___NO (Please describe the reasons for the IEP and the interventions used):

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Do you have any previous testing/assessment results? ☐ Yes ☐ No (**IF YES PLEASE BRING TO SESSION**)

Does your child have difficulties with:

☐ Sitting still	☐ Speaking out of turn	☐ Staying Focused during independent work	☐ Keeping hands to self
☐ Following instructions	☐ Working in groups	☐ Daydreaming	☐ Getting started on tasks
☐ Works too slowly	☐ Works too quickly	☐ Worries about tests/work	☐ Transitioning to new task

Describe any changes in the child's school performance:

Favorite subjects or activities?

What subjects or activities does the child have problems with?

Extracurricular activities (school or outside):

Please consider the following social characteristics of the child:

Has several intimate or "best" friends: ☐ Yes ☐ No

Is invited for extracurricular activities (e.g., birthday parties, play dates/outings): ☐ Yes ☐ No

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Is able to spend night away from home: ☐ Yes ☐ No ☐ NA

Shows an interest in getting to know other children when in a new setting (e.g., park, party): ☐ Yes ☐ No

Plays/interacts with children his/her ☐ same age ☐ younger ☐ older

Gets into frequent conflict/fights with peers: ☐ Yes ☐ No

Is your child bullied: ☐ Yes ☐ No Does your child bully other children: ☐ Yes ☐ No

Difficulty initiating activities with other peers: ☐ Yes ☐ No

Does the child seem to miss social cues (e.g., not understanding when being teased, not understanding humor, not recognizing when children are disinterested in what he or she is talking about, perceive hostility when there is none): ☐ Yes ☐ No Please describe:

Overall, how does the child get along with his/her friends or peers?