**WILSON PSYCHOLOGICAL ASSOCIATES, PLLC**
**417 East Silas Street**
**Bartlesville, Oklahoma 74003**
**(918) 337-6050 Phone**
**(918) 337-6061 Fax**

## NEURO/PSYCHOLOGICAL EVALUATION PATIENT AGREEMENT AND CONTRACT – MINOR

This contract is designed to explain the policies, procedures, risks, benefits, and patient responsibilities for psychological evaluation at Wilson Psychological Associates, PLLC. Please note that there is a separate agreement for treatment/counseling. Please thoroughly review this document as it contains information that is important for you to know.

While the detail included in this document may seem tedious, I believe it is important that you understand from the beginning how situations will be handled in the typical work encountered in my practice. I believe you have the right to know the parameters of our relationship at the outset of our work together. *Please sign the final page* if you are in agreement with the terms presented.

### Process of the Evaluation

The evaluation takes place in three primary stages:

1. Diagnostic Interview: to obtain history, review concerns, and to discuss the reason for the evaluation, to determine what testing should be done, and review informed consent, patient agreement, and evaluation procedures.
2. Testing: may take place in one multi-hour session, several 1- or 2-hour appointments, or other arrangements based on your or your child's needs as determined during the Diagnostic Interview.
3. Feedback: to provide feedback about testing results, diagnostic impressions, and disposition and treatment recommendations, about 1-3 weeks after the completion of the testing process.

Scoring, interpretation, and professional report writing by the psychologist will also be completed. In addition to the stages of the evaluation described above, other services are sometimes needed. It is often helpful for the doctor to speak with other professionals who have worked, or who are working with you. This could include physicians, mental health therapists or counselors, teachers/professors, speech and language therapists, occupational therapists, or other individuals. If this is necessary, you will be asked to sign additional written consent(s).

The doctor will spend several hours scoring and interpreting the test results, and writing the professional report. In truth, you will only be charged for a portion of these hours. As with most medical testing, only sometimes is the written report provided to the patient, but most often the report is inappropriate for dissemination to laypersons and will be released only to your physician or therapist. If you desire a report of the results for your use, you will be charged additionally for the preparation of the lay report as most insurance carriers do not cover the writing of additional reports for patient use. The rationale for this stipulation is that professional psychological evaluation reports are written in technical language and could be easily misunderstood or even

damaging to untrained readers; consequently, mental health records are held under a separate legal standing than typical medical records and are therefore not accessible routinely by you as the patient without sitting down with the evaluator to discuss the contents. The evaluation includes one copy of the evaluation report to be sent to the professional of your choosing (physician, therapist, etc.). If you require multiple copies of the report, they will be sent upon receipt of the typical record copy charge of $2.00 for the first page and $1.00 for each additional page, which must be paid prior to the distribution of the additional copies.

## Benefits and Risks of Evaluation

The primary benefits of evaluation include diagnostic clarification, appropriate treatment recommendations to handle challenges and maximize strengths, written documentation to facilitate services in both medical and educational settings, and gaining insight into the nature of the strengths and weaknesses the patient may possess. Nonetheless, there may be some risks involved. Although most individuals respond positively to the evaluation procedure, some patients and/or their parents, guardians, or loved ones may experience some discomfort such as frustration, anxiety, or embarrassment. It is possible the evaluation will not answer all your questions and further evaluation by the doctor or another professional may be needed. While the testing and recommendations are based on best practices, you and/or others may not agree with the clinical decisions and diagnoses. Ultimately, it is your decision whether to follow the recommendations generated during the evaluation.

## Appointments and Scheduling

*Private Insurance or Private Pay Cancellation Policy*: For those insured by private insurance, Medicare, or who pay privately, you are obligated to provide notice of cancellation at least forty-eight (48) hours prior (or by noon on Friday preceding a Monday appointment or if Monday is a holiday) to your *scheduled diagnostic interview or feedback appointment* or you will be charged a late cancellation/no-show fee of $100.00. If the office is closed or if someone is unable to answer the phone when you call, you MUST leave a message on the secure voicemail indicating that you are cancelling the appointment.

With regard to the scheduled evaluation appointment(s) (the second phase of the process), as these appointments block a significant portion of the schedule, the late cancellation deadline is by forty-eight (48) hours prior to the testing appointment(s), or by noon Friday preceding a Monday appointment. If you do not provide sufficient notice of cancellation, the late notice/missed visit fee is $100.00 per hour scheduled. Late cancellation/missed visit fees must be paid in full before appointments may be rescheduled. By entering into this agreement, you agree to not contest these fees as "unauthorized" with your bank or credit card issuer. If you contest these charges with your bank, an additional $100.00 gratuitous contested fee charge will be added to your account.

*Public Insurance*: Those insured by Soonercare, under state law, may not be charged financially for late cancellations or no-shows. Therefore, those covered by Soonercare must provide notice by forty-eight (48) hours prior to the testing session of any cancellation. If this notice is not given, the evaluation will be stopped and notice may be sent to the patient's primary care provider and/or the Oklahoma Health Care Authority at the doctor's discretion. Once the evaluation is ceased for late cancellation or no-show, it may not be rescheduled or resumed.

***Testing Appointment Reminders: You will receive a call from the office staff approximately 48 hours prior to the testing appointment. If you do not answer your phone a message will be left on your voicemail. You <u>MUST</u> call the office to confirm your appointment. If you do not call the office to confirm, the appointment will be cancelled. It is the responsibility of the client to make sure there is a working voicemail box on your phone of choice.***

## Confidentiality and Limits to Confidentiality

In general, the privacy of all communications between a client and a psychologist or counselor is protected by law, and I can only release information about our work to others with your written authorization(s). *But, there are a few exceptions*.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if s/he determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another person, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I strive to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

Finally, if you drive to my office in an altered state of consciousness, such as intoxication with recreational drugs or alcohol, or are observably over-medicated with prescription medication, I reserve the option of contacting a family member, friend, or the authorities to arrange transportation and to ensure your safety and the safety of those whom you may encounter. This situation has also rarely occurred in my practice.

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 at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

## Consultation with Your Medical Physician

Often in the course of the evaluation or after it, I deem it helpful to consult with my clients' primary care physician and/or psychiatrist in order to best serve their health care needs; with some insurers (e.g., Medicare), this communication is *required*. This information will be limited to the minimum amount necessary to accomplish your best health care. Typically, before I contact your physician, I will discuss my impressions with you and the reasons I think it would be helpful to speak with him/her. If you have questions about this, we should discuss them at our next meeting. ***Your signature on this document serves as your agreement to this disclosure of Protected Health Information for the purpose of healthcare coordination. If you REFUSE THE RELEASE OF THIS INFORMATION UNDER HIPPA, please initial here _____. (If you refuse, it may make it impossible for us to serve you due to insurance regulations.) Your signature on this document, minus any initial on the line above, authorizes us to release information to your healthcare providers for the purpose of healthcare coordination.***

## Financial Policy

Obtaining a psychological evaluation is a substantial financial commitment on your part, so it is important for you to know exactly what your financial obligations will be. Because you are seeking this evaluation for yourself or your child, you are responsible for ensuring that all of the associated fees are paid. This means that if you think that another person/entity, such as another parent or your insurance company, will cover the charges and the person/entity does not do so, you are financially responsible. Please note that the person calling to request services is generally considered the guarantor of the account. If for any reason your account is delinquent, this office will pursue collections action, including but not limited to using our contracted collection agency or action in small claims court.

*Fee Structure*:

| | | |
|---|---|---|
| 90791 | Diagnostic Interview to begin Evaluation | $200.00 |
| 96101 | Psychological Assessment (Psychologist) | $190.00 |
| 96102 | Psychological Testing (Computer) | $190.00 |
| 96103 | Psychological Testing (Technician) | $190.00 |
| 96105 | Testing for Aphasia (per hour) | $220.00 |
| 96116 | Chart Review, Scoring of Instruments (per hour) | $190.00 |
| 96118 | Neuropsychological Testing (Psychologist) | $220.00 |
| 96119 | Neuropsychological Testing (Technician) | $220.00 |
| 96120 | Neuropsychological Testing (Computer) | $220.00 |
| 97770 | Cognitive Rehabilitation (per hour) | $190.00 |
| 90889 | Preparation of Psychological Report (per hour) | $190.00 |
| 90889 | Preparation of Neuropsychological Report (per hour) | $220.00 |
| 99373 | Telephone Consultation (per hour) | $190.00 |
| 99075 | Legal Partic, Deposition, Testimony, Preparation, Att. (per hour) | $775.00 |
| 99049-P | Missed Visit, PSY(per scheduled hour) | $100.00 |
| 99049-N | Missed Visit, NEUROPSY(per scheduled hour) | $100.00 |

Document Fees for Record Copy, Preparation, and Recording: $2.00 first page; $1.00 for each additional page.

*Private Insurance/Private Pay Patients*: Before the evaluation appointment(s) is/are scheduled, you will receive a written estimate of the charges for the evaluation, including testing with the client, scoring the testing, reviewing records, conducting the Feedback Session, and writing the report. At times, though not frequently, data is obtained in the evaluation that may necessitate additional testing beyond that originally estimated. If the testing process takes longer than estimated for any reason, you will be responsible for paying any additional fees prior to the feedback session. An advance deposit is required to reserve your testing evaluation.

After making the testing appointment, if you decide to cancel without rescheduling to another date, you will forfeit the testing deposit. Therefore, please do not schedule testing unless you are certain you want to go through with the evaluation and will have the funds available when they are due.

For some insured by companies that have made changes to the preauthorization process, though Dr. Wilson may be in-network with the company, the full amount of the testing must be paid prior to beginning testing. Additional information will be provided prior to beginning the evaluation.

*Public Insurance with/without Supplemental:* For those who are insured by public insurance (e.g., Medicare or Soonercare), no deposit will be required as state law prohibits collecting fees from those covered by this public insurance.

## Payments

Payment is preferred by cash, personal check, or money order made payable to Wilson Psychological Associates, PLLC. Payment is also accepted by way of Visa, Mastercard, Discover, or American Express. Payment plans for evaluations will be granted only for extenuating circumstances and only when a valid credit/debit card is provided to which charges may be made through the course of the payment plan. There will be a fee that will be associated with setting up a payment plan and the amount of fee will depend upon the terms of the plan.

If a personal check is returned, you will be notified that an alternative means of payment is required immediately, along with a $30.00 returned check fee that will be added to your account. Continuation of the psychological evaluation cannot occur until the situation has been rectified. Wilson Psychological reserves the right to refuse personal checks as method of payment after a check has been returned for insufficient funds or closed account. Your account must be current before any professional report, lay report, or other correspondence will be distributed.

## Additional Services

There is a $25.00 document charge for completion of short forms, preauthorization forms, or brief letters that are needed (over and above the professional report produced as a result of the evaluation), such as letters to insurance companies for justification of diagnosis(es), evaluation or treatment; letters or forms needed for schools or state agencies regarding diagnosis, treatment, or information for IEP planning; letters to other professionals, etc. Lengthy letters, forms, or layperson evaluation reports will be billed at $190.00 per hour for psychological evaluations or $220.00 per hour for neuropsychological evaluations. Payment must be made before the correspondence will be distributed. Please be aware that, in most cases, the doctor will not be able to provide letters or complete forms on the same day they are requested; in some instances, there may be a seven day turnaround period for completion of forms or letters. However, the doctor will make every effort to be as prompt as possible in addressing your request(s).

The doctor is most often not immediately available by phone due to the nature of the work. Consequently, if you need to speak directly to the doctor, phone calls lasting less than five (5) minutes may be scheduled through the office manager on most clinic days. If you require a phone call that will last longer than five minutes, those calls must be scheduled in advance and will be during the typical clinic day as the doctor's schedule permits. Calls lasting longer than five minutes will be prorated and charged at the psychological assessment rate ($190.00 per hour) or the neuropsychological evaluation rate ($220.00 per hour). This fee must be paid at the next appointment, or if no future appointments are scheduled, a valid credit card number must be provided prior to the phone call.

Due to the difficulty of court-related services, the hourly rate for those services is $775.00 per hour. Fees are charged for travel time, record review, consultation, phone calls, and any other time needed, in addition to time away from the office for court proceedings. There is a minimum of 4-hour charge for time away from the office. Due to the nature of the services associated with legal cases, a $5,000 retainer deposit will be required at the outset of legal involvement (i.e., at first notification of the doctor's required or requested participation), from which the associated fees will be deducted. Regardless of whether you or another party associated with you requires my participation in legal proceedings, you as the guarantor of your account will be responsible for the court-related fees associated with my participation as my professional relationship with you will necessitate my involvement in the legal proceeding. When the legal fund reaches $2325.00, another $3,000 deposit will be required, and so on, until the completion of the legal involvement, at which time any remaining balance will be refunded to you along with a detailed summary of charges and expenses. In addition to fees associated with time for the doctor's participation, any expenses will also be deducted from the legal deposit, including, but not limited to travel, lodging, meals, legal consultation, copies, phone, etc. As insurance does not cover court-related costs, the deposit and fees *MUST be paid in advance* of any work being conducted.

## Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the follow policy. This is because the use of various types of electronic communication is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

*Email Communications*

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it

during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

*Text Messaging*

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

*Social Media*

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

*Websites*

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

*Web Searches*

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for the matter, please discuss this with me during our time together so that we can deal with and its potential impact on your evaluation.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me, please share it with me so we can discuss it and its potential impact on your evaluation. Please do not rate my work with you while we are working together on any of these websites. This is because it has a significant potential to damage our ability to work together.

## Informed Consent for Evaluation

It is very important that you have read, or had read to you, the information contained in this document so that you will understand all the office policies, procedures, and responsibilities outlined herein. *Your signature below indicates that*:

1. You have had sufficient opportunity to read and understand this document.
2. You have asked the doctor to clarify anything you did not understand.
3. You agree to abide by the terms of this agreement in their entirety.
4. You understand that this form applies only to the policies and procedures for TESTING with the doctor. A separate consent and agreement is needed for treatment/therapy.
5. You are giving the doctor your consent to conduct an evaluation with you and/or your child.

*(PLEASE NOTE: ANY PARENT/GUARDIAN SEEKING SERVICES FOR A MINOR CHILD MUST HAVE:*

*1) FULL LEGAL CUSTODY (NOT ONLY FULL PHYSICAL CUSTODY; IF DIVORCED OR SEPARATED, COURT ORDERED DOCUMENTATION OF CUSTODY MUST BE PROVIDED PRIOR TO OR AT THE FIRST VISIT)*

*Or, 2) CO-SIGNATURE FROM ANY OTHER CUSTODIAL PARENT/GUARDIAN IF THERE IS A JOINT CUSTODY ARRANGEMENT.*

*If parents are divorced and documentation of FULL CUSTODY or JOINT SIGNATURES on all documents are not provided prior to or at the first appointment, the appointment will be cancelled and a broken appointment fee will be charged.)*

Client Name:_____ Date of Birth: _____

Printed Name of Person Completing This Form: _____

_____
Signature of Client, Parent, or Guardian

_____
Signature of Co-Parent or Co-Guardian if Joint Custody

---

OFFICE USE ONLY

My signature below indicates that I have answered any questions raised by the client/parent/guardian. I have been told and believe that the person understands all of the issues discussed in this form, and I find no reason to believe that this person is not fully competent to give informed consent to the evaluation.

_____
K. Spencer Wilson, Ph.D.
Oklahoma Licensed Psychologist #966
Health Service Provider

# INSURANCE PAYMENT INFORMATION

**Responsible Party**

Last Name_____ First Name _____ M.I._____
Address_____
City_____ State_____ Zip_____ Home Phone (____)_____
Date of Birth_____ SSN_____ Relationship to Patient _____
Employer_____ Address_____
Occupation_____ Business Phone (____)_____
Spouse Name_____ Spouse's SSN_____

**Primary Insurance Co**_____ Effective Date_____
Insured's Name_____ DOB_____ SSN_____
Address (if different)_____
Policy No._____ Group No_____ Relationship to Patient _____

**Secondary Insurance Co**_____ Effective Date_____
Insured's Name_____ DOB_____ SSN_____
Address (if different)_____
Policy No._____ Group No_____ Relationship to Patient _____

I (we) authorize payment of medical benefits to the provider herein for all medical/psychological services rendered. I (we) authorize the provider or Wilson Psychological Associates to release any information required to process my insurance claims. I (we) authorize my insurance benefits to be paid directly to Wilson Psychological Associates. I (we) understand that I (we) am (are) financially responsible for payment of any insurance deductible, copayments, and non-covered charges or services. A photocopy of this signature is valid as the original.

Signature of Responsible Party_____ Date_____
Signature of Spouse_____ Date_____
(required if marital therapy)

**Please provide us with your insurance card so that we may have a copy on file. Please notify us of any changes to your insurance. We reserve the right to require you to file your own insurance if we are not made aware of insurance changes within two visits of the policy change. Thank you for your consideration in this matter.**


417 East Silas Street, Bartlesville, OK 74003 (918) 337-6050 fax: (918) 337-6061

**Child's Name** _____Date of Birth (DOB) _____ Age _____

Child's Social Security Number _____ Soonercare/Medicaid #_____

Address _____City _____State _____Zip_____

School _____ Grade _____

Child's Sex: __ Male __Female

**PARENTS/GUARDIANS**

_____

Name of person completing this form Relationship to Child

_____ _____

Mother's name DOB Father's name DOB

_____ _____

Stepfather (Mother's spouse – if applicable) Stepmother (Father's spouse – if applicable)

_____ _____

Mother's address (if different from child's) Father's address (if different from child's)

_____ _____

Mother's Home/Cell Telephone # Father's Home/Cell Telephone #

_____ _____

Mother's Employer Work # Father's Employer Work #

_____ _____

Legal Guardian's Name (if different from above) Emergency contact (other than parent or guardian)

_____ _____

Home/Cell # Work # Home/Cell # Work #

_____

Child's Pediatrician Address City, State, Zip
Office #

**Others in the Home: name age rel to child**

**Immediate family living outside the home** (such as biological parent, brothers, sisters, etc.)

## REFERRAL HISTORY

1. Who referred to this clinic and what were the concerns that prompted the referral? Or, if you come seeking assistance without a physician referral, what prompted you?

2. Describe the problems that are affecting your child and family.

3. How long have the concerns been a problem for your child and/or family?

4. What seems to make the problems improve or lessen?

5. What seems to make the problems worse?

6. Have the problems persisted since they began or have they come and gone over time?

7. Have the problems worsened steadily over time or have they remained about the same since you noticed them? _____
_____
_____

8. What do you hope to gain from this visit and in what way do you hope we will be able to be helpful with these problems? _____
_____
_____

9. Has your child ever been seen by a psychologist, psychiatrist, or mental health counselor/therapist?
YES NO

If yes, please describe why and by whom:
_____
_____

10. Please list any mental health diagnoses your child has been given by a mental health or medical professional: _____
_____

11. Alcohol or Drug Use:
Alcohol: ___Don't Know ___None ___Child/Adolescent Drinks Alcohol
___Child/Adolescent Used to Drink Alcohol
Drug Use: ___Don't Know ___None ___Child/Adolescent Uses Drugs
___Child/Adolescent Used to Use Drugs
Please list or describe any use of alcohol, illegal drugs, or abuse of prescription medications:
_____
_____
_____

**SOCIAL HISTORY**

12. Does your child have friends in the neighborhood? YES NO At school? YES NO

13. Does your child have the opportunity to play with same age children? YES NO

14. Does your child participate in extracurricular, church, synagogue, parachurch, group, or club activities?
YES NO

If yes, please list:
_____
_____

15. Is your child involved in community support or self-help groups? (E.g., Big Brothers/Big Sisters, The Landing, etc.) YES NO

If yes, please list:
_____
_____

16. What toys or types of activities does your child seem to enjoy?

_____

_____

17. Do you have any concerns with your child's social skills or social life? YES NO
If yes, please describe:

_____

_____

**PROBLEM AREAS** (Please check any problems your child has experienced):

- ☐ Attention Problems/ Easily Bored or Distracted
- ☐ Developmental Delays
- ☐ Atypical or Odd Behaviors
- ☐ Depressed/Low Mood
- ☐ Sleeping too Much
- ☐ Anxious/Nervous/Worried
- ☐ Mood Swings
- ☐ Defiance of Authority/Disobedience
- ☐ Nightmares
- ☐ Perfectionism
- ☐ Impulsive Behavior
- ☐ Argumentative
- ☐ Hallucinations (Seeing, Hearing Things Not There)
- ☐ Having to Do Things Over and Over
- ☐ Specific Fears or Phobias
- ☐ Parents' Separation or Divorce
- ☐ Lack of Ambition or Energy
- ☐ Shyness
- ☐ Sexual Problems
- ☐ Addictive Behaviors (e.g., gambling)
- ☐ Excessive Energy, Like Driven By a Motor
- ☐ Social Awkwardness
- ☐ Poorly ControlledAnger/Temper
- ☐ Not Sleeping
- ☐ Inferiority Feelings
- ☐ Elevated/Overly Excited Moods
- ☐ Aggressive Acting Out
- ☐ Suicidal Thoughts
- ☐ Self Harm
- ☐ Compulsive Behaviors
- ☐ Poor Relationships with Family
- ☐ Delusions (odd, untrue thoughts)
- ☐ Need to be inControl
- ☐ Poor Self-control
- ☐ Violent Thoughts or Behaviors
- ☐ Relationship Problems
- ☐ Slow Cognitive Processing
- ☐ Problems with Appetite
- ☐ Significant Loss/UnresolvedGrief
- ☐ Learning Difficulties
- ☐ Other: _____

Please explain any checked items from the list in detail; use additional pages if necessary):

_____

_____

_____

_____

**ABUSE/TRAUMA HISTORY:** Has your child ever been abused, experienced a traumatic event, or caused harm to another?

YES If yes, check all below that apply. NO If no, SKIP THIS SECTION

☐ Victim of emotional abuse
☐ Victim of verbal abuse
☐ Victim of physical abuse
☐ Victim of physical neglect
☐ Victim of domestic violence/abuse
☐ Victim of sexual abuse/molestation
☐ Experienced a traumatic event (witnessed violence, etc.)
☐ Witnessed or community violence
☐ Physically harmed anotherperson
☐ Sexually abused or molested
☐ Harmed an elderly or disabled
☐ Purposely cut or burned
☐ Been cruel to animals
☐ Intentionally set fires to property

Please explain any checked (yes) answers:
_____
_____

**DISCIPLINE:** Please check the types of discipline used in your home for your child's behavior management:

☐ Time out ☐ Taking things away ☐ Grounding ☐ Extra chores ☐Ignoring

☐ Spanking ☐ Talking it out ☐ Praise/Reward for good behavior ☐ Yelling/Screaming

☐ Behavior chart ☐ Asking repeatedly ☐ Sending him/her outside or to a friends

☐ Other: _____

Consistency of your methods: ___ MOSTLY ___ SOME ___ NOT CONSISTENT

Please comment on the effectiveness of your discipline methods:
_____
_____

**BIRTH, DEVELOPMENT AND PHYSICAL HEALTH HISTORY** To be completed by birth mother if possible

Length of pregnancy (how many months, weeks?) _____

Child's birth weight _____ Number of hours in active labor _____

Mother's age when child was born _____Did mother receive regular prenatal care YES NO

Delivery was by: Vaginal birth Caesarian section (C-section) Was delivery difficult? YES NO

Please check any problems with delivery:
☐ Breech ☐ Emergency C-section ☐ Slow heart rate ☐ Fever ☐ Cord around neck
☐ Child required oxygen ☐ Other (please describe) _____

Apgar score at 1 minute _____Apgar score at 5 minutes _____ Don't know

**MOTHER'S HEALTH *DURING PREGNANCY*** Please check all that apply.

☐ **NOCOMPLICATIONS**

☐ Had to take prescription medication(s) Names of medication(s):_____
☐ Bleeding ☐ Toxemia ☐ Pre-eclampsia/Eclampsia ☐ Serious illness or injury ☐ Diabetes
☐ Used Alcohol – Month _____ to Month _____ ☐ Used illegal drugs – Month _____ to Month
☐ Smoked cigarettes – Month _____ to Month _____☐ Had fever, rash, infection, or other illness
☐ Other_____

**INFANT'S HEALTH AT DELIVERY** Please check all that apply
☐ **NO COMPLICATIONS**
☐ Trouble breathing☐ Hospitalized after birth for longer than 7 days ☐ Turned blue (cyanosis)
☐ Needed oxygen ☐ Birth defects ☐ Jittery ☐ Required **any** special care after delivery:
☐ Blood transfusions ☐ Incubator ☐ Medications
☐Other:_____
_____

**INFANT'S HEALTH DURING 1ST MONTH** Please check all that apply
☐ **NO COMPLICATIONS**
☐ Infections ☐ Feeding problems ☐ Gagged or vomited often
☐ Difficulty latching on to breast or sucking ☐ Hospitalizations
Please explain any checked answers_____
_____

**DEVELOPMENTAL HISTORY** At what age did your child….

Sit up without help _____ Say single words meaningfully_____

Crawl _____ Combine two or more words in phrase speech

Walk without help _____ Use sentences_____

Walk up and down stairs _____ Show a hand preference_____

Which hand? RIGHT LEFT Is anyone in your family left handed or ambidextrous?
YES NO Whom? _____

Was your child fussy as an infant? YES NO Difficult to rouse/overly sleepy? YES NO

Responsive to you when cuddled? YES NO Was your child sociable? YES NO

How insistent was he/she when he/she wanted something? VERY AVERAGE
LESS THANAVERAGE

How active was your child as a toddler? VERY AVERAGE LESS THAN AVERAGE

Has this child had difficulty separating? YES NO At what age? _____

Compared to other children her/his age, has your child been SLOWER in learning (check all that apply):

□ To talk □ To build with blocks, play with puzzles, draw pictures

□ To understand other people talk □ Gross motor skills (crawling, walking, riding bicycles)

□ To sit still for stories, TV, or video games? □ Fine motor skills(fastening buttons, zippers,drawing)

Is your child toilet trained? YES NO If yes, at what age? _____

Does your child wet her/himself during the day? YES NO How often? _____

Does your child wet her/himself at night? YES NO How often? _____

Does your child soil him/herself during the day? YES NO How often? _____

Does your child soil him/herself at night? YES NO How often? _____

Does your child have sleeping difficulties? YES NO

Difficulty: Going to bed Falling asleep Staying asleep

Other problems with sleep?

_____

Do you have concerns about your child's sexual development or sexual activity? YES NO If yes, please explain:_____

_____

_____

**CHILD'S HEALTH HISTORY** After the first month of life, has your child had any of the following medical conditions?

| | | |
|---|---|---|
| ☐ Eye or vision problems | ☐ Chronic ear infections | ☐ Became ill after an immunization/shot |
| ☐ Appetite or feeding problems | ☐ Speech/hearing problems | ☐ Lead poisoning |
| ☐ Food allergies | ☐ Kidney problems | ☐ Asthma |
| ☐ Seasonal allergies | ☐ Other allergies | ☐ Pneumonia |
| ☐ Frequent or severe headaches | ☐ Frequent abdominal pain | ☐ Heart problems or high blood pressure |
| ☐ Seizures | ☐ Broken bones | ☐ Hospitalizations |
| ☐ High fevers ( > 103 degrees) | ☐ Head injury (knocked out) | ☐ Surgery/operation |
| ☐ Developmental delay/Intellectual disability | | ☐ Impaired mobility |

☐Other_____

Please explain in detail any checked answers from the previous section (Child's health problems):

_____

_____

Are your child's immunizations up to date? YES NO

If no, please explain. _____

Has your child's vision been checked? YES NO
By whom? _____

Has your child's hearing been checked? YES NO
By whom? _____

Does your child receive regular dental care? YES NO
Dentist Name: _____

When was your child last seen by his/her physician/pediatrician?
_____(date)

**Females only:**

Has your child started menstruation (had her first period)? YES NO If yes, at what age? _____

Has your child ever been pregnant? YES NO

## MEDICATION HISTORY

Is your child taking **any** medications (prescription, over the counter, herbal, supplements) on a regular basis? YES NO

Has your child taken **any** medications (prescription, over the counter, herbal, supplements) in the past on a regular basis? YES NO

**Please complete this section for any medications your child has taken in the past year:**

| Medication | Dose | How Often | Current | Prescribed by: |
|---|---|---|---|---|
| | | | **Y/N** | |
| | | | **Y/N** | |
| | | | **Y/N** | |
| | | | **Y/N** | |
| | | | **Y/N** | |
| | | | **Y/N** | |
| | | | **Y/N** | |

Are you/your child compliant with the medication prescription direction for each of the medications listed as current? YES NO

If no, please explain:
_____
_____

Are there any significant negative side effects of any of the medications that you have listed as current? YES NO

If yes, please explain

_____

_____

## FAMILY HISTORY AND INFORMATION

**Mother's highest level of education:** (circle one)

Grade School High School, didn't graduate High School, completed Technical Training after High School
Some college College Graduate Post Graduate Degree (Master's, Specialist, Doctorate)

Mother's occupation and place of employment (if applicable):

_____

Work hours: _____

**Father's highest level of education:** (circle one)

Grade School High School, didn't graduate High School, completed Technical Training after High School

Some college College Graduate Post Graduate Degree (Master's, Specialist, Doctorate)

Father's occupation and place of employment (if applicable):

_____

Work hours: _____

Marital Status of Parents: Married Separated Divorced Unmarried Widowed

Date: _____ _____ _____ _____ _____

If parents are divorced, who has legal custody of the child? MOTHER FATHER JOINT OTHER
If other, please specify:

_____

If parents are separated or divorced, please describe physical custody and visitation arrangements:

_____

_____

Child is: Biological Step-child Adopted Foster child
Other_____

If the child is **adopted** or a **foster child**: How long has the child been in your home? _____

Is the child aware that she/he is adopted or a foster child? YES NO

If the child is adopted or a foster child, please give as much information about the biological parents as you can:_____

_____

_____

**HUMAN SERVICES AGENCY INVOLVEMENT:**

Has your child ever been involved with the following agencies? If yes, please explain below.

Child Protective Services YES NO Caseworker/phone #
_____

Department of Human Services YES NO Caseworker/phone #
_____

Court Appointed Special Advocate YES NO Advocate/phone #
_____
or, Guardian Ad Litem

Law Enforcement YES NO

Probation/Juvenile Detention YES NO

Youth Shelter YES NO

Please explain any yes answers:

_____

_____

_____

_____

**FAMILY HISTORY AND PROBLEMS:**

During the past 12 months, has your family experienced any of the following situations? (List relationship to child for each checked answer)

☐ Death of a family member _____ ☐ Financial difficulties_____

☐ Marital problems _____ ☐ Legal problems _____

☐ Unemployment _____ ☐ Moved in the past 3 years_____

☐ Serious medical illness/medical problems _____ Which problems?
Headaches Chronic pain Stomach Nerves Asthma Diabetes Heart

☐ Serious mental/emotional problems _____ Which problems? Major Depression Anxiety Bipolar Disorder (Manic Depression) Thought Disorder (e.g., Schizophrenia)

How long has the child lived in the **current** home?
_____

Has anyone in the **child's biological family** (other than the child) experienced any of the following?

(Again, please list the relationship of the person to the child. E.g., "maternal uncle, paternal grandfather, 1st cousin," etc.)

☐ Speech or language problems _____ ☐ Alcohol abuse _____
☐ Trouble learning to read _____ ☐ Substance abuse _____
☐ Held back in school _____ ☐ Other addictive behaviors _____
☐ Mental retardation _____☐ Seen a counselor/therapist/psychologist _____
☐ Anxiety_____☐ Seen a psychiatrist_____
☐ Autism Spectrum _____ ☐ Legal problems _____
☐ Behavioral problems _____☐ Victim of physical abuse _____
☐ Suicide or attempted suicide _____☐ Victim of sexual abuse _____
☐ Depression _____☐ Sexually abused/molested another person_____
☐ Bipolar (Manic Depression) _____☐ Physically harmed another person_____
☐ Other:_____

**CULTURAL/SPIRITUAL HISTORY:** Which of the following best describes …

**Your child:** ☐ White, not of Hispanic origin ☐ African American/Black , not of Hispanic origin ☐ Hispanic ☐ American Indian/Native American ☐ Asian/Pacific Islander ☐Other_____

**The child's mother:** ☐White, not of Hispanic origin ☐African American/Black,,not of Hispanic origin ☐ Hispanic ☐ American Indian/Native American ☐ Asian/Pacific Islander ☐ Other_____

**The child's father:** ☐White, not of Hispanic origin ☐African American/Black,,not of Hispanic origin ☐ Hispanic ☐ American Indian/Native American ☐ Asian/Pacific Islander ☐ Other_____

Does your child have any cultural or religious preferences or restrictions? YES NO If yes, please explain:_____
_____

**Religious Affiliation:** Protestant Christian Catholic Jewish 7th Day Adventist Jehovah's Witness None
Other:_____

**Cultural Background:** Caucasian African American Hispanic American Indian Asian Pacific Islander Mixed
Other:_____
**Predominant language spoken at home:** English Spanish
Other:_____

**Other languages spoken at home:** English Spanish Sign Language/ASL Other: _____

**SCHOOL HISTORY:**

Current school's name, address and school system (if a public school):
_____

Did/does your child receive early intervention services? (e.g., Head Start) YES NO

Did your child attend preschool? YES NO If yes, name of school:_____
Age: _____

Age at Kindergarten entrance _____Age at first grade entrance_____
Has your child ever repeated a grade? YES NO If yes, what grade(s)? _____

Has your child had frequent changes of schools? YES NO If yes, how many schools? _____

Has your child ever completed intelligence, achievement (other than standardized end of instruction tests), or other testing through the school? YES NO
If yes, when was your child tested? _____ Please either bring with you or request those records.

Does your child receive services through an **Individual Education Plan (IEP)** or educational **504 plan**?
YES NO If yes, at what age/grade was the plan started? _____

Has your child ever been placed in a **special education program**? YES NO
If yes, please check the program type/classification:

☐ Cognitive disability ☐ Emotional Disability ☐ Specific Learning Disability
☐ Multiple Disability ☐ Other Health Impairment ☐ Traumatic Brain Injury
☐ Hearing Impairment ☐ Visual Impairment ☐ Orthopedic Impairment
☐ Other:_____

Has your child received any of the following services? If so, please note at what age, and, if outside of school, where.

Speech and Language Therapy YES NO
_____
Physical Therapy YES NO
_____
Occupational Therapy YES NO
_____
Learning Disability Tutoring YES NO
_____
Counseling YES NO
_____
Special Communication Devices YES NO
_____
Other services (Please describe)
_____

Is your child involved in any vocational education? YES NO NOT APPLICABLE

If yes, please describe:_____

If you child is in school, please indicate how she/he is doing in each of the following areas of instruction:

| | FAILING | BELOW AVERAGE | AVERAGE | ABOVE AVERAGE | EXPLAIN |
|---|---|---|---|---|---|
| Reading | ☐ | ☐ | ☐ | ☐ | _____ |
| Spelling | ☐ | ☐ | ☐ | ☐ | _____ |
| Language Arts | ☐ | ☐ | ☐ | ☐ | _____ |
| Math | ☐ | ☐ | ☐ | ☐ | _____ |
| Writing | ☐ | ☐ | ☐ | ☐ | _____ |
| Science | ☐ | ☐ | ☐ | ☐ | _____ |
| Social Studies | ☐ | ☐ | ☐ | ☐ | _____ |
| Elective | ☐ | ☐ | ☐ | ☐ | _____ |

Does your child have difficulties in any of these areas? If so, please describe.

Problems with teachers? YES NO

_____

Problems with classmates? YES NO

_____

Behavioral problems? YES NO

_____

Emotional problems? YES NO

_____

Absenteeism or truancy? YES NO

_____

Completing or turning in work? YES NO

_____

Suspensions/Expulsions? YES NO

_____

Other areas? Please describe:

_____

Does your child receive daycare, or before/after school services? YES NO

**EMPLOYMENT HISTORY**

Has your child ever had a job? YES NO If yes, please complete the following information.

Type of work:_____

Name of employer: _____Job title: _____

Employment skills/interests:

_____

Does your child receive SSDI? YES NO Does your child receive SSI? YES NO

**BEST THINGS ABOUT YOUR CHILD**

What are the things you like best about your child?

_____
_____
_____
_____
_____
_____

**IMPORTANT INFORMATION NOT COVERED IN THIS QUESTIONNAIRE?**

_____

Referral Source:_____

Address and phone number:_____

Psychologist Signature: _____ Date: _____