Client/Patient Information

Name:_____ Birthday:____/____/____Age:_____
Last First Middle initial Month Day Year

Address: _____Home Phone: _____

City: _____State: _____ Zip: _____Work/Cell Phone:_____

Social Security Number: _____:_____:_____ Sex: _____ Race: _____

Marital Status: S M W Sep. D Spouse's Name: _____

Referred By:_____

Family Physician and Phone: _____

What drug store do you use: _____

Have you been a patient in this office before? Yes No

Person Financially Responsible Or Parent

Name: _____

Address: (if different from above): _____

Relationship: _____ Social Security Number: _____

Occupation: _____ Employer: _____

Employer's Address: _____Work Phone: _____

Contact In Case of Emergency

Local relative or Friend: _____

Address: _____ Phone: _____

Relationship: _____

Signature: _____ Date: _____

Please DO NOT Write in This Space---------- For Office Use Only
Dx: _____

Client Confidentiality Agreement

As a client of Clovis Counseling Center, you have the right to expect your sessions to be confidential. However, there are two situations that permit information to be released:

1) If, as client, you want information released and sign a "Release of Information" form designating whom is to receive the information, what kind of information is to be released, and what kind of information is to be released, and what dated period information can be released.

2) If suicidal or homicidal behaviors exist that may make it necessary for your therapist to divulge information to protect you and/or others.

The other clients of Clovis Counseling Center also have the right to privacy and confidentiality. Therefore, the following paragraph also applies to you, as well as your spouse, or client's guardian/parent (if the client is a minor or otherwise in need of guardianship). Please read the paragraph below before signing this form.

I understand that I am responsible for maintain the privacy and confidentiality for the clients as Clovis Counseling Center. I understand and agree I will not divulge the identity of any client I see at the clinic, nor will I divulge any other information I may hear, see, or obtain while at the center.

Client/Guardian	Date
Spouse/Significan Other (if applicapble)	Date
Witness	Date

Please read and initial ***all*** spaces of the following sections on both sides of this form... then sign and date in the presence of a witness.

Thank you

Insurance Authorization

_____ I authorize the use of this form on all my insurance submissions

_____ I authorize the release of information to all my Insurance Companies

_____ I authorize Clovis Counseling Center (Consulting Psychological Services, P.A.) to act as my agent in submitting claims to my Insurance Companies

_____ I authorize payment directly to Consulting Psychological Services, P.A.

_____ I permit a copy of this authorization to be used in place of the original

Clovis Counseling Center

Continued on other side

Office Policy

Please initial:

_____ You will be charged for the scheduled time. The scheduled time includes time with the therapist and time for the therapist to complete case notes.

_____ We reserve the right to charge for any excess time the therapist is required to take to write additional letters or fill out additional paperwork required by you or your insurance company.

_____ Any psychological testing, reports, and/or letters that might be needed are a separate charge from individual sessions, and may or may not be covered by your insurance.

_____ It is important that you keep your scheduled appointments. If you fail to show, or do not cancel 24 hours prior to the appointment time, you will be charged the full fee. This is not billable to your insurance and must be paid prior to your next appointment.

_____ We will bill your insurance Company for you as a courtesy. If your insurance company plan has a deductible and/or co-payment, it is your responsibility to make these payments in full at the time of each visit.

_____ Verification of Benefits is NOT a guarantee of payment and the account is ultimately the client's responsibility.

_____ The insurance payments and co-payments are estimated. We do not know what the exact amounts are until your insurance company makes their payment and sends us an Explanation of Benefits (EOB). Patient balances will be adjusted according to these EOB's.

_____ In the event an insurance payment is sent directly to you, you are responsible for signing the check over to Clovis Counseling Center or paying the amount of the insurance payment yourself.

_____ You should receive an Explanation of Benefits (EOB) directly from your insurance company. It is your responsibility to follow up with them in the event of a problem.

_____ Statements are mailed on a monthly basis. They will reflect any charges, payments, adjustments, interest on unpaid balances of 1.5% monthly (18% per annum) made to the account as of the statement date.

I have read, understand, and will abide by the above stated policies.

_____
Printed Name of Responsible Party

_____ _____
Signature of Responsible Party Date

_____ _____
Witness Date

Clovis Counseling Center

Medication List

Name _____ Date _____

Please list all medications you are currently taking

Medication	Dose/Frequency	Start	End	Presc. MD

Drug Allergies:

_____

_____

_____

_____

_____

Acknowledgement and Agreement Form

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and have been provided an opportunity to review it

_____	_____
Name	Date of Birth
_____	_____
Signature	Date
_____	_____
Witness	Date

Psychotherapist-Patient Acknowledgement

I have received the Psychotherapist-Patient Services Agreement for the State of New Mexico and have been provided an opportunity to review it.

_____	_____
Name	Date of Birth
_____	_____
Signature	Date
_____	_____
Witness	Date

Psychiatric Advance Directives

These Advance Directives are similar to healthcare advance directives. They are used for psychiatric illnesses and allow individuals to select another person to make healthcare decisions for them in the times of incapacitation. Would you like information on Psychiatric Advance Directives?

Yes No

Grievance/Complaint Policy

If you have a complaint about someone or something regarding your treatment at Clovis Counseling Center, please advise the receptionist, your therapist, or another staff member immediately to obtain a complaint form. Complaints are reviewed and will be dealt with by management.
I understand the Grievance/Complaint Policy:

Yes No

Authorization to Disclose Information to Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, (42 CRF, part 2), and cannot be regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve (12) months from the date signed.

I, _____ hereby authorize _____
Patient's Name Behavioral Health Provider's Name

Please check one:

_____ To release any applicable information to my Primary Care Physician.

_____ To release medication information only to my Primary Care Physician.

_____ Not to release information to my Primary Care Physician.

_____ _____
Patient or Guardian Signature Date

_____ _____
Printed Name Date

Primary Care Physician's Name, Address & Phone

_____

_____

_____

_____

Consent To Treatment And Patient Rights

As a patient, you have a right to appropriate care and protection. State and Federal laws and regulations guard your confidentiality. You also have other rights, which are listed below. Read them carefully and be sure to ask your provider if you have any questions about them.

1. Consent to Treatment: I understand that the provider assigned to me, or to my child, will explain the nature of the assessments and treatment to be provided, the expected benefits and risks, and alternatives available. I understand that, although a reasonable standard of care will be provided, improvement, though expected, is not guaranteed. If I wish to withdraw from treatment at any time, the therapist will help me with an appropriate referral if I so choose.

2. Confidentiality and Release of Information: I understand that information concerning my contacts with Clovis Counseling Center will be held confidential. I further understand that such information will not be disclosed without my written permission, or that of my legal Guardian, except under special circumstances such as:

   a. If I threaten to injure myself or someone else.
   b. When such information is required by law to be reported; for example, information regarding abuse, neglect, molestation, or exploitation of a minor, incapacitated adult, elder person 65 or older; or in the case of a court order.
   c. For medical emergency.
   d. Use of pertinent parts of my record pertaining to my treatment for the purpose of quality improvement activities.

3. I understand and have the right to:

   a. Privacy
   b. Considerate care that respects my privacy and individual needs.
   c. Information about my assessments and treatment.
   d. Know the names and functions of anyone involved in my treatment.
   e. Make my care decisions before and during the course of the treatment.
   f. Refuse a recommended treatment or plan of care.
   g. Expect clinical staff to treat all communications and records about my care confidentially.
   h. Expect continuity of care and be told about choices that are provided outside of Clovis Counseling Center.
   i. Appropriate recognition and consideration of my spiritual and cultural values.
   j. Review my assessment and treatment records and have information provided to me.

Having been informed of my rights and obligations as a patient, I hereby give my consent for assessment and treatment.

_____ _____

Patient Date

_____ _____

Parent or legal guardian, if for minor child Date

_____ _____

Provider Date

CLOVIS COUNSELING CENTER

New Mexico Notice Form

Notice of Psychologists'/Psychiatrists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
- Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist/counselor.
- Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, busi ness-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, exam ining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing ac cess to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: In certain circumstances, I am required to report child abuse in a variety of forms, including neglect, to (1) a local law enforcement agency; (2) the office of the Department of Child, Youth and Family Services in the county where the child resides; or (3) tribal law en forcement or social services agencies for any Indian child residing in Indian country.

- Adult and Domestic Abuse: If I have reasonable cause to believe that an incapacitated adult is be ing abused, neglected or exploited, I must immediately report that information to the Depart ment of Child, Youth and Family Services.

- Health Oversight: If the New Mexico. Board of Psychology is conducting an investigation; I am re quired to disclose your mental health records upon receipt of a subpoena from the Board.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such infor mation is privileged under state law, and I may not release information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety: When I judge that a disclosure of confidential information is necessary to protect against a substantial and imminent risk that you will in flict serious harm on yourself or another person, I have a duty to report this information to the appropriate people who would address such a risk (for example, the police or the potential victim).

- Worker's Compensation: When a claim is filed, I am required by law to release those records that are directly related to any injuries or disabilities claimed by you (for which you are receiving benefits from your employer) to you, your employer, your employer's insurer, a peer review organization or the health care selection board.

IV. Patient's Rights and Psychologist's/Psychiatrist's and Counselor's Duties

Patient's Rights:

- Right to Request Restrictions -- You have the right to request restrictions on certain uses and disclo sures of protected health information about you. However, I am not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- Right to Request Restrictions -- You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- Right to Inspect and Copy-You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- Right to Amend- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- Right to an Accounting- You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- Right to a Paper Copy- You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's/Psychiatrist's/Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes; however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with the revisions at the next therapy session.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Diane True, Privacy Officer, at 505-762-0212 any morning, Monday through Friday, between 8:00a.m. and 12:00 p.m. for further information. You may also send a written complaint to her at 921 E. 21st Street, Suite D, Clovis, NM 88101. If you call and Diane is not in, leave your name and number. She will return your call as soon as possible, usually in the same day.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice at your next therapy session.

Payment Policy

It is office policy that any unpaid balances beyond 90 days will be sent to a collection agency. You will be notified 10 days prior to this action to give you an opportunity to take care of the balance.

Co-pays or deductibles are due at time of service, prior to seeing the counselor. If you do not have your payment, additional appointments cannot be made until co-pay is made. An initial appointment cannot take place without payment.

Signature:_____

Date:_____

Developmental Questionnaire

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in making an accurate diagnosis. Please complete this form as best as you can. We will have the opportunity to discuss your responses at the time of your child's appointment.

PLEASE PRINT

Please circle or write in your answers for all of the questions. Thank you.

Child's Name	Birth Date	Age
Person Completing Form	Your Relationship to Child	Today's Date
Mother's Name	Work Phone	Home Phone
Father's Name	Work Phone	Home Phone
Address		
Is this your biological, adopted, step, or foster child? If other, please explain.		
If adopted, how old was the child when she/he was adopted?		
Are you the child's legal guardian? If no, please explain. YES NO		
Name of Guardian	Work Phone	Home Phone
Address		

Mother's Marital Status	
☐	Married How many times have you been married? _____ How long have you been married to your present spouse? _____
☐	Separated How long did you live with your spouse before you separated? _____ How long have you been separated? _____
☐	Divorced How long were you married to your last spouse? _____ How long have you been divorced? _____
☐	Widowed
☐	Never Married
☐	Other Please explain.

Father's Marital Status	
☐	Married How many times have you been married? _____ How long have you been married to your present spouse? _____
☐	Separated How long did you live with your spouse before you separated? _____ How long have you been separated? _____
☐	Divorced How long were you married to your last spouse? _____ How long have you been divorced? _____
☐	Widowed
☐	Never Married
☐	Other Please explain.

Referred by	Phone
Address	
Child under medical care of (physician)	Phone
Address	
Have you notified the child's physician of your appointment here? YES NO	
Have you discussed the child's problems with the physician? YES NO	

Others in the home			
Name	Age	Birthday	Relationship to patient

Siblings who have moved out of the home			
Name	Age	Birthday	Relationship to patient

What are your concerns about this child? What are the difficulties/problems that caused you to seek help at this time?
Do you see this child as being hyperactive or as having problems with attention and concentration? If yes, please explain.

Complete this page for ADHD screening only. If not, continue to page 5

Do you believe this child has it in him/her to exert control over their behavior and attention? Please explain.
Has this child ever been diagnosed by a school psychologist or other professional (e.g. mental health clinician/physician) as having ADHD? If yes, please explain.
Has this child ever been previously evaluated for Attention-Deficit/Hyperactivity Disorder specifically? If yes, please explain.
Has this child received treatment for ADHD? If yes, please explain.
Is this child on any kind of medication for ADHD? YES NO If YES, please list the name of the medication and the dosage the child is given daily. How long has this child been on medication? Has this child experienced any problems while on medication?

List any other members (e.g. parents, siblings, grandparents, aunts/uncles) who suffer from a problem with inattentiveness/hyperactivity, or some other type of psychological, emotional, learning problems and/or nervous disorder?				
Family member's relationship to child	Current Age	Type of Problem	Severity	Type of Treatment

Child's Educational Placement		
Name of School	School District	Grade
Type of class placement (e.g. regular, special education, resource)	How many children are in this child's class?	

Check all official school classifications which apply to this child.

- ☐ Learning Disabled
- ☐ Emotionally Disturbed
- ☐ Mentally Retarded/Intellectually Limited
- ☐ Other
- ☐ Visually Impaired
- ☐ Hearing Impaired
- ☐ Physically Handicapped

Teacher's Name	Resource Teacher's Name
Principal's Name	School Psychologist and/or Counselor's Name

Please write the name, address, and phone numbers of any other person involved in the child's education that you feel we should contact.

Did this child attend any type of preschool program? If YES, what type of program and at what age did she/he begin and how often did they attend (e.g. nursery school; age 4; 2xweek)?	☐ YES ☐ NO
Did this child experience any problems in preschool? If YES, please explain.	☐ YES ☐ NO
Did this child repeat any grades? If YES, which grades were repeated and what was the reason for repeating that particular grade?	☐ YES ☐ NO
Did this child fail any subjects? If YES, which subjects?	☐ YES ☐ NO
Does this child currently receive any special education services? If YES, please specify the type (e.g. self-contained class, resource room, reading or math lab) What is the frequency of attendance in these special classes? (e.g. full-time, 2 days per week for 30 minutes)	☐ YES ☐ NO

Please list or describe any other school problems.

Mother's Family History	
Name	
Birth Date	Birth Place
Age	Religion
Highest Grade Completed	Highest Degree
Were you ever in any type of special education classes? If YES, please explain.	☐ YES ☐ NO
Have you experienced difficulties with reading? If YES, please explain.	☐ YES ☐ NO
Have you experienced difficulties with writing? If YES, please explain.	☐ YES ☐ NO
Have you experienced difficulties with math? If YES, please explain.	☐ YES ☐ NO
Generally, what kind of a student were you grade wise?	☐ A/B ☐ B/C ☐ C/D ☐ D/F
Did you repeat any grades? If YES, which ones and what was the reason for repeating the grade?	☐ YES ☐ NO

Did you fail any subjects? If YES, which ones?	☐ YES ☐ NO
Did you have any behavior problems? If YES, please explain.	☐ YES ☐ NO
Did you have any mental problems for which you have received treatment? If YES, please describe the problem and the treatment you received.	☐ YES ☐ NO
Have you ever been told or thought yourself that you might have an attention deficit or be hyperactive?	☐ YES ☐ NO
Do you have any medical problems? If YES, please specify. If YES, how old was your child when they began?	☐ YES ☐ NO
Your age at the time of your pregnancy with this child _____	
Total number of pregnancies _____	Number of pervious pregnancies _____
Number of miscarriages _____	Number of induced abortions _____
Occupation	
Current Place of Employment	
During which years of your child's life have you worked?	
Previous Work History	

Father's Family History	
Name	
Birth Date	Birth Place
Age	Religion
Highest Grade Completed	Highest Degree

Were you ever in any type of special education classes? If YES, please explain.	☐ YES ☐ NO
Have you experienced difficulties with reading? If YES, please explain.	☐ YES ☐ NO
Have you experienced difficulties with writing? If YES, please explain.	☐ YES ☐ NO
Have you experienced difficulties with math? If YES, please explain.	☐ YES ☐ NO
Generally, what kind of a student were you grade wise?	☐ A/B ☐ B/C ☐ C/D ☐ D/F
Did you repeat any grades? If YES, which ones and what was the reason for repeating the grade?	☐ YES ☐ NO

Did you fail any subjects? If YES, which ones?	☐ YES ☐ NO
Did you have any behavior problems? If YES, please explain.	☐ YES ☐ NO
Did you have any mental problems for which you have received treatment? If YES, please describe the problem and the treatment you received.	☐ YES ☐ NO
Have you ever been told or thought yourself that you might have an attention deficit or be hyperactive?	☐ YES ☐ NO
Do you have any medical problems? If YES, please specify. If YES, how old was your child when they began?	☐ YES ☐ NO
Do you smoke cigarettes? If YES, please specify average number of cigarettes per day.	☐ YES ☐ NO
Do you drink alcohol? If YES, please specify what type of alcohol and how much you drink per day.	☐ YES ☐ NO
Do you use any type of drugs? If YES, please specify what type(s) and how much you use per day .	☐ YES ☐ NO
Current Occupation	
Current Place of Employment	
During which years of your child's life have you worked?	

Previous Work History

Child's Developmental History

Pregnancy Length in Months or Weeks _____

X-Ray Studies?
If YES, when during your pregnancy and what type of x-ray?
☐ YES
☐ NO

Were any medications used during pregnancy?
If YES, please specify.
☐ YES
☐ NO

Did you smoke during pregnancy?
If YES, please specify the number of cigarettes per day.
☐ YES
☐ NO

Did you drink alcohol during pregnancy?
If YES, please specify the type of alcohol and how much was consumed per day.
☐ YES
☐ NO

Do you currently drink alcohol?
If YES, what type of alcohol do you drink and how much do you consume per day?
☐ YES
☐ NO

Did you use any type of drugs during pregnancy?
If YES, please specify what type and how much was consumed per day.
☐ YES
☐ NO

Do you currently use any type of drugs?
If YES, please specify what type of drugs you use and how much you use per day.
☐ YES
☐ NO

Pregnancy Complications (check all that apply)

☐ Bleeding	☐ Kidney Trouble	☐ Swelling
☐ Excessive Vomiting	☐ Diabetes	☐ Fever
☐ Excessive Weight Gain	☐ High Blood Pressure	☐ Toxemia
☐ Infections	☐ Sonograms	☐ Other, please specify
☐ Weight Lose	☐ Rash	

Delivery
Type of Labor: ☐ Spontaneous ☐ Induced If labor was induced, please specify the reason for induction.
Type of Birth Delivery: ☐ Normal ☐ Breech ☐ Cesarean Section
Duration of labor: _____ hours
Check all that apply: ☐ Forceps Used ☐ Hemorrhage/ Excessive Blood Loss ☐ Multiple Birth ☐ Baby born in some type of danger (e.g. cord around neck, heart rate problems) Please Specify.
Anesthesia: ☐ None ☐ Local Anesthetic (e.g. epidural/spinal) ☐ General ☐ Muscle Relaxant
Were there any problems with labor and/or delivery? If YES, please explain. ☐ YES ☐ NO
Perinatal History
Baby's weight at birth: _____ pounds, _____ ounces Baby's length at birth: _____ inches Number of days baby stayed in the hospital following his/her birth: _____ days Number of days mother stayed in the hospital following baby's birth: _____ days APGAR Score: At birth _____, at 5 minutes _____

Check all that apply:

- ☐ Jaundice
- ☐ Incubator
- ☐ Blood Transfusions (baby)
- ☐ Rashes
- ☐ Problems Breathing
- ☐ Given Oxygen (baby)
- ☐ Very Quiet
- ☐ Very Active
- ☐ Problems Sucking
- ☐ Problems Eating/Digestion
- ☐ Baby on Heart Monitor
- ☐ Other, Please Explain.

Any birth defects?
If YES, please explain.

☐ YES
☐ NO

Any other problems or comments regarding this child when he/she was a newborn?
If YES, please specify.

☐ YES
☐ NO

Any other problems or difficulties concerning the birth?
If YES, please specify.

☐ YES
☐ NO

Was your doctor worried about the overall health of the baby within the first few days?

☐ YES
☐ NO

Infancy and Early Childhood

Check all that apply:
If checked, please specify.

- ☐ Colicky
- ☐ Feeding Problems
- ☐ Sleeping Problems
- ☐ Restlessness
- ☐ Active
- ☐ Did Not Enjoy Cuddling
- ☐ Head Banging
- ☐ Accident Prone
- ☐ Uncoordinated

Are there other problems or comments regarding the child's infancy and early childhood development? If YES, please specify.	☐ YES ☐ NO
Child's approximate age when she/he began… Walking: _____ Talking (Single Words): _____ Speaking in Short Sentence: _____ Toilet Training: Daytime _____ Nighttime _____	
Does this child continue to have wetting accidents in bed? If YES, day or night?	☐ YES ☐ NO
Does this child continue to have wetting accidents in clothing? If YES, day or night?	☐ YES ☐ NO
Does this child continue to have soiling accidents in bed? If YES, day or night?	☐ YES ☐ NO
Does this child continue to have soiling accidents in clothing? If YES, day or night, and please explain.	☐ YES ☐ NO
Overall, at what rate did your child develop? Please explain. ☐ Slow ☐ Normal ☐ Rapid	
Childhood Diseases	
Check all that apply. In the extra space provided, please describe the condition and specify the type of treatment received. Please indicate if the child continues to receive treatment for the condition.	
☐ Asthma	
☐ Anemia	
☐ Lead Poisoning	

☐ Meningitis
☐ Encephalitis
☐ Seizures
☐ Epilepsy
☐ Hydrocephalus
☐ Cerebral Palsy
☐ Mental Retardation/ Intellectual Disability
☐ Heart Problems
☐ Emotional Problems
☐ Vision Problems
☐ Hearing Problems
☐ Other handicapping conditions or special health consideration
Has this child ever been taken to the emergency room? If YES, please list why and how old she/he was at the time of the visit. ☐ YES ☐ NO

Has this child undergone any type of surgery?

☐ YES
☐ NO

Type of Surgery	Age	Length of Stay

Was this child hospitalized for any other type of illness thus far not covered?

☐ YES
☐ NO

Reason for Hospitalization	Age	Length of Stay

Has this child suffered any type of head injury?
If YES, please indicate whether or not consciousness was lost and your child's age at the time of the incident.

☐ YES
☐ NO

Has this child experienced any convulsions?
If YES, please indicate the nature of the convulsions and whether or not these occurred with high fevers.
Please indicate the child's age at the time of the convulsions.

☐ YES
☐ NO

What was the highest fever this child has had?

What was the nature of the illness associated with this fever?

Has this child experienced consistent high fevers?
If YES, please explain.

☐ YES
☐ NO

Was this child ever in a coma? If YES, please explain.	☐ YES ☐ NO
Does this child suffer from allergies? If YES, please explain the type of allergic reaction and Treatment she/he is receiving.	☐ YES ☐ NO
Has this child ever suffered from any type of poisoning? If YES, please explain.	☐ YES ☐ NO
Has this child ever suffered from ear infections? If YES, please answer the following.	☐ YES ☐ NO
This child's age at the time of his/her first infection: _____	
This child's age at the time of his/her most recent infection: _____	
Types of medical treatments this child has received for his/her infections: (e.g. antibiotics, tubes, antihistamines)	
Total number of ear infections: _____	

Please indicate the number ear infections which occurred between the following stages of this child's development and the type of treatment he/she received during that age range.

Age	Number of Infections	Type of Treatment
Birth-2 years		
2-5 years		
5 years and above		

Child's Present Medical Status

Current Health:

☐ Poor ☐ Good

☐ Fair ☐ Excellent

Child's Present Height

_____ Feet _____Inches

Child's Present Weight

_____ Pounds

Is this child physically ill at this time?
If YES, please explain and indicate how they are being treated.

☐ YES
☐ NO

Is this child taking any type of medication at this time?
If YES, please explain.

☐ YES
☐ NO

Has this child ever taken any type of medication on an ongoing basis?
If YES, please list the medications and provide dosages and frequency of administration.

☐ YES
☐ NO

Has this child ever been involved in any type of professional mental health treatment?
If YES, please completed below.

☐ YES
☐ NO

Name of Therapist	Duration	Purpose of Therapy

Is your child *currently* involved in any type of professional mental health treatment?
If YES, please completed below.

☐ YES
☐ NO

Name of Therapist	Duration	Purpose of Therapy

Please list any unusual and/or traumatic events in the child's life which you feel may have affected his/her development and ability to function (e.g. birth of sibling, deaths in family, divorce, moves, school changes).

Incident	Child's Age	Comments