David F. Dahl, Ph.D.
Clinical and Forensic Neuropsychology
PSY 19014

2542 South Bascom Ave. Suite 265, Campbell, CA 95008
408-793-0313
david@drddahl.com
www.drddahl.com

NEW PATIENT INTAKE FORMS: **CHILD**

Welcome to this professional psychology practice.

All new patients must fill out these forms in their entirety and submit them to Dr. Dahl. For minors under age 18, parents must fill out the forms on behalf of **each** of their dependents.
Please note: all forms are double-sided to conserve paper use. Please fill out both sides of each page. You may use adobe filler to complete the form digitally.

Please have your insurance ID card out and ready to be copied at the beginning of your first appointment.

It is imperative that all pages of Part 1 (pages 3-9) are completed, signed and dated before your first appointment begins.

We understand that these forms are very in-depth and thank you for taking the time needed to complete them as honestly and thoroughly as possible. Your cooperation in providing all of this information will greatly enhance your therapeutic process with Dr. Dahl. It is best if you can have the forms all completed before you enter your first session with Dr. Dahl. However, if you need additional time to fill in the remaining pages of personal and medical history in Part 2 (pages 11-15), you may either complete them on-site after your appointment concludes or finish them at home and bring them to your second appointment. **All forms must be complete and submitted by your second appointment with Dr. Dahl.**

We thank you for your help in ensuring that we have all your records up-to-date.

Notes:

For EAP patients, please provide the pre-authorization form from your insurance carrier with your EAP Claim Number and number of authorized visits (you can request this directly from your insurance carrier)

For Victim-Witness patients, please have your Victim Witness Application Number and confirmation letter from CalVCP available on your first appointment.

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Patient Intake Form: CHILD
PART 1

This is a strictly confidential patient medical record.

Today's Date:_____

1. Child's Information

Legal Name: Last: _____ First:_____ Middle initial:_____

Date of birth: _____ Age: ____ Gender: female__ male__

Last 4 digits of Social Security #: XXX-XX-_____ Photo ID/Driver's license #: _____

Race/Ethnicity: African-Am __ Asian (Specify) _____ Caucasian__ Hispanic__ Native Am__ Pacific Islander__ Other_____

Handedness: Right__ Left__ Ambidextrous__ Height: ___'_____" Weight: _____lbs.

Home address: _____ City:_____ State:_____ Zip:_____

Child's Cell Phone (if applicable): _____ Email: _____

Emergency contact name and phone number: _____

2. Payment / Insurance Information

We will be paying for these sessions by cash, personal check, or credit card: ☐yes ☐no *(note: a 4% fee applies for credit card)*
We would like insurance to be billed and have received approval for therapy from our insurance company: ☐yes ☐no

Please complete ALL below information if billing insurance:

Insurance company: _____Insured's ID number: _____

Policy group name/number: _____ Plan name/number: _____

Copay: _____ Deductible: _____ Number of appointments approved: _____

Insured's Relationship to Child: self__ Mother__ Father__ Guardian__ other relationship_____

Insured's name: Last _____ MI ___ First _____

Birthdate _____ Gender_____

Insured's address: _____City_____State____Zip_____

Insured's employer: _____

3. Presenting Problems / Reason for today's appointment:

What are the problems that caused you to seek help for this child? _____

_____

_____

4. Parent/Guardian Contact Information:

Which Parent/Guardian(s) will be the primary contact person?:_____

Cell/Home Phone #: _____

How did your family hear of this practice? ☐ web ☐ referral ☐phone book ☐ other: _____

Please provide detailed information for each of the child's parents and/or caregivers:

1) Mother

Name:_____ Date of Birth:_____
Address:_____ State:_____ Zip:_____
Home phone: _____ OK to leave messages? ☐yes ☐no
Cell Phone: _____ OK to leave messages? ☐yes ☐no
Work Phone: _____OK to leave messages? ☐yes ☐no
Email: _____
How and when do you prefer to be contacted? _____

2) Father

Name:_____ Date of Birth:_____
Address:_____ State:_____ Zip:_____
Home phone: _____ OK to leave messages? ☐yes ☐no
Cell Phone: _____ OK to leave messages? ☐yes ☐no
Work Phone: _____OK to leave messages? ☐yes ☐no
Email: _____
How and when do you prefer to be contacted? _____

3) Identify: Stepfather__ Stepmother__ Guardian

Name:_____ Date of Birth:_____
Address:_____ State:_____ Zip:_____
Home phone: _____ OK to leave messages? ☐yes ☐no
Cell Phone: _____ OK to leave messages? ☐yes ☐no
Work Phone: _____OK to leave messages? ☐yes ☐no
Email: _____
How and when do you prefer to be contacted? _____

Are you here in relation to the following (please check all that apply)?
Victim Witness case__ Employee Assistance Program (EAP)__ Addictions__ Family Problems__ Marital Problems__
Mood/anxiety__ Neurocognitive__ Worker's Compensation__ Other__

If applicable, please provide:
Victim Witness application number: _____
EAP Claim Number: _____# of pre-authorized EAP visits from your insurance provider: _____

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for $175.00, the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 48-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

Credit Card ▫ American Express ▫ Visa ▫ Master Card ▫ Discover ▫ Health Savings Account

Card Number:_____ Expiration Date:_____ Security Code:_____

I understand the cancellation policy outlined above
I authorize Dr. David F. Dahl, Ph.D. to charge my credit card or health savings account for the balance of the fees due. I agree to pay all remaining fees at the final session.

_____ Client signature (Client's parent/guardian if under 18)

_____ Today's date

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PATIENT RIGHTS AND HIPAA AUTHORIZATION

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your psychologist if you do not understand this authorization, and the psychologist will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization: or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address:

   David F. Dahl, Ph.D., 2542 South Bascom Avenue, Suite 265, Campbell, CA 95008.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are requesting a psychological evaluation for the purposes of:
   i. A court order
   ii. An attorney's recommendation
   iii. A pre-employment screening evaluation
   iv. A legal matter in which your mental status is at question, you must be aware that your refusal cancels the purpose for which the evaluation was ordered or recommended and you will still be held responsible for the fees ordinarily charged for this evaluation by the psychologist up to the point of the refusal.

   If you refused to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right not to treat you or accept you as a patient in this practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiates this authorization, you must receive a copy of the signed authorization.
6. **Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes**. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes". All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.
7. According to HIPAA, you have the right to review the record within 10 days of your request. You will be charged the full hourly fee for reviewing the record in the office with the psychologist.
8. According to HIPAA, you have the right to a summary of the record within 15 days of your request. You will be charged the equivalent of the hourly fee required by the psychologist to review and summarize the record. This summary will be one page, brief and general. If there are more than one person in the record, each party will receive the same summary.

Name:_____ Signature:_____ Date: _____

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INFORMATION AND CONSENT FOR TREATMENT

Welcome! I am a licensed clinical psychologist. I hold a doctoral degree (Ph.D.) in clinical psychology with specialized training and experience in: neuropsychological, forensic, vocational, and educational assessment & treatment; family/couples therapy; addictions treatment, & parenting coordination. Qualifications include: a) psychological evaluation and treatment for children and adolescents with learning, attentional, mood, anxiety, behavioral difficulties, addictive or obsessive compulsive behaviors, phobias, autism spectrum, trauma; juvenile competency to stand trial; child custody and brief focused assessments; b) psychological evaluation and treatment for adults with attentional, mood, anxiety, addictions, dual disorders, disability determination, child custody, reunification therapy, behavioral difficulties; c) faith-based or spiritual abuse issues; d) contracts with POST certification; e) neurocognitive evaluation for the CA state boards of Medicine, Nursing, Chiropractic, Pharmacy; f) Qualified Medical Evaluator for Worker's Compensation. My experience includes: a) conducting over 6000 disability determination evaluations; b) work in adolescent, women's and men's correctional facilities; c) adjunct faculty in 6 graduate programs; d) having served 7 severely conflicted congregations as a licensed pastor; d) initiated and COO of a community hospice society; e) Certificate of Personal and Executive Coaching (C.P.E.C.); f) certified in communication skills; g) evaluations of veterans with PTSD and other mental illnesses; h) consultation; i) graduate courses on psychological assessment, research methods, neuropsychology, human sexuality, health psychology, dual disorders, marriage and family, law and ethics, and preparation for ministerial students.

I am glad that you are here. I trust that you will find help for the situations and issues that you face -- in a caring and a safe place where your needs for counseling will be met confidentially, competently and compassionately.

Confidentiality . . .
All information and records disclosed within sessions and the written records pertaining to those sessions are confidential and may not be disclosed to anyone without your written, signed permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure are described to you in the Notice of Privacy Practices that you received with this form. Please refer to the Notice for further details. You have the right to review the record in my office within 10 days of your request and receive a brief written brief summary within 15 days of your request. These services will be charged at the normal hourly rate. If the treatment is for a family or a couple and a written summary is requested by one individual, all parties will receive the same summary.

Circumstances where disclosure is required by law are as follows: a) there is a reasonable suspicion of child, dependent or elder abuse or neglect, b) a client presents a danger to self, to others, to property, and/or c) a client is gravely disabled.

Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain your psychotherapy records and/or testimony. Due to the nature of the therapeutic process, it is agreed that neither you, your attorney, nor anyone else acting on your behalf will call on me to testify in legal proceedings, nor will a disclosure of the psychotherapy records be requested unless specifically authorized by you in writing.

In couple and family therapy or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized with signature to do so by family members who are in treatment.

If you are under 18 years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request an agreement from your parents or guardians indicating that they consent to give up access to such information and/or to your records. If they agree, I will provide them only with general information about our work together subject to your approval, or, if I feel it is important for them to know in order to make sure that you and people around you are safe.

E-mail, Cell phone and Fax: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Faxes can easily be sent erroneously to the wrong address. Please notify me at the beginning of treatment if you decide to limit in any way the use of these devices.
Health Insurance and Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier in order to process your claims. The Psychotherapy Notes will not be disclosed to your insurance carrier without your authorization. Please be aware that submitting claims for reimbursement carries a certain amount of risk to confidentiality, and/or to future eligibility to obtain health or life insurance.

Consultation: I consult regularly with other professionals regarding my clients/patients, however, the client/patient's name or other identifying information is never mentioned. The client/patient's identity remains completely anonymous, and confidentiality is fully

maintained.

Appointment Times…
Your appointment time has been especially reserved for you. In order to honor your needs and the needs of others, please call at least 48 hours before your appointment to avoid being charged for the session. Most insurance companies do not reimburse for missed sessions. You will be billed.

Telephone Calls…
Your calls are important to me. Unless I am out of town, I check for my messages several times a day during the weekdays. I will return your phone calls as promptly as possible.

Emergencies….
In times of crisis, I will give you the earliest available appointment or arrange for emergency care. If I am not available, please call one of the following emergency numbers in Santa Clara County: Emergency Psychiatric Services at 408-885-6100, Suicide and Crisis Services at 408-279-3312, Contact Hotline including Parental Stress at 408-279-8228.

Paying for Psychotherapy or Psychological Evaluation…
My normal fees are as follows: $175 per clinical hour for therapy (approximately 45-50 minutes), $200 per hour for psychological evaluation, $225 per hour for neuropsychological or forensic evaluation, $350 per hour to testify in court, or, as determined the flat fee of $_____. **Payment is due in cash or check at the outset of the session** when services are rendered. When credit cards are used an additional 4% must be added to the customary fees. When my time is used on your behalf at your request (e.g., telephone conversations, writing letters, consultations with other professionals involved in your care, reading records), you will be charged at the appropriate hourly rate (pro-rated). There is a $20.00 fee for a returned check. Please be advised that **not all issues/conditions are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage in advance**. In the case an insurance company refuses coverage, the patient will be responsible for all payments. My insurance is with: (please circle) Aetna, Anthem, Beacon Health Strategies, Blue Cross, Blue Shield, Cigna, Concern EAP, First Five, HealthNet, Kaiser, Magellan, Managed Health Plan, Medicare, MediCal, Private Pay, Sutter Select, TriCare, Valley Health Plan, Victim Compensation Fund. My copay per visit is: $_____after the deductible of $_____ has been met.

The Process of Therapy or Psychological Evaluation…
Participation in therapy or psychological evaluation can result in a number of benefits to you, including resolution of the specific concerns that led you to seek therapy or psychological evaluation and improved interpersonal relationships. Working toward these benefits requires your very active involvement, honesty, and openness to change. During therapy or psychological evaluation, discussing unpleasant events, thoughts, or feelings can result in your experiencing considerable discomfort (e.g., strong feelings of anger, sadness, anxiety, or fear). Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Sometimes a decision that is positive for one family member can be viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often, it will be slow and even frustrating. There is no guarantee that psychological will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include psychodynamic, cognitive-behavioral, existential, family systems, development and/or psycho-educational therapy.

At various times, I may discuss my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. You have the right to ask about any of the procedures used in the course of your therapy, and to ask about other treatments for your condition. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments. If at any point during psychotherapy or psychological evaluation, I assess that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. If you request it, and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. You have the right to terminate therapy at any time.

I have read and understood all the information on this form. I agree to the above conditions, and to avail myself and/or the named minor or dependent adult _____ to the professional services of Dr. David Dahl and consent accordingly to the use of individual, couples, family, and/or group psychotherapy, and/or assessment. Furthermore, I acknowledge that I have received the Notice of Privacy Practice (HIPPA Notice) and have understood the nature and limits of Confidentiality.

_____	_____	_____
signature of the client(s)	signature of the payee, parent(s)/guardian(s)	date
_____	_____	_____
signature of the client(s)	signature of the therapist/evaluator	date

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____

DUTY TO WARN AND PROTECT

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

ABUSE OF CHILDREN AND VULNERABLE ADULTS

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

MINORS / GUARDIANSHIP

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

INSURANCE PROVIDERS (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications

_____ Client signature (Client's parent/guardian if under 18)

_____ Today's date

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DISCLOSURE AUTHORIZATION FORM

Please sign the statement below giving your permission for me to communicate with individuals or agencies on your, or your dependent's behalf.

I (your name), _____

hereby give consent to David F. Dahl, Ph.D. to release or receive any information deemed necessary to or from:

name of individual or providing agency _____

address _____

phone _____

fax _____

which is relevant to the purpose stated below, from the case records of:

(name of patient) _____

Your relationship to the patient (circle one) self spouse parent child personal representative

for the purpose of: (check one)

□ Evaluation

□ Treatment

□ Other: _____

This authorization is valid for □ one year □ until revoked by me □ indefinite.

Authorization and signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The recipient may re-disclose the information that is used and/or disclosed pursuant to this authorization unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature:_____Personal representative:_____

Print name:_____Personal representative: _____

Signature:_____Personal representative:_____

Print name:_____Personal representative: _____

Date:_____

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Patient Intake Form: CHILD
PART 2

This is a strictly confidential patient medical record.

1. Family History **Patient Name:**_____

Where was the child born?_____ Raised?_____

US Citizen? ☐yes ☐no Date citizenship received_____ If immigrated, when?_____ from where?_____

Child is living with: Both Parents__ Mother__ Father__ Mother and Stepfather__ Father and Stepmother__ Legal Guardian__
Other (please specify)_____

Is the child adopted? ☐yes ☐no
If yes, with which parent(s) (if any) does the child live? Natural__ Adoptive__ Child's age at adoption_____

Status of parents' marriage: Married__ Partnered__ Separated__ Divorced__ Widowed__ Single__
How long?_____ How long divorced? _____ Child's age at divorce_____

Birth Mother:
Age:_____ Highest Grade Completed:_____ Diploma/Degree:_____ Occupation:_____
Please describe any special education or tutoring: _____
Please describe and grades repeated or subjects failed: _____
Please describe any learning difficulty, and subject and grade level at which it occurred: _____
_____
Please describe any behavior problems and treatment received: _____
_____
Please describe any psychological or psychiatric problems for which treatment was received: _____
_____
Any Attention-Deficit Disorder or hyperactivity? Please describe treatment: _____
_____

Birth Father:
Age:_____ Highest Grade Completed:_____ Diploma/Degree:_____ Occupation:_____
Please describe any special education or tutoring: _____
Please describe and grades repeated or subjects failed: _____
Please describe any learning difficulty, and subject and grade level at which it occurred: _____
_____
Please describe any behavior problems and treatment received: _____
_____
Please describe any psychological or psychiatric problems for which treatment was received: _____
_____
Any Attention-Deficit Disorder or hyperactivity? Please describe treatment: _____
_____

Adoptive Mother__ or Stepmother__ or Other_____ (check one)

Age:_____ Highest Grade Completed:_____ Diploma/Degree:_____ Occupation:_____

Adoptive Father__ or Stepfather__ or Other_____ (check one)

Age:_____ Highest Grade Completed:_____ Diploma/Degree:_____ Occupation:_____

Other Children
(Including step-siblings and half-siblings) Please fill out chart below.

Name	Age / Gender	In home?	School/behavioral/health problems
	☐M ☐F	☐yes ☐no	
	☐M ☐F	☐yes ☐no	

	☐M ☐F	☐yes ☐no	
	☐M ☐F	☐yes ☐no	
	☐M ☐F	☐yes ☐no	

Please describe the child's parents' relationship with one another _____
_____

Please describe the child's relationship with each parent _____
_____

Please describe the child's parents' physical health, drug or alcohol use, mental or emotional difficulties_____
_____

Please describe the child's relationship with his or her brothers and sisters _____
_____

Was the child ever abused? ☐yes ☐no *Please describe circumstances, child's age, and effects on him/her:*
_____
_____

Biological Extended Family
Please supply description of any extended family members (grandparents, uncles, aunts, cousins) who suffer from a problem with inattentiveness or hyperactivity, epilepsy, seizures, migraines, alcoholism or substance abuse, psychological, emotional, or personality difficulty, learning problems or developmental disabilities, a "nervous" or neurological disorder, etc.

Maternal (Mother's Side)	**Paternal (Father's Side)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please provide any other information about the child's extended family that might help us understand the child's needs (medical, developmental, behavioral, educational, emotional, or psychological):
_____
_____
_____

2. Birth and Developmental History

Pregnancy
Full term__ Premature__ at week #_____ Late__ at week #_____
Any illnesses or complications while pregnant? ☐yes ☐no If yes, please explain: _____
_____

Medications taken by mother **during** pregnancy? Please list:_____

Substances used **during** pregnancy: None _____
☐Cigarettes How many? _____per ☐day ☐week
☐Alcohol How many drinks? _____per ☐day ☐week ☐month
☐Drugs Please describe type(s) of drug, frequency of use, and at what month of pregnancy use was stopped (if applicable): _____
_____

Was the father taking any medications or drugs at the time of conception? ☐yes ☐no If so, what? _____
_____

Did the mother suffer abuse during pregnancy? ☐yes ☐no What?_____

How many pregnancies and/or miscarriages has the mother had? _____

Labor and Delivery
Delivery: Vaginal__ C-Sect__ Breach__ Anoxia__

Was the birth of the child "normal?" ☐yes ☐no If no, please explain: _____
_____

Do you think the child's problems might be related to pregnancy, labor, or delivery? ☐yes ☐no If yes, please explain:
_____
_____

Perinatal History
Birth weight: _____ Length: _____ APGAR Scores: _____

Did the mother or baby stay in Special or Intensive care? ☐yes ☐no
Please describe any problems: _____
_____

Please list any birth defects: _____

Infancy and Early Childhood
Please rate your child on the following behaviors: Circle *1* if the behavior on the left was present the majority of the time. Circle *5* if the behavior on the right was present the majority of the time. Stages in between are represented by *2, 3,* and *4*. If there are two behaviors listed (e.g., tantrums and head-banging), please check the one that was present.

Quiet and content	1	2	3	4	5	colicky and irritable
Very easy to feed	1	2	3	4	5	daily feeding problems
Slept well	1	2	3	4	5	frequent sleeping problems
Usually relaxed	1	2	3	4	5	often restless
Underactive	1	2	3	4	5	overactive
Cuddly, easy to hold	1	2	3	4	5	did not enjoy cuddling
Easily calmed down	1	2	3	4	5	☐tantrums ☐headbanging
Cautious and careful	1	2	3	4	5	☐accident prone ☐daredevil
Coordinated	1	2	3	4	5	uncoordinated
Enjoyed eye contact	1	2	3	4	5	avoided eye contact
Liked people	1	2	3	4	5	disliked contact with people

Other problems or comments regarding infancy or early childhood development: _____
_____
_____

Did any event, health condition, separation, etc., disturb any early infant/mother bonding or the developing toddler/mother relationship? ☐yes ☐no If yes, please describe condition/injury, treatment, and surgery, when, how long, and where:
_____
_____
_____

Please describe your child as an infant (temperament, sleeping, eating patterns, etc.):
_____
_____
_____

Ages at Milestones
(please fill in child's age in blanks)
Gross Motor: crawled_____ walked alone_____ ran well_____
Fine Motor: fed self with spoon_____ scribbled_____ tied shoes_____
Language: used single words_____ used sentences (2+ words) _____ described activity_____
Social/Adaptive: potty trained/day_____ potty trained/night_____
Rate of development overall: ☐slow ☐normal ☐fast

3. Medical History

Child's primary care physician:_____ Phone: _____

Date of last physical examination:_____ Findings if any?_____

Please list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, convulsions, seizures and/or any other medical conditions the child has ever experienced:

Age	Illness/Injury/Medical Problem	Treatment	Result

Does the child have any allergies? (food, drug, etc.) ☐yes ☐no If yes, please describe them: _____
_____

Any diet restrictions? _____

Please list medications (with dosage and times) that have been taken by the child, including nonprescription medications:

Drug	Dose	Helps?	Reason	Taking presently?
		+ -		
		+ -		
		+ -		
		+ -		

Has your child ever had a head injury? ☐yes ☐no Describe:_____
Did he or she lose consciousness? ☐yes ☐no How long?_____Was he or she in a coma? ☐yes ☐no How long?_____

Do you see your child as being ☐hyperactive? ☐inattentive? ☐a behavioral problem?

Does your child seem to be able to control his or her behavior and attention? ☐yes ☐no Please explain:
_____
_____

Has your child ever been diagnosed by a psychologist, physician, or other professional as having ADHD (Attention-Deficit/Hyperactivity Disorder)? ☐yes ☐no If yes, When? _____

What treatment (**not medication**) has your child had for ADHD? _____
_____

What medication (include dosage and times) has your child received for ADHD? _____
_____

Please describe any other handicapping conditions or special health considerations and their treatments: _____
_____

Date of last hearing test: _____ Result:_____ Does the child wear ☐glasses? ☐contacts?

The child's current health is: ☐poor ☐fair ☐good ☐excellent

4. Self Care Information

What type of physical exercise does your child get weekly? _____

What in his/her life is currently stressful? _____

What does he/she do for stress management?_____

When does he/she go to sleep?_____How long does it take to fall asleep?_____When does he/she wake up?_____

What does he/she do to help fall asleep? _____If he/she wakes up in the middle of sleep, for how long?_____

Has his/her weight fluctuated in the past 2 months? ☐yes ☐no By how much?_____lbs. gained__ lost__

Has he/she restricted his/her eating in any way? ☐yes ☐no How? Why? _____

5. Behavior and Mental Health History

Please describe any behaviors that are particularly concerning to you or others: _____
_____
_____

Please list any unusual, traumatic, or possibly stressful events in your child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments:
_____
_____
_____
_____

Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, psychiatric or psychological treatment, alcohol treatment etc.? ☐yes ☐no
If yes, please list provider's name(s) and dates of service_____
Describe the treatments:_____
_____
_____

Does your child have a current mental health diagnosis? ☐yes ☐no What? _____

Has your child ever taken medications for psychiatric or emotional problems? ☐yes ☐no Adherence to prescription: full, partial, non
If yes, please list medication(s), dose, duration, problem(s) and results: _____
_____

Prior psychiatric hospitalizations: ☐yes ☐no When?_____How long?_____
Prior out treatment: ☐yes ☐no When?_____How long?_____
Prior therapy? ☐yes ☐no When?_____How long?_____

Has your child heard, seen or sensed things other people around do not hear, see or sense? ☐yes ☐no When?_____
Describe:_____

Has your child ever attempted and/or thought of suicide? ☐yes ☐no When?_____How?_____

Has your child ever attempted and/or thought of hurting themself? ☐yes ☐no When?_____How?_____
Has your child ever attempted to and/or thought of hurting SOMEONE ELSE? ☐yes ☐no When?_____How?_____

Self harm/Aggression? (check all that apply): Head banging__ cutting__ picking at skin__ pulling out hair__ hurt animals__ eating dirt or other materials__ high risk behaviors__

Has your child ever been abused/tortured? ☐yes ☐no Physically__ emotionally__ sexually__ verbally__ Explain:_____
_____

Has your family had a child protective services or police call? ☐yes ☐no When?_____ Regarding what?_____

Please indicate whether or not your child is **currently / recently** experiencing any of the following symptoms:

Suicidal thoughts/impulse	☐yes ☐no	Homicidal thoughts/impulses	☐yes ☐no
Appetite problems	☐yes ☐no	Sleep problems	☐yes ☐no
Isolation/social withdraw	☐yes ☐no	Anxiety/panic	☐yes ☐no
Phobia	☐yes ☐no	Binging/purging	☐yes ☐no
Poor impulse control	☐yes ☐no	Violence toward others	☐yes ☐no
Destruction of property	☐yes ☐no	Strange or unusual behavior	☐yes ☐no
Confused or irrational thinking	☐yes ☐no	Bothersome thoughts or behaviors	☐yes ☐no
Self-harm	☐yes ☐no	Hearing or seeing things others do not	☐yes ☐no
Preoccupations	☐yes ☐no	Compulsive behaviors	☐yes ☐no
Fluctuations in their mood	☐yes ☐no	Collecting things that crowd things out	☐yes ☐no

Trouble making decisions	☐yes ☐no	Sexual preoccupation	☐yes ☐no
People bugging them about internet use	☐yes ☐no	Relationship problems with a parent/sibling	☐yes ☐no
Relationship problems at work	☐yes ☐no	Chronic pain	☐yes ☐no
Problems with gambling	☐yes ☐no	Depression	☐yes ☐no

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

6. Drug and Alcohol History

CHILD HAS NEVER USED DRUGS OR ALCOHOL _____ ***(skip to section 7)***

Has your child ever injected drugs?	☐yes ☐no
Has your child ever shared needles?	☐yes ☐no
Has your child ever felt the need to cut down on his/her drinking?	☐yes ☐no
Has your child ever felt guilty about his/her drinking?	☐yes ☐no
Has your child ever used inhalants such as glue, gasoline or paint thinner?	☐yes ☐no
Has your child ever used cough syrup or mouthwash as a psychoactive drug?	☐yes ☐no
Has your child used medications not prescribed for him/her in the past ten years?	☐yes ☐no
Has your child ever been in trouble with the law because of drinking or drug use?	☐yes ☐no

If you answered yes to any of the above questions, please supply details about the child's use of drugs or chemicals including amounts, how and why he or she used them?

_____
_____

7. Educational History

Briefly describe your child's performance and any concerns in each grade:

	Academic Performance	Behavioral Issues	Social Interactions	Specific Interests
Kindergarten				
1st grade				
2nd grade				
3rd grade				
4th grade				
5th grade				
Middle school				

Best subject(s)_____ Worst subject(s)_____

Learning disability?	☐yes ☐no What?_____	How long?_____
Special education?	☐yes ☐no What?_____	How long?_____
Special assistance?	☐yes ☐no What?_____	How long?_____
Speech assistance?	☐yes ☐no What?_____	How long?_____

If your child is/was receiving tutoring, for what subjects?_____

Has your child ever had trouble in school with any of the following? (please check all that apply): Anxieties__ Obsessions__ Friends__ Cheating__ Stealing__ Fighting__ Setting fires__ Skipping school__ Running away__ Using drugs/alcohol__ Isolating__ Selling Drugs__ Talking too much in class__ Not sitting still__ Inattention__ Bullying__ Being picked on__ Harming animals__ None of the above__

8. Employment Information

Is your child currently employed? ☐yes ☐no

Employer: _____Position: _____Length:_____Reason for Leaving:_____
Employer: _____Position: _____Length:_____Reason for Leaving:_____

9. Legal History

Has your child ever been arrested? ☐yes ☐no Charged with a misdemeanor? ☐yes ☐no
Charged with a felony? ☐yes ☐no Been to Juvenile Hall? ☐yes ☐no
Been to state/federal/youth prison? ☐yes ☐no
If you answered yes to any of the above, please explain: _____
_____

Is your child now on probation? ☐yes ☐no Until?_____ On parole? ☐yes ☐no Until?_____

10. Personal

Present Personality and Behavior

Please circle all traits that apply to your child **now**:

sad	happy	leader	follower	moody
friendly	quiet	overactive	independent	dependent
sensitive	affectionate	fearful	cooperative	tantrums
lethargic	too responsible	trouble sleeping	hard to discipline	even-tempered
prefers to be alone				

What are your child's current interests/hobbies/pastimes? _____

What are some of his/her character strengths? _____

What are some of his/her character shortcomings? _____

Describe his/her religious or spiritual interests and practices: _____

What do you believe a therapist/evaluator should be like? _____

What is your child prepared to change about him/herself? How? _____

_____

11. Additional Information / Comments

Please attach results of any previous testing. If this is an evaluation: full legal (if applicable) medical and educational records must be supplied with any other pertinent information like drawings, diary entries or photos.

Please add any additional comments you think might be helpful:

_____

_____

_____

_____

_____

_____

Thank you for completing this confidential form. Please sign below.

Signature: _____ Date: _____

Printed Name:_____ Relationship to Child: _____
Individual completing form