



# Dyer Counseling & Psychology, PLLC

9821 E. Bell Rd., Ste. 100  
Scottsdale, AZ. 85260  
480-290-0179

## Child Developmental History Record

### A. Identifications

1. Child's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Person(s) completing this form: \_\_\_\_\_ Today's date: \_\_\_\_\_

2. Mother's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Currently employed:  No  Yes, as: \_\_\_\_\_ Work phone: \_\_\_\_\_

3. Father's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Currently employed:  No  Yes, as: \_\_\_\_\_ Work phone: \_\_\_\_\_

4. Parents are currently  Married  Divorced  Remarried  Never married  Other: \_\_\_\_\_  
Child's custodian/guardian is: \_\_\_\_\_

5. Stepparent's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Currently employed:  No  Yes, as: \_\_\_\_\_ Work phone: \_\_\_\_\_

6. Other adult family members? \_\_\_\_\_  
\_\_\_\_\_

### B. Development

Please fill in any information you have on the areas listed below.

#### 1. Pregnancy and delivery

Prenatal medical illnesses and health care: \_\_\_\_\_  
\_\_\_\_\_

Was the child premature?  No  Yes. Weight and height at birth: \_\_\_\_\_ pounds \_\_\_\_\_ inches

Any birth complications or problems? \_\_\_\_\_  
\_\_\_\_\_

#### 2. The first few months of life

Breast-fed? If so, for how long? Any allergies? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sleep patterns or problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Personality: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Milestones: At what age did this child do each of these?

Sat without support: \_\_\_\_\_ Crawled: \_\_\_\_\_ Walked without holding on: \_\_\_\_\_

Helped when being dressed: \_\_\_\_\_ Tied shoelaces: \_\_\_\_\_ Buttoned buttons: \_\_\_\_\_

Ate with a fork: \_\_\_\_\_

Stayed dry all day: \_\_\_\_\_ Didn't soil his or her pants: \_\_\_\_\_ Stayed dry all night: \_\_\_\_\_

4. Speech/language development

Age when child said first word understandable to a stranger: \_\_\_\_\_

Age when child said first sentence understandable to a stranger: \_\_\_\_\_

Any speech, hearing, or language difficulties? \_\_\_\_\_  
\_\_\_\_\_

C. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

D. Residences

1. Homes

Dates		Location	With Whom	Reason for Moving	Any Problems?
From	To				

2. Residential placements, institutional placements, or foster care

Dates		Program name or location	Reason for placement	Any Problems?
From	To			

E. Schools

Dates		School (name, district, address, phone)	Grade	Age	Teacher
From	To				

May I call and discuss your child with the current teacher?  Yes  No

F. Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.: \_\_\_\_\_

\_\_\_\_\_

G. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

\_\_\_\_\_

\_\_\_\_\_

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## Child Checklist of Characteristics

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Person completing this form: \_\_\_\_\_ Relationship: \_\_\_\_\_

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first please mark all of the items that apply to you on the "Adult Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

- Affectionate
- Argues, "talks back," smart-alecky, defiant
- Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- Cheats
- Cruel to animals
- Concern for others
- Conflicts with parents over rule breaking, money, chores, homework, grades, choices in music/clothes/hair/ friends
- Complains
- Cries easily, feelings are easily hurt
- Dawdles, procrastinates, wastes time
- Difficulties with parent's paramour/new marriage/new family
- Dependent, immature
- Developmental delays
- Disrupts family activities
- Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- Distractible, inattentive, poor concentration, daydreams, slow to respond
- Dropping out of school
- Drug or alcohol use
- Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- Exercise problems
- Extracurricular activities interfere with academics
- Failure in school
- Fearful
- Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- Fire setting

Child Checklist of Characteristics (p. 2 of 3)

- Friendly, outgoing, social
- Hypochondriac, always complains of feeling sick
- Immature, "clowns around," has only younger playmates
- Imaginary playmates, fantasy
- Independent
- Interrupts, talks out, yells
- Lacks organization, unprepared
- Lacks respect for authority, insults, dares, provokes, manipulates
- Learning disability
- Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- Likes to be alone, withdraws, isolates
- Lying
- Low frustration tolerance, irritability
- Mental retardation
- Moody
- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Obedient
- Obesity
- Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- Oppositional, resists, refuses, does not comply, negativism
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors—biting or hitting self, head banging, scratching self
- Speech difficulties

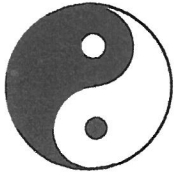
Child Checklist of Characteristics (p. 3 of 3)

- Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, blasphemes, bathroom language, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics—involuntary rapid movements, noises, or word productions
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Underactive, slow-moving or slow-responding, lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothes
- Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics: \_\_\_\_\_

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with and circle it.

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# Dyer Counseling & Psychology, PLLC

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## Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

\_\_\_\_\_  
Signature of client (or person acting for client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

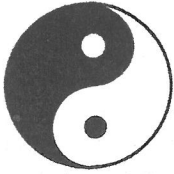
\_\_\_\_\_  
Deborah E. Dyer, Ph.D.  
Licensed Psychologist

\_\_\_\_\_  
Date

Copy accepted by client     Copy kept by therapist

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### What You Should Know about Confidentiality in Therapy

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about values and moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the “confidentiality” of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a “secret” that I cannot keep secret. So please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

- 1) **When you or other persons are in physical danger, the law requires me to tell others about it. Specifically:**
  - a) If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
  - b) If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
  - c) In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
  - d) If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To “abuse” means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

- 2) **In general, if you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. This is called “privilege,” and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:**
  - a) In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.
  - b) In cases where your emotional or mental condition is important information for a court's decision.
  - c) During a malpractice case or an investigation of me or another therapist by a professional group.
  - d) In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
  - e) When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.
  - f) If you were sent to me for an evaluation by worker's compensation or Social Security disability, I will be sending my report to a representative of that agency and it can contain anything that you tell me.
- 3) **There are a few other things you must know about confidentiality and your treatment:**
  - a) I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you.
  - b) I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.
- 4) **Here is what you need to know about confidentiality in regard to insurance and money matters:**
  - a) If you use your health insurance to pay part of my fees, the insurance company, the managed care organization, or perhaps your employer's benefits office will require me to provide information about your functioning in many

areas of your life, your social and psychological history, and your current symptoms. I will also be required to provide a treatment plan for your problems and information on how you are doing in therapy.

- b) I usually give you my bill with any other forms needed, and ask you to send these to your insurance company to file a claim for your benefits. That way, you can see what the company will know about our therapy. It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information after it leaves my office. You cannot be required to release more information just to get payments.
  - c) If you have been sent to me by your employer's employee assistance program, the program's staffers may require some information. Again, I believe that they will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the program before we talk further.
  - d) If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.
- 5) **Children and families create some special confidentiality questions.**
- a) When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have the right to general information, including how therapy is going. They need to be able to make well informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told, especially if these others' actions put them or others in any danger.
  - b) In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist.
  - c) If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this.
  - d) If you and your spouse have a custody dispute I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.
  - e) If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.
  - f) At the start of family treatment, we must also specify which members of the family must sign a release form for the common record I create in the therapy or therapies. (See point 7b, below.)
- 6) **Confidentiality in group therapy is also a special situation.** In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws that I have to work under. You cannot be certain that they will always keep what you say in the group confidential.
- 7) Finally, here are a few other points:
- a) I will not record our therapy sessions on audiotape or videotape without your written permission.
  - b) If you want me to send information about our therapy to someone else, you must sign a "release-of-records" form. I have copies you can see, so you will know what is involved.
  - c) Any information that you tell me and also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally and to act in your best interests.

The signatures here show that we each have read, discussed, understand, and agree to abide by the points presented above.

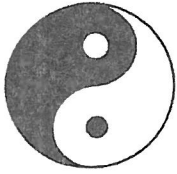
\_\_\_\_\_  
Signature of client (or person acting for client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature of therapist

\_\_\_\_\_  
Date



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## Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: \_\_\_\_\_.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at 480-290-0129.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

\_\_\_\_\_  
Signature of client or his or her personal representative      Date

\_\_\_\_\_  
Printed name of client or personal representative      Relationship to the client

\_\_\_\_\_  
Description of personal representative's authority

\_\_\_\_\_  
Signature of authorized representative of this office or practice

Date of NPP: \_\_\_\_\_

Copy given to the client/parent/personal representative