Athens Psychological Services

Patient / Client Information

Today's date:_____ Which provider do you wish to see? ❍ Toni L. Mason, PhD ❍ A. Shayne Abelkop, PhD ❍ Millie Kelleher, LCSW ❍ Jaclyn Peters, PhD ❍ Jessica Prowell, MD ❍ First available provider

Child/Patient Name:_____ Date of Birth:_____

Address:_____

City/State:_____Zip Code:_____School:_____

Child's SSN:_____Age:_____Sex:_____Grade:_____

Parent's Name:_____ Relationship_____SSN:_____DOB:_____

Address:_____City/State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell:_____

Parent's Email:_____

Employer:_____Occupation:_____

Parent's Name:_____ Relationship_____SSN:_____DOB:_____

Address:_____City/State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell:_____

Parent's Email:_____

Employer:_____Occupation:_____

Emergency Contact:_____Phone:_____

Insurance Information

Person Responsible for Paying Bill:_____

Relationship to Patient:_____SSN:_____DOB:_____

Primary Insurance Company:_____Phone:_____

Policy#_____Group #_____Insured's Name_____

Secondary Insurance Company:_____Phone:_____

Policy#_____Group #_____Insured's Name_____

Assignment of Insurance Benefits

I request that payment of authorized third party benefits be made on my behalf to the Rendering Provider and/or Athens Psychological Services for any services provided to me or my dependents. I understand my signature also authorizes release of any information contained in my child's records to any relevant insurer, or to its assignees, necessary to pay a claim. By my signature I acknowledge that I am ultimately responsible for payment of all fees for all services rendered regardless of insurance coverage.

_____ _____

Signature of responsible party Date

Statement of Provider Independence

Each provider works with a group of independent mental health professionals under the name, Athens PsychologicalServices. This group is an association of independently practicing professionals which shares certain expenses and administrative functions. While the members share a name and office space, each provider is completely independent in providing you or your child with clinical services and as such is fully responsible for those services. Each provider's professional records are separately maintained and no member of the group can have access to patient / client records without your specific, written consent.

Acknowledgement of Privacy Practices

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act (HIPAA)

I have had the opportunity to review and/or request a copy of the Notice of Privacy Practices of Athens Psychological Services. I understand that if any changes are made to this Notice of Privacy Practices, a revised copy will be posted in the office. I also understand that if I wish to receive additional copies of this notice, or if I have any questions with regard to this notice of privacy practices, I may contact:

Joseph E. Mason, CEO
Athens Psychological Services, LLC
1090 Founders Blvd, Suite B
Athens, GA 30606
Phone: 706-548-8697
Fax: 706-548-8698

_____ _____

Signature of responsible party Date

PATIENT-THERAPIST AGREEMENT and Informed Consent to Receive Psychological Services

Psychotherapy has potential risks as well as potential benefits. These risks may include, for example, uncomfortable levels of unpleasant emotions and that individuals receiving therapy may feel worse, emotionally, before they begin to feel better. Informed consent refers to your right to an explanation of your child's condition and proposed treatment plan. You have a right to participate in the planning of treatment, to refuse treatment, or to discontinue treatment at any time. Respect and non-discrimination are offered to all regardless.

The initial diagnostic interview takes place during the first few sessions. During this time, the provider will be reviewing your child's symptoms and prior history of treatment. After the initial session, you and your provider will decide together if psychotherapy would be helpful, and who would be the best treating provider for your child. You or your provider may decide that your child would be better treated with a different service provider. We can help make a referral to another mental health provider.

Confidentiality statement. The patient's right to privacy is protected by federal and state laws. For minor children, the parent/guardian is the holder of privilege within the therapist/patient setting. this means that information discussed during treatment is confidential and that no information can be released to anyone without written authorization from the parent/guardian or patient (if 18 or older), subject to the exceptions outlined below:

1. If your provider has reason to believe that a child, disabled person, or elder person has been abused or neglected, then the provider is legally required to file a report with the appropriate authorities.
2. If a patient expresses serious intent to harm him/herself or another person, the provider may be required to take protective actions. These may include, but are not limited to, crisis mental health evaluation at a hospital emergency room, calling police, and/or voluntary or involuntary hospitalization.

3. There may be other situations that limit the provider's legal ability to maintain patient confidentiality, for example, if psychological assessment or treatment is ordered by a court.
4. If the parent/guardian chooses to use insurance to pay for services, clinical information will be released to obtain payment of fees.
5. If your account is turned over to a collection agency, necessary information will be released in order to secure payment or settle the debt.

Parents as Collaterals

In treatment involving children, parents are usually viewed as collaterals who participate in therapy to assist the identified patient. Thus, a collateral is not considered to be a patient/client and is not the subject of the treatment. Collaterals have less privacy protection and should not expect full confidentiality rights. No record or chart will be maintained on you in your role as a parent/collateral. Notes about you may be entered into the identified patient's chart as it reflects important information about family dynamics that promote or interfere with your child's adjustment. If you have privacy concerns, please discuss with your treating provider.

Confidentiality of minors. Adolescents age 14 and over have the right to request treatment and confidentiality, and confidentiality may also be an important issue for youth under the age of 14. You may be asked to agree to certain limitations to your access to your child's records in order to facilitate your child's ability to benefit from treatment. Your provider reserves the right to make clinical decisions regarding confidentiality issues between adolescents and parents/guardians. Parents / guardians will be informed of any serious health or safety issue concerning the patient/client, with the understanding that this determination will be based upon the provider's clinical judgement. Please feel free to discuss any questions or concerns about this with your child's treating provider.

Phone calls. You are welcomed and encouraged to call the office if there is a major change or crisis with the patient/client between sessions. The occasional telephone consultation is not charged. However, if you or your child desire further assistance, we may need to increase the frequency of sessions.

Email. Email is not a secure form of communication to discuss confidential matters, nor is it a way to receive emergency mental health treatment. However, if you accept these risks and limitations, you are allowed to contact your provider by email. Depending on the confidential matter of the communication, the provider may email back a brief message or contact you by phone. Please understand that we cannot provide treatment recommendations or emergency mental health assessment by email.

Communication with primary care physician. Treatment with your provider will be coordinated medically with your child's primary care physician. By signing this consent to evaluation and treatment, you also consent and give authorization for records to be exchanged between your child's provider and the primary care physician.

Documentation required in certain cases. We cannot schedule any appointments until we have a copy of legal papers specifying guardianship or custody arrangements (including who has final decision making authority for medical decisions) for children in foster care, being raised by grandparents, or with separated or divorced parents.

Your signature below indicates that you have read the information in this therapist-patient agreement and agree to abide by its terms during our professional relationship. Your signature below indicates consent for your child to receive psychological services under these conditions.

_____

Signature Date

Financial Policy and Payment Agreement

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or about your financial responsibility.

We will ask to see your insurance card and driver's license on your first visit and will scan your card into our system as needed to keep our information current. Please notify us of any changes in insurance coverage.

Professional Fees. For Dr. Mason, Dr.Abelkop, Dr. Peters, and Mrs. Kelleher: Self-Pay fees are as follows: the new patient diagnostic interview is $180 per 45-55 minute session. Individual therapy is $150 per 45-55 minute session. Family therapy is $165 per 45-55 minute session.

Professional Fees for Dr. Prowell, MD: Self-Pay Fees are as follows: New patient evaluation is $450 for 75-min session (approx.); First follow-up visit is $150; subsequent follow-up visits are $100; Therapy appointments (which include medication management) are $225 for each 40-min session.

Fees for other services, such as letter writing or attendance at meetings are described elsewhere in this document. Fee payment is due at the time of service. Once an appointment is scheduled, you will be expected to pay for the reserved time unless you provide 24 hours advance notice of cancellation. It is your responsibility to inform our office of any changes in address, phone number, or insurance.

Forensic Fees. Because of the difficulty of legal involvement, Providers charge a Forensic Rate of $250 per hour for preparation and attendance at any legal proceeding. Forensic fees must be paid in advance. If you or your child become involved in legal proceedings that require your provider's participation, you will be expected to pay the forensic rate for all of the provider's professional time, including phone calls, meeting with your attorney, preparation for the case, record copying and mailing, time traveling to and from legal proceedings, travel and parking expenses, time testifying, and time spent waiting to be called to testify. You should understand that insurance does not pay for these services. Further, you will be responsible to pay the provider's forensic rates even if the provider is called to testify by another party. Finally, forensic fees are non-refundable.

Copayments. Your insurance requires us to collect your designated copay at the time of service. Please be prepared to pay the copay prior to your child's session.

Insurance. As a courtesy, we will bill your insurance carrier for your child's services if the provider is a participating provider with that company. However, you are expected to pay any deductibles, copays, or coinsurance amounts not paid for by your insurance company. If the provider is not a participating provider with your insurance company, you are responsible for paying the full fees for services provided. If requested, we will, as a courtesy, provide you with information should you decide to request reimbursement from your insurance company.

Self Pay. You may choose to self pay for various reasons. Examples include patients whose insurance provides insufficient or no coverage, those without insurance coverage, or those who do not want to use their insurance. Patients may choose to self pay for services and then file their own insurance claim with their insurance company if the provider is not in their network. Patients must self pay for services provided in addition to treatment/evaluation which may include attendance at school meetings, letter writing on behalf of the patient, or treatment provided outside the office.

Attending meetings: Providers charge a fee of $150 per hour for attendance at meetings, such as IEP meetings, on behalf of the patient/client. Travel time may also be assessed in certain cases.

MISSED APPOINTMENTS. YOU WILL BE CHARGED A MISSED APPOINTMENT FEE OF $75 IF YOU FAIL TO KEEP A SCHEDULED APPOINTMENT WITHOUT GIVING US AT LEAST 24 HOURS ADVANCE NOTICE. AS A COURTESY, WE WILL EMAIL TO REMIND YOU OF YOUR APPOINTMENT. HOWEVER, REMEMBERING TO KEEP, CANCEL, OR RESCHEDULE YOUR APPOINTMENT IS YOUR RESPONSIBILITY. IF YOU MISS OR CANCEL YOUR FIRST APPOINTMENT, UNLESS THERE ARE EXTRAORDINARY CIRCUMSTANCES, YOU WILL NOT BE RESCHEDULED. TWO OR MORE NO SHOW OR LATE CANCELLED APPOINTMENTS MAY RESULT IN A TERMINATION OF YOUR CHILD'S THERAPEUTIC RELATIONSHIP WITH THE PROVIDER.

RETURNED CHECK FEES. IF YOUR CHECK IS RETURNED FROM THE BANK FOR NONPAYMENT, WE WILL CHARGE YOU A RETURNED CHECK FEE OF $30, PLUS ANY ADDITIONAL BANK CHARGES THAT MAY RESULT.

OVERDUE ACCOUNTS. IF YOUR ACCOUNT IS NOT PAID FOR 60 DAYS, AND ARRANGEMENTS HAVE NOT BEEN MADE FOR PAYMENT, YOUR ACCOUNT WILL BE IN COLLECTIONS STATUS. THIS MEANS THAT WE MAY CHOOSE TO USE LEGAL MEANS TO SECURE PAYMENT. THIS MAY INCLUDE TURNING YOUR ACCOUNT OVER TO A COLLECTION AGENCY OR GOING TO SMALL CLAIMS COURT WHICH WILL REQUIRE THE DISCLOSURE OF OTHERWISE CONFIDENTIAL INFORMATION.

LETTERS: PROVIDERS CHARGE $30 FOR EACH HALF HOUR REQUIRED TO WRITE A LETTER ON BEHALF OF A PATIENT/CLIENT.

RECORDS REQUESTS: THE MINIMUM FEE FOR PROVIDING A COPY OF PATIENT/CLIENT RECORDS IS $25 BUT WE RESERVE THE RIGHT TO CHARGE A HIGHER FEE FOR LARGE OR EXTENSIVE RECORDS.

BY SIGNING BELOW, YOU INDICATE THAT YOU HAVE READ THE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS TERMS.

SIGNATURE OF RESPONSIBLE PARTY_____DATE:_____

EMAIL AUTHORIZATION

WE CAN SEND YOU AN APPOINTMENT REMINDER BY EMAIL. THE EMAIL WILL ONLY INCLUDE THE DATE AND TIME OF YOUR APPOINTMENT. THE EMAIL IS NOT ENCRYPTED. HEALTH CARE INFORMATION SENT BY REGULAR EMAIL COULD BE LOST, DELAYED, INTERCEPTED, DELIVERED TO THE WRONG ADDRESS, OR ARRIVE INCOMPLETE OR CORRUPTED. IF YOU UNDERSTAND THESE RISKS AND WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS BY EMAIL, PLEASE SIGN BELOW, CONFIRMING THAT YOU WILL ACCEPT RESPONSIBILITY FOR THESE RISKS AND WILL NOT HOLD US RESPONSIBLE FOR ANY EVENT THAT OCCURS AFTER WE SEND THE MESSAGE.

_____ _____

PRINT NAME OF PARENT/GUARDIAN (OR PATIENT, IF 18 OR OLDER)

SIGNATURE OF PARENT/GUARDIAN (OR PATIENT, IF 18 OR OLDER)

_____ _____

DATE

EMAIL ADDRESS (PLEASE PRINT CLEARLY)

Athens Psychological Services

Toni L. Mason, PhD
A. Shayne Abelkop, PhD
Millie S. Kelleher, LCSW
Jaclyn Peters, PhD
Jessica Prowell, MD

1090 Founders Blvd, Suite B
Athens, Georgia 30606
Phone: 706-548-8697
Fax: 706-548-8698
athenspsychological.com

Authorization to Share Health Information with Primary Care Physician

Patient / Client name:_____Date of Birth:_____

❍ I authorize:
- ❍ Toni L. Mason, PhD
- ❍ A. Shayne Abelkop, PhD
- ❍ Millie Kelleher, LCSW
- ❍ Jaclyn Peters, PhD
- ❍ Jessica Prowell, MD

and Athens Psychological Services to release health information on behalf of the patient / client named above to the Primary Care Physician named below:

_____.
(Primary Care Physician)

I understand that this release of information is to permit my treating physician to monitor the patient's health status and to coordinate care with the provider. This release will automatically expire 12 months from the date signed or at the conclusion of treatment. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and still receive treatment from the provider. I understand I may inspect or copy the information to be disclosed. I understand that information that is disclosed as a result of this authorization may be re-disclosed by the recipient and no longer protected by law.

_____

Signature of patient or parent/guardian Date

Athens Psychological Services

Toni L. Mason, PhD
A. Shayne Abelkop, PhD
Millie S. Kelleher, LCSW
Jaclyn Peters, PhD
Jessica Prowell, MD

1090 Founders Blvd, Suite B
Athens, Georgia 30606
Phone: 706-548-8697
Fax: 706-548-8698
athenspsychological.com

Authorization to Release Protected Health Information

Patient:_____Date of Birth:_____

I hereby authorize Athens Psychological Services and the following provider(s):

❍ Toni L. Mason, PhD ❍ Millie S. Kelleher, LCSW ❍ Jessica Prowell, MD
❍A. Shayne Abelkop, PhD ❍ Jaclyn Peters, PhD

(check all that apply)

❍ to disclose health information ❍ to obtain IEP information
❍ to obtain health information ❍ to obtain psychological evaluation information
❍ to exchange health information ❍ to obtain academic, behavioral, and disciplinary information

to / from / with the following individual(s) or organization(s):

_____
_____
_____
_____

For the purpose of: ❍ assessment, treatment planning, and treatment continuity
❍ other purpose:_____

I understand my or my child's health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), treatment for drug and alcohol abuse, or human immunodeficiency virus (HIV). It will include information about behavioral and mental health services.

I understand I have a right to revoke this authorization at any time and that I must do so in writing to the provider. I understand revocation will not apply to information already released under this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire when treatment is terminated, when the child reaches the age of adulthood, or under the following situation:
_____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information before it is disclosed. I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations. If I have questions about the disclosure of my or my child's health information, I can contact the provider at 706-548-8697.

I give permission for a faxed or photocopied signature to serve as an original signature regarding this authorization.

_____
Signature of patient or parent/guardian Date

CHILD DEVELOPMENTAL HISTORY

PATIENT NAME:_____ NICKNAME: _____AGE: ___DATE OF BIRTH_____

SEX: ❍ M ❍ F SCHOOL:_____GRADE:_____TEACHER:_____

PERSON COMPLETING THIS FORM:_____RELATIONSHIP TO CHILD _____

REFERRED BY:_____

EMERGENCY CONTACT:_____PHONE:_____

SERVICES REQUESTED: ❍ THERAPY/COUNSELING ❍ MEDICATION ❍ OTHER: _____

PLEASE SUMMARIZE THE PROBLEMS YOUR CHILD IS EXPERIENCING:

_____

_____

_____

_____

_____

_____

_____

HOW LONG HAS YOUR CHILD BEEN EXPERIENCING THESE PROBLEMS? _____

_____

WHY DO YOU THINK YOUR CHILD IS EXPERIENCING THESE PROBLEMS?_____

_____

CHILD'S PARENTS ARE: ❍UNMARRIED ❍MARRIED ❍SEPARATED ❍DIVORCED ❍SINGLE
OTHER_____

CHILD RESIDES WITH: ❍BOTH BIOLOGICAL PARENTS ❍ BIOLOGICAL MOM ❍BIOLOGICAL DAD ❍FOSTER PARENTS ❍ADOPTIVE PARENTS ❍GRANDPARENTS ❍STEP-PARENT OTHER _____

IF SEPARATED/DIVORCED, HOW MUCH TIME DOES YOUR CHILD SPEND WITH EACH PARENT? _____

_____

IF SEPARATED / DIVORCED, PLEASE PROVIDE A COPY OF THE CUSTODY AGREEMENT REGARDING YOUR CHILD.

LIST OTHERS LIVING IN THE HOME: (NAME, AGE, RELATIONSHIP)

_____
_____
_____
_____
_____
_____

Psychiatric History

Anyone in the family with any mental health or developmental problems such as autism, asperger's, anxiety, depression, bipolar disorder, substance abuse, adhd, learning problems, suicide attempts, or mental retardation? please list below:

Family Member	Type of Problem	Treatment

Has your child ever threatened or attempted to commit suicide? If so please explain:

_____

_____

_____

Has your child ever had psychological therapy or testing? If so, please list below:

Doctor / Therapist	Therapy or Testing?	When? List Date or Duration

Has your child ever received inpatient mental health treatment? If so, please list below:

Name of Hospital	Reason for hospitalization	Date(s)

Has your child ever taken any psychiatric medications? If so, please list below:

Rx Name	Reason Given	% Improvement	Side Effects	Dates Taken

Health And Developmental History

Pregnancy:

Please check if any of the following apply to the mother's pregnancy with this child:

	Explain
❍ tobacco use	_____
❍ alcohol or substance use	_____
❍ prescription medication use	_____
❍ accident or injury	_____
❍ emotional trauma	_____
❍ domestic violence	_____
❍ elevated blood pressure	_____
❍ premature labor	_____
❍ anemia or toxemia	_____
❍ gestational diabetes	_____

Birth:

Delivery was: ❍ spontaneous vaginal ❍ induced ❍ caesarean

Birth weight: _____ ❍ full term ❍ premature

Any complications? Check all that apply:

❍ breech
❍ breathing problems
❍ premature birth (how many weeks? _____)
❍ meconium
❍ other _____
❍ infection
❍ abnormal color
❍ cord around neck
❍ abnormal muscle tone
❍ birth injury_____

Developmental milestones: indicate age your child:

sat up_____ crawled _____ walked without holding on _____ fed self_____
spoke first words besides ma-ma or da-da _____ tied shoes_____ dressed self_____
spoke in short phrases or sentences _____ toilet trained during day_____
speech was clearly understood by others outside the family _____

Did you have any concerns about your child's development in the first few years? ❍ no ❍ yes

If yes please describe_____

Which of the following describes your child's temperament in infancy or early childhood?

❍ good natured	❍ sluggish	❍ irritable	❍ active
❍ cuddly	❍ resistant to touch	❍ easily soothed	❍ affectionate
❍ difficulty separating	❍ clingy	❍ anxious/fearful	❍ shy or timid
❍ prolonged tantrums	❍ highly emotional	❍ easy	❍ slow to warm up

Medical history:

child's pediatrician or family doctor _____
list any medical problems your child has _____
list all medications child currently takes_____
any drug allergies? _____
any operations? _____

has your child ever had any of the following?

❍ seizures / convulsions
❍ frequent ear infections
❍ serious injury
❍ frequent headaches
❍ frequent stomachaches
❍ vision or hearing problems
❍ frequent constipation
❍ urinating in clothes or bed
❍ defecating in clothes or bed
❍ speech/language therapy
❍ physical therapy
❍ tics / twitches
❍ concussion
❍ ear tubes
❍ fainting
❍ migraines
❍ frequent nausea / vomiting
❍ food allergies
❍ gastrointestinal problems
❍ self-injurious behavior _____
❍ eating disorder
❍ occupational therapy
❍ sleep problems
❍ speech problems

CURRENT GENERAL HEALTH AND PHYSICAL CONDITION:

❍ SEEMS TO BE IN GOOD HEALTH ❍ TIRES EASILY, LISTLESS, LACKS ENERGY ❍ OVERWEIGHT
❍ SLEEPS TOO MUCH ❍ UNDERWEIGHT ❍ SLEEPS TOO LITTLE
❍ OVERLY ACTIVE, ALWAYS MOVING ❍ AWKWARD IN RUNNING, WALKING, OR PLAYING

BEHAVIORAL CHECKLIST: PLEASE CHECK BEHAVIORS THAT BEST DESCRIBE YOUR CHILD

❍ FEELS HAPPY WITH SELF	❍ SUCKS THUMB	❍ WORRIES
❍ DEMANDS EXCESSIVE ATTENTION	❍ OVERLY DEPENDENT ON OTHERS	❍ WETS BED
❍ PLAYS WELL WITH OTHERS	❍ OVERLY ANXIOUS TO PLEASE	❍ CRIES OFTEN
❍ EXHIBITS UNCOOPERATIVE ATTITUDE	❍ TRIES TO CONTROL OTHERS	❍ POOR SELF-CONTROL
❍ HAS VERY FEW CLOSE FRIENDS	❍ RELATES WELL TO ADULTS	❍ FRIENDLY
❍ LACKS MOTIVATION, LAZY	❍ OFTEN SAD OR DEPRESSED	❍ AGGRESSIVE
❍ DOES NOT ADJUST WELL TO CHANGE	❍ FEARFUL	❍ SHY, WITHDRAWN
❍ ACTS YOUNGER THAN AGE	❍ OPENLY AFFECTIONATE TO FAMILY	❍ DAYDREAMS OFTEN
❍ CAN BE TRUSTED	❍ JEALOUS OF SIBLING(S)	❍ LOUD
❍ DISORGANIZED	❍ IMPULSIVE, ACTS WITHOUT THINKING	❍ MOODY

DISCIPLINE USED AT HOME:

HOW OFTEN IS CHILD DISCIPLINED? ❍ FREQUENTLY ❍ OCCASIONALLY ❍RARELY
WHO ADMINISTERS PUNISHMENT? ❍ MOTHER ❍ FATHER ❍ GRANDPARENT(S) ❍ NANNY/SITTER ❍OTHER(S)
TYPES OF DISCIPLINE USED: ❍ SPANKING ❍ TIME OUT ❍ LOSS OF PRIVILEGES ❍ TAKING THINGS AWAY
❍ TALKING / REASONING ❍ GROUNDING ❍ SENT TO ROOM ❍ ISOLATION ❍ REWARDS
HOW DOES YOUR CHILD REACT TO DISCIPLINE? ❍ BECOMES ANGRY ❍ CRIES ❍ WITHDRAWS ❍ FIGHTS BACK
❍ ARGUES ❍ SCREAMS ❍ HITS / KICKS / BITES ❍ LAUGHS ❍ ACCEPTS IT ❍ SULKS / POUTS
EFFECTIVENESS OF DISCIPLINE METHODS: ❍ BEHAVIOR IMPROVES ❍ REMAINS SAME ❍ BEHAVIOR CHANGES
❍ BEHAVIOR WORSENS

WHAT IS CHILD'S BEDTIME: _____ TIME CHILD GETS UP IN MORNING_____

LIST CHILD'S MAJOR INTERESTS / ACTIVITIES:

_____

EDUCATIONAL HISTORY:

ATTENDED DAYCARE AGE _____ ❍ FULL TIME ❍ PART TIME
PRESCHOOL AGE _____
KINDERGARTEN AGE _____
GRADES REPEATED _____
ANY LEARNING PROBLEMS _____
SPECIAL EDUCATION ❍YES ❍NO
RECEIVES TUTORING IN _____
ANY BEHAVIOR PROBLEMS AT SCHOOL _____
ACADEMIC GRADES OR PERFORMANCE ❍ BELOW AVERAGE ❍ AVERAGE ❍ ABOVE AVERAGE
STRUGGLES WITH:
❍ READING ❍ MATH ❍ WRITING ❍ SPELLING ❍ ATTENTION/FOCUS ❍ COMPLETING WORK ❍ TEST ANXIETY
❍ HOMEWORK ❍ ORGANIZATION ❍ SOCIAL SKILLS ❍ BULLYING ❍ DISRUPTIVE BEHAVIOR ❍ PEER GROUP
WHAT IS YOUR CHILD'S ATTITUDE TOWARD SCHOOL? _____
DESCRIBE YOUR CHILD'S STUDY HABITS AT HOME: _____
_____
CHILD'S BEST SUBJECTS:_____WORST SUBJECTS:_____

TRAUMA HISTORY:

HAS YOUR CHILD EXPERIENCED: ❍ DOMESTIC VIOLENCE ❍ PHYSICAL ABUSE ❍ NEGLECT ❍ SEXUAL ABUSE
❍ NO ❍ YES PLEASE EXPLAIN:_____

LEGAL ISSUES:

HAS YOUR CHILD EVER BEEN ARRESTED, ON PROBATION, OR OTHERWISE INVOLVED WITH THE LEGAL SYSTEM?
❍NO ❍YES PLEASE EXPLAIN_____

SUBSTANCE USE:
DO YOU SUSPECT OR HAS YOUR CHILD EVER USED TOBACCO, ALCOHOL, OR DRUGS? ❍ NO ❍YES IF YES, PLEASE EXPLAIN _____

RELIGIOUS PRACTICES:
RELIGIOUS BELIEFS: ❍ PREFER NOT TO ANSWER ❍ NONE ❍ JEWISH ❍ MUSLIM ❍ HINDU
❍ CHRISTIAN (LIST DENOMINATION)_____
❍ OTHER (PLEASE LIST)_____
DOES YOUR FAMILY PARTICIPATE IN RELIGIOUS SERVICES? ❍ YES ❍ NO ❍ SOMETIMES ❍ DOES NOT APPLY
IS THE PRACTICE OF YOUR FAITH AN IMPORTANT PART OF YOUR FAMILY LIFE? ❍ YES ❍ NO ❍ SOMEWHAT
❍ DOES NOT APPLY

WHAT ARE YOUR CHILD'S STRENGTHS? WHAT IS GOING WELL FOR YOUR CHILD?

_____

_____

_____

ADDITIONAL INFORMATION:
PLEASE USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION YOU CONSIDER IMPORTANT REGARDING YOUR CHILD:

_____

_____

_____

_____

_____

_____

THANK YOU FOR PROVIDING THIS HELPFUL INFORMATION.