Northbrook Psychological Clinic, PLC

Child/Adolescent Personal History

(All information obtained in this form is confidential)

Child's Name: _____ Date: _____

Birth Date: _____ Age: _____ Gender:_____

Address : _____

School: _____ Grade: _____

Referred by: _____ Address/Phone: _____

Parent Name: _____ Age: _____

Occupation: _____

Parent Name: _____ Age: _____

Occupation: _____

Sibling's Names, Ages, Grades: _____

Step Parent's Names, Ages, Occupations: _____

Developmental History Record

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

Pregnancy and Delivery (circle all that apply):

Type of Labor: Spontaneous, Induced Type of Delivery: Normal, Breech, Other _____

Fetal distress, forceps used, hemorrhage/blood loss, multiple births

Anesthesia Used: None, local anesthetic, general, muscle relaxant

Was child premature: Y or N Birth weight: _____ Birth height: _____

Days in hospital following birth (child): _____

Days in hospital following birth (parent): _____

Did parent smoke during pregnancy? Y or N, if yes, number of cigarettes per day: _____

Did parent alcohol during pregnancy? Y or N, if yes, what type and how much per day:

_____

Did parent use any drugs (illegal or legal) during pregnancy? Y or N, if yes, what type and how much per day: _____

Did parent use any type of drugs PRIOR to pregnancy? Y or N, if yes, what type and how much per day:

_____

Does this parent currently use any type of drug/medication? Y or N, if yes, please specify: _____

_____

_____

Prenatal medical illnesses and health care: _____

_____

_____

Please circle any that applied to your child as an infant:

jaundice, incubator, blood transfusions, rashes, breathing problems, baby given oxygen, very quiet, very active, problems sucking, problems with eating/digestion, baby on heart monitor

Please list and explain any birth defects your child has: _____

_____

_____

Any birth complications or problems? _____

_____

Milestones:

Please write age that your child reached the following milestones:

Sit without support _____ Crawled _____ Toilet trained (day) _____

Walked w/o holding on _____ First steps _____ Toilet trained (night) _____

Dressed self with help _____ Ran _____ Dressed self alone _____

Does/did your child have wetting accidents? Y or N, if yes, how frequently? _____

Does/did your child have soiling accidents? Y or N, if yes, how frequently? _____

Overall, do you feel that your child developed at a slow, normal, or rapid rate? Please explain: _____

_____

_____

Speech and Language Development

Any speech, hearing, or language difficulties? Y or N, please explain: _____

_____

Health

Name of child's physician: _____

Address: _____

Phone: _____

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

Condition	Age	Treated by whom?
___Asthma	_____	_____
___Anemia	_____	_____
___Lead poisoning	_____	_____
___Meningitis	_____	_____
___Encephalitis	_____	_____
___Seizures	_____	_____
___Epilepsy	_____	_____
___Hydrocephalus	_____	_____
___Cerebral palsy	_____	_____
___Heart problem	_____	_____
___Emotional problem	_____	_____
___Vision difficulties	_____	_____
___Hearing difficulties	_____	_____

___Other: _____

Please list any medications (including how long been taking, dose, frequency): _____

_____

_____

Has your child received his/her immunizations? Y or N

Please list any surgeries/ hospitalizations (include age of child/ length of hospital stay): _____

_____

_____

Has your child suffered from any type of head injury? Y or N, if yes please indicate child's age, how injury occurred, and if there was a loss of consciousness: _____

_____

_____

Has your child suffered from persistent ear infections? Y or N

Age at first ear infection: _____

Any medical treatment for ear infections (antibiotics, tubes, etc.): _____

_____

Homes where child and family have lived:

Date from:	Date to:	City/State:	Reason for Moving:	Any Problems?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Residential Placements, Institutional Placements, or Foster Care:

Date from:	Date to:	Program Name/Location:	Reason for Placement:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personality as an Infant/Toddler

Below is a list of words that describe a child's personality and behavior. Please circle that describe your child.

happy, independent, prefers to be alone, follower, cheerful, quiet, even tempered, very active, friendly, disruptive, leader, affectionate, trouble sleeping, moody, hits others, sad, temper tantrums, trouble eating, fearful, inattentive, angry, sucks thumb, dependent, cries, often loud

Describe the above behaviors that you consider to problems for your child: _____

_____

_____

Has your child been diagnosed by a professional as having developmental delays and/or learning problems? Y or N, if yes, please explain: _____

_____

Family History

Parent 1 Name: _____ Education: _____

Was Parent 1 in any type of special education classes? Y or N

What was Parent 1 age at the time of pregnancy with this child? _____

Number of prior pregnancies: _____ Number of spontaneous abortions (miscarriages): _____

Did this parent experience difficulties with any of the following?

Reading: Y or N If yes, please explain: _____

Writing: Y or N If yes, please explain: _____

Math: Y or N If yes, please explain: _____

Did this parent repeat any grades? Y or N If yes, please specify: _____

Did this Parent have any behavioral problems? Y or N If yes, please specify: _____

_____

Any psychiatric problems for which this parent has received treatment? Y or N If yes please describe the problems and the treatment received: _____

_____

_____

Parent 2 Name: _____ Education: _____

Was Parent 2 in any type of special education classes? Y or N

Did this parent experience difficulties with any of the following?

Reading: Y or N If yes, please explain: _____

Writing: Y or N If yes, please explain: _____

Math: Y or N If yes, please explain: _____

Did this parent repeat any grades? Y or N If yes, please specify: _____

Did this Parent have any behavioral problems? Y or N If yes, please specify: _____

_____

Any psychiatric problems for which this parent has received treatment? Y or N If yes please describe the problems and the treatment received: _____

_____

_____

Please list any unusual and/or traumatic family events in your child's life which you feel may have impacted upon his/her development and current functioning (birth of a sibling, death of a family member, divorce, etc.): _____

_____

_____

_____

_____

_____

This is strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Therapist Signature/Credentials: _____ Date: _____

NORTHBROOK PSYCHOLOGICAL CLINIC

CONSENT TO TREATMENT AND CLINICAL SERVICES &
HEATH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Client _____ Date of Birth _____

I give my permission to Northbrook Psychological Clinic (NPC) to provide mental health, counseling, psychiatric and educational services and any testing/treatment related to those services to me or my dependent.

I understand that the services received at NPC are based on currently accepted practice in the fields of mental health or substance abuse. I also understand that the outcome of treatment cannot be guaranteed and that the services continue with my voluntary consent.

If my dependent or I threaten to harm either myself or someone else, I understand that the law obligates NPC to take whatever action is necessary to protect people from harm. This may include divulging confidential information to others. Such action would be taken when someone's life appears to be in danger.

I understand if my dependent or I have been ordered by the court to seek treatment or diagnostic services, the court will require one or more reports. My written consent to release information will be requested.

I understand if my dependent or I have been involved in litigation of any kind and the court is informed of mental health/substance abuse treatment, I may be waiving the right to keep records confidential. I further understand I may want to consult with my attorney before disclosing to a court that my dependent or I are receiving treatment or diagnostic services.

I understand it may be necessary to reach me by mail, email or telephone during or after my or my dependent's treatment for the purpose of scheduling or confirming appointments, billing or payment issues, completion of forms, conducting surveys or any necessary follow-up. I also understand that to communicate via email or text message I will provide consent, recognizing that email or text message is not a secure form of communication. There is some risk that any protected health information that may be contained in such email or text message may be disclosed to or intercepted by unauthorized third parties.

I understand that the State of Michigan and Federal laws and regulations do not protect any information about suspected child and/or elder abuse or neglect from being reported to the appropriate state or local authorities.

I am voluntarily authorizing diagnostic and/or treatment services for my dependent or myself. I may refuse any aspect of treatment, understanding that such a refusal could, in some instances, result in termination of treatment and/or services.

I acknowledge that NPC's Notice of Privacy Practices is available upon request at any time.

__ I authorize NPC to communicate with me via text message
__ I authorize NPC to communicate with me via email at this address _____

By signing below, I agree to comply with the policies and procedures of NPC.

X_____ X_____
(Client/Parent/Guardian Signature) (Date) (Witness) (Date)

NORTHBROOK PSYCHOLOGICAL CLINIC
23965 Novi Rd Suite 110 Novi, MI 48375
Phone: (248) 344-7420 Fax: (248) 344-7423

Primary Care Physician Notification Form

THIS IS **NOT** A REQUEST FOR MEDICAL RECORDS

TO THE PATIENT:

☐ I **DO NOT** wish Northbrook Psychological Clinic to notify my primary care/family doctor that I am receiving services.

☐ I **DO** wish Northbrook Psychological Clinic to notify my primary care/family doctor that I am receiving services. Please provide the complete name and address of your Primary Care Physician.

Primary Care Physician: _____ Phone: ( ) _____

Clinic Name (if any): _____ Fax: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

Please read and complete the following:

I, _____ DOB _____ hereby authorize Northbrook Psychological Clinic to exchange information regarding my mental health and/or substance abuse treatment and medical healthcare for the purpose of continuity of care as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on mental health care or substance abuse treatment as protected under 42 CFR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for one year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the behavioral health care provider indicated herein. I also understand that it is my responsibility to notify my behavioral health care provider if I change my primary care physician.

X_____ X_____
Signature Patient/Parent/Guardian Date Witness Signature Date

ATTENTION PRIMARY CARE PHYSICIAN:
Your patient is a client at Northbrook Psychological Clinic. With patient authorization, we are providing diagnoses and the therapist's contact information. Please retain for your records.

Patient Name: _____

ICD-10 Diagnoses (Including Codes): _____

_____

Therapist Name & Credentials: _____

Northbrook Psychological Clinic

FAILED APPOINTMENTS/LATE CANCEL POLICY

Failed appointments or those cancelled less than 24 hours prior to your scheduled time are subject to a fee that cannot be billed to your insurance. The fee equals the amount that we ordinarily bill your insurance – which can range from roughly $80-150, depending on your policy.

Thank you for your understanding. If you have any questions or concerns, I would be glad to discuss these with you.

_____ _____

Patient/Client Date

_____ _____

Witness Date