BAY AREA
PSYCHOLOGY & COUNSELING

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Please answer **ALL** information on this form about the **CHILD** being seen. Please be as thorough and detailed as possible!

Date of Appointment: _____

Child's Name: _____ **Date of Birth**: _____

Social Security #: _____ **Age:** _____ **Gender:** _____ **Race:** _____

Address: _____ May we send mail there?

_____ { } Yes { } No

Parents' Phone: ( ) _____ May we leave a message? { } Yes { } No

Your Phone: ( ) _____ May we leave a message? { } Yes { } No

Email: _____ @ _____ May we email you? { } Yes { } No

*Please be aware that email may not be confidential.

Referred by: { } Self { } Friend { } Family { } Dr _____ { } Other _____

Please describe, in detail, the present problem (including when the problem started, how often it occurs, and what stressors may contribute to the problem, etc.) :

_____

_____

_____

_____

Have you received any previous treatment for the problem? { } Yes { } No If yes, please explain below.

Dates Treated By Whom or Where

_____

_____

_____

_____

Name of Pediatrician or Family Doctor: _____ Date last seen: _____

Please check any of the following stressors that presently affect, or recently affected you:

- ☐ Financial problems
- ☐ Family relationship problems
- ☐ Legal problems
- ☐ Child rearing problems
- ☐ Drug or alcohol problems
- ☐ Employment problems
- ☐ School problems
- ☐ Peer relationship problems
- ☐ Marital Problems

Please check any of the following medical conditions for which you were ever evaluated or diagnosed:

- ☐ Seizures
- ☐ Heart Problems
- ☐ Weight Problems
- ☐ Head Injury
- ☐ Asthma
- ☐ Chronic Fatigue
- ☐ Chronic Headaches
- ☐ Depression
- ☐ Surgeries
- ☐ Stomach Problems
- ☐ Suicidal Thoughts
- ☐ Chronic Hearing Loss

Please indicate which, if any, of the following symptoms you are exhibiting:

ADHD	***Depression***	***Anxiety***	***Abuse***
Hyperactive	Sad	Excessive Worrying	Physical
Impulsive	Sleep Problems	Panic Attacks	Emotional
Under Achievement	Negative Thinking	Irrational Fear	Domestic Violence
Non-Compliant	Poor Concentration	Obsessions	Rape
Inattentive	Hopeless/Worthless	Social Isolation	Sexual
Poor Concentration	Mood Swings	Phobias	Dissociative
Disorganized	Guilt	Compulsive	
Self-Control	Fatigue/Lethargy	Shyness	

Relationship	***Anger***	***Addictions***	***Other***
Too Clingy/Dependent on Adults	Short-fused	Alcohol	Agitated
Too Attention Seeking	Temper Tantrums	Drugs	Mania
Bullying/Teasing	Impulse Control	Gambling	Paranoia
Difficulty With Friends	Violent/Assaultive	Relationships/Sex	Delusions
Work/School Problems	Runaway Risk	Eating Disorders	Tics/Tourettes
Personal Growth	Fighting	Cyber/Internet	Cutting Behavior
Grief/Loss	Irritable	Stealing	Appetite Changes
Sexual Behavior	Oppositional	Tobacco	Nightmares
	Refuses To Go To Bed		Flashbacks
			Bed Wetting
			Immature

Mental Health History

Have you ever had outpatient treatment? { } Yes { } No If yes, please explain below.
Reason Dates Treated By Whom or Where

_____
_____
_____
_____

Have you ever had inpatient treatment? { } Yes { } No If yes, please explain below.
Reason Dates Treated By Whom or Where

_____
_____
_____
_____

Have you ever been prescribed psychiatric medication in the past? { } Yes { } No If, yes please explain below
Name of Medication Prescribed By Side Effects Dose Level

_____
_____
_____

Do you have a history of being abused emotionally, sexually, physically, or by neglect? { } Yes { } No
If yes, please describe when, where, and by whom? _____
_____
_____

Medical and Health Background

Do you have any current medical problems? { } Yes { } No
If yes, please list diagnoses: _____
_____
_____

Have you been hospitalized or had any surgical procedures? { } Yes { } No
If yes, when and for what: _____
_____
_____

Current Weight _____ **Height** _____ **Right or Left Handed** _____
Are you having trouble with your sleep? { } Yes { } No
If yes: { } Difficulty falling asleep { } Sleeping too much { } Waking up during the night
{ } Disturbing dreams { } Sleeping too little { } Not feeling refreshed
Are you having difficulties with your appetite or eating habits? { } Yes { } No
If yes: { } Eating less { } Eating more { } Restricting { } Binging or out-of-control eating { } Diminished appetite
List all current prescription medications and how often you take them: (if none, write "none")
Medication Name Dosage Frequency Estimated Start Date Doctor

_____
_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements: _____

List any Allergies that you may have: (if none, write "none)

_____
_____
_____

Childhood History and Family Background

Were you adopted? { } Yes { } No
Where were you born? _____ **Where did you grow up**? _____
Mother: Name _____ Age _____ Occupation _____
If deceased- Age _____ Cause of Death _____
Father: Name _____ Age _____ Occupation _____
If deceased- Age _____ Cause of Death _____
Biological Siblings: (Name and list ages from oldest to youngest)
_____
_____
Half-Siblings: (Name, ages from oldest to youngest, and to which biological parent they belong)
_____
_____
Did your parents divorce? { } Yes { } No
If yes, how old were you? _____ With whom did you live? _____

Please fill out if any of the following applies:

This is Father's _____ marriage. This is Mother's _____ marriage.

Stepfather's Name: _____ **Stepmother's Name: _____**

Step-siblings' Names, Ages, Grades Enrolled:

_____
_____
_____
_____
_____

Step-siblings, Names, Ages, Grades Enrolled:

_____
_____
_____
_____
_____

Child currently lives with: **Percent of Time:**

_____ Mother and Father _____
_____ Mother without Father _____
_____ Father without Mother _____

Other: _____
_____

Child is in legal custody of: **Percent of Time:**

_____ Mother and Father _____
_____ Mother without Father _____
_____ Father without Mother _____

Other: _____
_____

Please identify below if there is a family history of any of the following:

	CHECK ONE	LIST FAMILY MEMBER
Alcohol/Substance Abuse	{ } Yes { } No	
Anger Management Issues	{ } Yes { } No	
Anxiety	{ } Yes { } No	
Bipolar Disorder	{ } Yes { } No	
Depression	{ } Yes { } No	
Domestic Violence	{ } Yes { } No	
Eating Disorders	{ } Yes { } No	
Obsessive Compulsive Behavior	{ } Yes { } No	
Personality Disorders	{ } Yes { } No	
Post Traumatic Stress Disorder	{ } Yes { } No	
Schizophrenia	{ } Yes { } No	
Suicide Attempts	{ } Yes { } No	

Please list all family memebrs living in the same household as you: (include their name and relationship to you)

_____

_____

_____

_____

_____

Relationship History and Current Family

Are you currently involved in an intimate relationship ? { } Yes { } No

If yes, Name _____ How long? _____

Do you have any children? { } Yes { } No

If yes, list ages and gender from oldest to youngest _____

_____

Educational History

Are you currently enrolled in school? { } Yes { } No

If yes, where? _____ Grade? _____

Name of past schools: Dates Attended: Behavior Problems (yes or no)? Learning Problems (yes or no)?

_____

_____

_____

Please identify any school-related problems:

{ } Inattentiveness { } Bullying { } School-related anxiety { } Refusing to do or complete work

{ } Refusal to attend { } Being bullied { } Suspensions or Expulsion { } Current problems with truancy

Is there a history of an IEP or Special Education Placement? { } Yes { } No

Are you currently receiving Special Education Accommodations? { } Yes { } No

Have you been tested by the school system? { } Yes { }No If yes, when? _____

Is there a history of repeated grades or courses? { } Yes { }No If yes, which ones? _____

Have you been suspended from school? { } Yes { } No

When_____

Reason _____

Legal History

Have you ever been arrested? { } Yes { } No

If yes, date of arrest _____ Charge _____ Punishment _____

date of arrest _____ Charge _____ Punishment _____

date of arrest _____ Charge _____ Punishment _____

Do you have any current, pending, or expected future legal issues? { } Yes { } No

If yes, please explain _____

_____

_____

Has any family member ever been reported to DHR? { } Yes { } No If yes, whom: _____

Have you ever been assigned a DHR caseworker? { } Yes { } No If yes, their name: _____

Substance Use

Have you ever tried the following:

			If yes, for how long and when did you last use?
Methamphetamine	{ } Yes	{ } No	
Cocaine	{ } Yes	{ } No	
Stimulants (pills)	{ } Yes	{ } No	
Heroin	{ } Yes	{ } No	
LSD or Hallucinogens	{ } Yes	{ } No	
Marijuana	{ } Yes	{ } No	
Pain killers (not as prescribed)	{ } Yes	{ } No	
Methadone	{ } Yes	{ } No	
Tranquilizer/sleeping pills	{ } Yes	{ } No	
Ecstasy	{ } Yes	{ } No	

Other _____

Have you ever been treated for alcohol or drug use or abuse? { } Yes { } No

If yes, for which substances? _____

where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

Have you ever abused prescription medication? { } Yes { } No

If yes, which ones and for how long? _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Have you smoked cigarettes:

Currently? { } Yes { } No How many packs per day on average? _____ How many years? _____

In the past? { } Yes { } No How many years did you smoke? _____ When did you quit? _____

Have you used pipe, cigars, or chewing tobacco: Currently? { } Yes { } No In the past? { } Yes { } No

What kind? _____ How often per day on average? _____ How many years? _____

Social and Cultural History

Do you consider yourself to be spiritual or religious? { } Yes { } No

If yes, what is the level of your involvement? _____

Please state or describe your faith or belief _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? { } more helpful { } more stressful

Are there any ethnic or cultural practices or beliefs which we need to be aware of? { } Yes { } No

If yes, please describe _____

Which areas of your life are going well? _____

Favorite hobbies or activities: _____

Favorite movies, books, or TV shows: _____

Personal Strengths: _____

DEVELOPMENTAL HISTORY- CHILDREN

Birth Weight _____lbs. _____oz.

Full term birth? { } Yes { } No If no, please explain _____

Did either parent use drugs/alcohol at time of conception? { } Yes { } No

Were there any complications with delivery? { } Yes { } No If yes, please explain _____

_____

Were there any complications after birth? { } Yes { } No If yes, please explain _____

_____

Developmental Milestones: Please indicate the age at which you achieved the following tasks:

Walking _____ Talking _____ Toilet Training _____

Have you ever exhibited any of the following behaviors or speech patterns?

{ } Spinning { } Hand Flipping { } Putting things in mouth

{ } Repeating words or phrases inappropriately { } Sniffing excessively { } Saying "I" for "you"

Compared to others his/her age, how well does your child:

	Worse	About Average	Better
Gets along with his/her brothers & sisters?	_____	_____	_____
Get along with other kids?	_____	_____	_____
Behave with his/her parent?	_____	_____	_____
Play and work alone?	_____	_____	_____

Permission to Treat:

I am legally authorized as the { } parent { } guardian of _____ to enroll him/her in psychological services. I herby authorize clinicians at Bay Area Psychology & Counseling to evaluate/treat this patient.

Signature: _____ Date: _____

Appointment Policy:

I understand that when an appointment is scheduled for my child, a specific period of time is set-aside just for him/her. If we are late, the session cannot be extended beyond the time reserved because it would infringe on the next patient's appointment time. I understand that we will be charged the amount for a complete session.

I understand that we are responsible for providing at least a 48-hour notice to cancel an appointment. I understand that we will be billed a late cancellation/no show charge for all missed appointments not cancelled at least 48 hours in advance.

Signature: _____ Date: _____

Payment Policy:

It is the policy of this office to request payment at the time services are provided. We are available to assist in the billing of your insurance carrier and will accept assignment of benefits on your behalf. However, your insurance policy is a contact between you, your carrier, and possibly, your employer. The fees for services provided to the patient are part of a contract between you and this office. Therefore, you will be responsible for the fees, including those not paid for any reason by your insurance carrier.

If you have insurance, final determination of your copay (cost share) will be established by the actual payment made by your insurance company. You will be responsible for the difference between what your insurance pays and the fees set by this office (or the maximum fee set by your insurance company).

Insurance companies do not pay for reports, letter writing, telephone consultations, school consultations, or legal proceedings. While certain correspondence will be provided as a courtesy (i.e. a brief letter to excuse someone from work or school), other, more involved correspondence prepared at your request, the request of an attorney or outside agency or ordered by the court will result in a fee for time involved, in much the same way that an attorney or accountant would charge you for services rendered. If the psychological services requested are for matters involving legal proceedings, i.e. custody, visitation, probation, expert testimony, etc., a retainer may be required. You will be expected to pay for the professional time required even if I am compelled to testify by another party.

Your signature below signifies that you have read and understood the above.

Signature: _____ Date: _____

Confidentiality Policy:

Everything you say to your doctor is confidential, which means that it is private and cannot be shared with anyone outside this office without your permission. Your doctor cannot release any information about you without a signed consent for release of information, except in emergencies or when ordered by the court. Please note that information about dangerous behaviors, including serious thoughts of hurting yourself or someone else, as well as information about possible child abuse, is not confidential and will be reported by your doctor to the appropriate authorities to keep you and other people safe.

If you were referred by a court order, information about your treatment is not confidential and will be released to the court, regardless of your permission. Additionally, requests for psychological evaluations and/or psychotherapy by an employer or workman's compensation agency require that the information obtained by released to these agencies regardless of your permission as they are the ones paying for the appointment(s).

Your signature below signifies that you have read and understood the above.

Signature: _____ Date: _____

If you are a legal guardian of a patient under the age of 18, we ask that you provide documentation in order to access any records, schedule appointments, or attend sessions.

Please list any additional people who can have access to obtain information about the patients medical record, schedule appointments, or attend sessions.

1. **Name: _____ Phone #: _____**
2. **Name: _____ Phone #: _____**
3. **Name: _____ Phone #: _____**
4. **Name: _____ Phone #: _____**
5. **Name: _____ Phone #: _____**

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