AdultSpan Counseling

Insurance Verification - Clinician Name _____

Name of Patient	Name:	DOB:	Gender:
Street Address	Street:		Apt:
	City	State	Zip
Phone		Ok to Text? Y/N	OK to Voicemail Y/N
Email			OK appointment reminders Y/N
Emergency Contact		Relationship	Phone
Complete below if under 19 years old or under 26 using parents insurance			
Guardian/Parent	Name:		DOB:
	Street:		Apt:
	City	State	Zip
	Phone		

Insurance	
Subscriber Name	Male / Female
Subscriber DOB	Relationship: Self / Spouse / Child
ID Number	Group #
Employer (or ACA)	
Benefit Phone #	
Second Insurance	
Subscriber Name	Male / Female
Subscriber DOB	Relationship: Self / Spouse / Child
ID Number	Group #
Employer (or ACA)	
Benefit Phone #	

Please call your insurance ahead of time and get the following information.

What is my Copay/Coinsurance? _____

How much Deductible is left? _____

Are hour sessions (CTP 90837) covered? Y / N _____

Are Family sessions (CTP 90847) covered? Y / N _____

Is "Marriage Counseling" ALLOWED with 90847? Y / N _____

Office use only: [ ] Scan [ ] Uploaded [ ] Faxed Ins Ver [ ] Update Address [ ] Square

Waiver for Private Pay Clients
(Skip if using insurance)

At times patients with insurance coverage prefer to pay privately for confidentiality reasons. Using your insurance requires passing along information regarding diagnosis necessary for reimbursement (see Confidentiality Statement and HIPAA policies). This information is discoverable by underwriters of life, long-term care, and medical insurance policies and may impact future premiums or coverage.

Also It is common for insurance not to pay for marriage/couples/sex therapy. It is unethical and a breach of contract with your insurance company to bill "as family therapy" in order to get paid. If your insurance does not cover either the diagnosis (Z codes), or Marriage Counseling – a payment at time of service discount rate listed below is the alternative.

The usual rate is$225.00 for intakes, $130.00 individual and $150.00 for couples; however, payment at time of service permits a discounted rate of:

$95.00 for intake appointment (60 minutes).
$75.00 for 45 minute session (individual)
$85.00 for 60 minutes session (individual)
$95.00 for family/couples (60 minutes).

_____ (initial) I understand that I do not have mental health/marriage counseling benefits as part of my insurance policy or I do not meet the criteria for medical necessity and choose to continue through private pay OR…

_____ (initial) I am choosing to pay privately and will not submit to my insurance company for reimbursement. Should I desire to use my insurance in the future. I understand that I must revoke this waiver in writing AND only submit to insurance those sessions that have occurred AFTER the date of my written notification.

_____

Client / Guardian Signature Date

CREDIT CARD ON FILE

At AdultSpan Counseling your credit/debit card information is kept confidential and secure using the Square credit card system. You may receive an email notifying you that your card has been linked to your AdultSpan PC account.

Our billing company sends bills towards the end of the month. You will only receive a bill only if we are sure it is your responsibility to pay. You will not receive a bill if you do not have a balance or until your insurance has paid (or applied it to your deductible or denied coverage of service or diagnosis). Your credit card on file will be used only as follows:

- At your request to pay by phone, or email.
- If you have a balance overdue by 90 days, I use the credit card on file to automatically charge the portion of the bill that is more than 90 days over due.

I authorize AdultSpan Counseling to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Last 4 of CC Number _____ Exp Date ___ / ____ CVV# _____

Cardholder Name _____

Billing Address _____

City _____ State_____ Zip _____

Email for Invoices/Receipts: _____

Cardholder Signature _____ Date ____/____/____

I (we), the above signed, authorize and request J. Kipp Lanning at AdultSpan Counseling to charge my credit card, as indicated above. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to AdultSpan PC in writing: 1001 S 70th St. #225 Lincoln 68510

This portion will be removed and shredded after card number is stored in accordance with regulations by Square for security purposes:

Full Credit Card Number: _____-_____-_____-_____

Informed Consent for Therapy

Therapy will work on the goals that you bring. When working as a couple for relationship counseling, the goals that support the relationship for the couple will be the focus of counseling. Generally this works well, but sometimes it can be challenging emotionally and take some additional time throughout your week. Sometimes looking at problems to make changes is uncomfortable, please let me know if this is happening so I can help.

I won't do tests or assessments without your knowledge and agreement. Your records are kept secure according to state and federal regulations. We use an electronic health record though a business agreement that is HIPAA compliant. If you have questions on this please feel free to ask. Your specific therapist and their supervisor/ administrator are the only ones with access to your records. Regarding couples counseling: Intakes will be stored individually. Couples counseling will be billed as "family" sessions, the identified patient for insurance billing purposes will be discussed at your intake session along with confidentiality of the file.

Unless you are using Medicaid, your physician will not be notified of your treatment unless you specifically request this. If you are using Medicaid and do not want your physician contacted, let your therapist know.

I do not provide crisis counseling. As I am in session with other patients and have office hours, I will return calls during those office hours (described on my voicemail). If you have a medical emergency, please contact 911 emergency services. Otherwise – please use family and friends for support until an "urgent" appointment can be scheduled (within 24 hours). I do provide some limited phone contact through scheduled arrangements, this is not covered by insurance and will be billed according to my private pay rate.

I do not use social media to connect with, friend, message or otherwise communicate with patients. Posts / messages that this therapist believes may compromise your confidentiality will be deleted.

As the work we do requires clear thinking and can stir strong emotions, you cannot come under the influence of drugs or alcohol. Weapons are not allowed in the office. If your therapist suspects this, your appointment will be rescheduled.

Missed appointments with less than 24 hours notice are subject to a $50.00 late cancel / no show fee.

Payments may be collected at the time of service. Any amounts not covered by insurance either due to deductibles; co-insurance; denied services, diagnoses, or dates of service will be the patient responsibility. Amounts over 90 days past due may be automatically collected by your therapist using the credit card on file.

_____

Name and date

Confidentiality of your Information

What is said in therapy needs to be confidential in order for therapy to work. Confidentiality means that your therapist will protect verbal, written/electronic information (i.e., your file) according to state and federal guidelines.

There are some limits to confidentiality. If you feel that you may harm yourself or others, your therapist will use the least information to the fewest people possible to reasonably ensure safety. Your therapist is required by law to report suspected abuse or neglect of a child or vulnerable adult to the authorities. At times your therapist will consult with other therapists about your treatment without identifying you.

Family or couples therapy is only as confidential as the other people in the room. Please respect each other's confidentiality. While your therapist would encourage you to use your support system (friends and family), please limit what you share about therapy. Sessions billed as a FAMILY session will require a release of information from all legal age persons attending. There will be only one "family" file. Your therapist will discuss who is the identified patient for the file/billing. At times it may make sense to see members of the family individually and as a family. The pro/cons of this will be discussed as well as how the confidentiality for individual sessions will be handled.

Parents are asked to respect that confidentiality is important for children too. Your therapist will let you know if your minor child is in imminent harm. Just because your child may discuss risky behaviors does not mean they are in imminent harm. If you would like to clarify what you'd like to be told about, please talk to your therapist.

Your insurance requires date, diagnosis and the service in order to pay. They may rarely also request your file to ensure the services were "medically necessary." If you're concerned about this you may pay for your services yourself; however, you cannot submit it to insurance for reimbursement. Payment information may be sent via the credit card system to the email on file if you request a receipt.

If you contact your therapist through an insecure means (e.g., email or text) you agree that your therapist may respond with the requested information with the same communication channel. However, your therapist may require you to schedule a session or phone contact to discuss complex or sensitive information.

Court or legal requests for records will start with an attempt to get a release from all legal age persons attending the sessions. If it is denied, this therapist will work to keep your information protected; however, ultimately may end up having to testify. This unlikely, and if you're concerned about this talk with your therapist about how this will be handled.

By signing below I agree I understand my rights and limits for confidentiality. I have been offered and received, if requested, a copy of the HIPAA policy for AdultSpan Counseling.

_____

Name and date

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

LEVEL 2—Depression—Parent/Guardian of Child Age 6-17*

*PROMIS Emotional Distress—Depression—Parent Item Bank

Child's Name: _____ **Age:** ____ **Sex:** ❑ Male ❑ Female **Date:**_____

What is your relationship with the child receiving care?_____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "not finding interest or pleasure in doing things" and/or "seeming down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) days, my child said he/she ...							Item Score
		Never	**Almost Never**	**Sometimes**	**Often**	**Almost Always**	
1.	Could not stop feeling sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	Felt alone.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	Felt like he/she couldn't do anything right.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	Felt lonely.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	Felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	Felt unhappy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	Thought that his/her life was bad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	Didn't care about anything.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
9.	Felt stressed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
10.	Felt too sad to eat.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
11.	Wanted to be by himself/herself.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

LEVEL 2—Anxiety—Parent/Guardian of Child Age 6-17*

*Adapted from PROMIS Emotional Distress—Anxiety—Parent Item Bank

Child's Name: _____ **Age:** _____ **Sex:** ❑ Male ❑ Female **Date:** _____

What is your relationship with the child receiving care? _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "feeling nervous, anxious, or scared", "not being able to stop worrying", and/or "couldn't do things he/she wanted to or should have done because they made him/her feel nervous" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS, my child said that he/she ...							Item Score
		Never	**Almost Never**	**Sometimes**	**Often**	**Almost Always**	
1.	Felt like something awful might happen.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	Felt nervous.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	Felt scared.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	Felt worried.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	Worried about what could happen to him/her.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	Worried when he/she went to bed at night.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	Got scared really easy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	Was afraid of going to school.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
9	Worried when he/she was at home.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
10.	Worried when he/she was away from home.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

P99

LEVEL 2—Substance Use—Parent/Guardian of Child Age 6–17*

*Adapted from the NIDA-Modified ASSIST

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:** _____

What is your relationship with the child receiving care: _____

Instructions to parent/guardian: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* your child receiving care has been bothered by "having an alcoholic beverage"; "smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco"; "using drugs like marijuana, cocaine or crack, club drugs, hallucinogens, heroin, inhalants or solvents, or methamphetamine"; and/or "using any medicine without a doctor's prescription." The questions below ask about these feelings in more detail and especially how often your child receiving care has been bothered by a list of symptoms **during the past two (2) weeks. Please respond to each item by marking (✓ or x) one box per row.**

								Clinician Use
Please respond to each item by choosing one option per question.		**Not at All**	**Less Than a Day or Two**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**	**Don't Know**	**Item Score**
During the past TWO (2) WEEKS, about how often did your child ...								
a.	Have an alcoholic beverage (beer, wine, liquor, etc.)?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
b.	Have 4 or more drinks in a single day?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
c.	Smoke a cigarette, a cigar, or pipe or used snuff or chewing tobacco?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
During the past TWO (2) WEEKS, about how often did your child use any of the following medicines without a doctor's prescription or in greater amounts or longer than prescribed?								
d.	Painkillers (like Vicodin)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
e.	Stimulants (like Ritalin, Adderall)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
f.	Sedatives or tranquilizers (like sleeping pills or Valium)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
Or drugs like:								
g.	Steroids	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
h.	Other medicines	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
i.	Marijuana	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
j.	Cocaine or crack	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
k.	Club drugs (like ecstasy)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
l.	Hallucinogens (like LSD)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
m.	Heroin	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
n.	Inhalants or solvents (like glue)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	
o.	Methamphetamine (like speed)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑	

INTAKE QUESTIONNAIRE

Description of Present Problem

What made it important to get help with this problem now?

What have you already tried to do to take care of this problem?

When did you first start to struggle with this problem?

How often is this a problem?
[ ]Continuous [ ]most days [ ] weekly [ ] monthly [ ] every couple of months

When this is a problem, how intense is it
[ ] overwhelming [ ] interferes with focus/tasks [ ] worrisome [ ] minor irritation

If this problem were to go away, what would you be doing differently or how would you be feeling differently than you do now?

Safety Issues:

Please Check the following that are problems - Star any issues you're here for today.

- Oppositional Behavior: _____
- Anger / Aggressive Behavior: _____
- Tantrum: _____
- Changes in mood / interest in activities: _____
- Fears / unwanted thoughts: _____
- Unusual habits / repetitive behavior: _____
- Sleep problems / changes: _____
- Appetite problems / changes: _____
- Suicidal / Homicidal thoughts: _____
- Self harming behaviors: _____
- Alcohol / drug use: _____
- Sexual problems: _____
- Abuse (sexual / physical): _____
- Neglect: _____
- Self Esteem: _____
- Adjustment (death / divorce): _____
- Toileting: _____
- Attention problems: _____
- Hyperactivity: _____
- Relationship problems: _____
- School problems: _____

PREVIOUS ATTEMPTS TO IMPROVE BEHAVIOR/OUTCOME:

Check what successful strategies have been implemented to address these problems or goals.

Verbal reprimands____ Time out (isolation) ____ Removal or privileges____

Rewards____

Physical punishment____ Give in to child request____ Avoidance of child____ Other_____

On the average, how much of the time does (s)he comply with **initial** commands?

Usually ___ Mostly ____ Half the time ____ Occasionally ____ Rarely/never _____

On the average, how much of the time does (s)he **eventually** comply with commands?

Usually ___ Mostly ____ Half the time ____ Occasionally ____ Rarely/never _____

To what extent are you and your spouse consistent with respect to disciplinary strategies.

Usually ___ Mostly ____ Half the time ____ Occasionally ____ Rarely/never _____

Past Psychiatric History:

Current and / or most recent previous counselor(s):

Counselor Name:	Started	Stopped
Issues addressed at that time?		
Should I contact them?		
What was most helpful and least helpful about this counseling experience?		

Previous mental health inpatient or partial care hospitalizations

Location:	Date(s)
Location:	Date(s)
Location:	Date(s)
Should I contact them?	
What was most helpful and least helpful about this experience?	

Previous Substance Abuse Treatment

Location:	Date(s)
Location:	Date(s)
Location:	Date(s)
Should I contact them?	
What was most helpful and least helpful about this experience?	

Past Trauma History: *For example*, Bullying, physical assaults, combat, discrimination, natural disaster, sexual assaults, sexual molestations, life threatening accidents, child verbal/emotional/physical abuse, child emotional/social neglect, intimate partner violence, intimate partner social/emotional/verbal abuse, others.

Type	Year(s)	Did you get help?	Is it a current issue?	OK to ask follow up questions?

Is there a family history of mental health or substance abuse?

Mother's Side

_____

_____

_____

_____

_____

Father's Side

_____

_____

_____

_____

_____

Medical History

Medical/Physical Health History – Please Check all he/she has been treated for in the past.

❍ AIDS ❍ Dizziness ❍ Nose bleeds ❍ Drug abuse
❍ Pneumonia ❍ Abdominal pain ❍ Epilepsy ❍ Rheumatic Fever
❍ Ear infections ❍ Allergies ❍ Eating problems ❍ Anemia ❍ High blood pressure
❍ Diarrhea ❍ Fainting ❍ Sore throat ❍ Appendicitis ❍ Fatigue
❍ Scarlet Fever ❍ Arthritis ❍ Frequent urination ❍ Sinusitis ❍ Asthma
❍ Headaches ❍ Smallpox ❍ Bronchitis ❍ Hearing problems ❍ Stroke
❍ Bed wetting ❍ Hepatitis ❍ Cancer ❍ Tonsillitis ❍ Thyroid problems
❍ Nausea ❍ Chest pains ❍ Kidney problems ❍ Tuberculosis ❍ Chronic pain
❍ Measles ❍ Toothache ❍ Colds/Coughs ❍ Mononucleosis ❍ Constipation
❍ Mumps ❍ Vision problems ❍ Chicken Pox ❍ Vomiting ❍ Sleeping disorders
❍ Miscarriages ❍ Whooping cough ❍ Diabetes ❍ Seizures ❍ Dental problems

Current Physical or Mental Health Treatments

Condition	Treatment provider	Current?

How long ago was your child's last physical? _____From? _____

Describe your child's exercise habits

_____

_____

Does (s)he have any problems sleeping?
None____ Difficulty falling asleep____ Sleep continuity disturbance____ Early morning awakening____ Is (s)he a restless sleeper? _____

Please list ALL your child's current medications, not just those for mental health.

Med	Dose	How many times a day?	Prescriber	Reason

Does (s)he have bladder control problems at night?
If yes, how often? _____If yes, was (s)he ever continent? ____ During the day?_____

Does (s)he have bowel control problems at night?
If yes, how often? _____If yes, was (s)he ever continent? ____ During the day? _____

Does (s)he have any appetite control problems?
Overeats____ Average____ Under eats____ Picky eater _____ (please describe):

CURRENT HEALTH STATUS:

Describe his/her health?	Very Good ____	Good ____	Fair ____	Poor ____	Very Poor ____
How is his/her hearing?	Very Good ____	Good ____	Fair ____	Poor ____	Very Poor ____
How is his/her vision?	Very Good ____	Good ____	Fair ____	Poor ____	Very Poor ____
Gross motor?	Very Good ____	Good ____	Fair ____	Poor ____	Very Poor ____
Fine motor?	Very Good ____	Good ____	Fair ____	Poor ____	Very Poor ____
Speech and language?	Very Good ____	Good ____	Fair ____	Poor ____	Very Poor ____

Has (s)he had any chronic health problems (e.g., asthma, diabetes, heart condition)?
No ____ Yes ____ If yes, please specify: _____

Has (s)he had any accidents resulting in the following? Please give date and cause of injury.
Broken Bones ____ Severe Lacerations____ Head Injury____ Severe Bruises____
Stomach Pumped____ Eye Injured____ Teeth injured____ Sutures____
Other (specify) _____

Family History

Who are the biological parents? Cultural/Ethnicity?

Are they married? If divorced (or deceased) how was the patient at the time?

If divorced or placed out of home, please describe the custody arraignment or visitation.

Describe the patient's relationship with their parental figures:

Are there other adult figures that are important (grandparents, foster parents, adoptive)?

List any siblings in order from oldest to youngest and **include the patient**. Include any important half or step sibling relationships.

Social History

Please list previous placements (foster care, other family members) and dates:

What, if any current life stressors (e.g., work, unemployment, health issues, parenting, caring for elder parents, etc.) are causing stress in your home?

Developmental History:

PRENATAL HISTORY

How was your (or child's mother's) health during pregnancy?

Good ___ Fair ___Poor ___DK _____

Did you (or his/her mother) have any illness or complications during pregnancy with this child? What type?

How old were you (child's mother) when she became pregnant? _____

Check any of the following substances or medications used during pregnancy?

____Beer or wine	____Coffee or other caffeine (Cokes, etc.)
____Hard liquor?	____Cigarettes?
____ Valium (Librium, Xanax)	____ Tranquilizers
____ Anti-seizure medications	____ Antibiotics
____ Sleeping pills	____ Other (please specify) _____

Was there toxemia or eclampsia? No ___ Yes ___ DK ___

Was there an Rh factor incompatibility? No ___ Yes ___DK ___

Was the pregnancy planned? No ___ Yes ___DK ___

Full Term 9 mos. __ Early __(weeks total _____) Late ___ (weeks total _____)

Signs of fetal distress during labor/birth? No ___ Yes ___DK ___

Delivery Normal? ____ Breech? ____ Caesarian? ____ Forceps? ____ Induced? ____

What was the child's birth weight?_____

Were there any health complications following birth? Please describe:

POSTNATAL PERIOD AND INFANCY

Were there early infancy feeding problems? No____ Yes____
Was the child colicky? No____ Yes____
Were there problems with the infant's alertness? No____ Yes____
Did the child have any health/congenital problems? No____ Yes____
If yes to any, describe, use back if needed:

DEVELOPMENTAL MILESTONES

At what age did (s)he sit up? 3-6 mos. ____ 7-9 mos. ____ Over 9 mon. DK ____
At what age did (s)he crawl? 6-12 mos. ____ 13-18 mo. ____ Over 18 mo. ____ DK____
At what age did (s)he walk? Under 1 yr____ 1-2 yr____ 2-3 yr____ over 3 yr DK____
At what age did (s)he speak single words (other than mama or dada)? _____
At what age did (s)he string two or more words together? _____
At what age was (s)he toilet trained (bladder control)? _____
At what age was (s)he toilet trained (bowel control)? _____
Approximately how much time did toilet training take from onset to completion? _____

SCHOOL HISTORY:

Current grade: _____ School: _____

Teacher's Name: _____

School Counselor: _____

Has the (s)he ever been in any type of special educational program, and, if so, how long?

Learning disabilities class____ Duration _____

Behavioral/emotional disorders class____ Duration _____

Speech and language therapy____ Duration _____

Other (please specify)_____

Has the (s)he ever been?

(Please describe reasons and give brief details on back if needed):

Suspended from school____ Number of Suspensions____ Expelled from school____

Number of expulsions____ Retained in grade____ Number of retentions ____

Have any other instructional modifications been attempted?

None____ Behavior modification program____ Daily/weekly report card____ Other (please specify) ____

Please describe the type of student or quality of their work.

Example: eager to please, but forgetful, distractible.

Please describe when the school problems (if any) started?

Example: Started in 4th grade – suspensions started in middle school.

Please describe what the child's social involvement is at school.

Example: shy, complains of bullying.

Legal History
Please list any current legal charges.

_____

_____

_____

Please list any past charges AND convictions (if any) and sentences.

_____

_____

_____

_____