Capitol Hill Consortium for Counseling & Consultation LLC
650 Pennsylvania Avenue SE, Suite 440, Washington, DC 20003
P | 202.544.5440 **F** | 202.544.3004

PATIENT REGISTRATION FORM

PATIENT FULL NAME	GENDER _____ PRONOUNS _____ Gender Insurance Has You Listed Under (if different) _____
PATIENT ADDRESS	
TELEPHONE NUMBERS HOME WORK CELL EMAIL	
AGE / DATE OF BIRTH (MM/DD/YYYY) / MARTIAL STATUS	
NAME OF EMPLOYER/ SCHOOL	SOCIAL SECURITY NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
NAME OF POLICY HOLDER DATE OF BIRTH	NAME OF POLICY HOLDER DATE OF BIRTH
POLICY NUMBER GROUP NUMBER	POLICY NUMBER GROUP NUMBER

RESPONSIBLE PARTY

RESPONSIBLE PARTY IS: ☐ PATIENT ☐ PRIMARY POLICY HOLDER ☐ SECONDARY POLICY HOLDER

RESPONSIBLE PARTY'S NAME AND DATE OF BIRTH (FIRST, M, LAST, DOB)	HAS THE RESPONSIBLE PARTY BEEN COURT-ORDERED? TO PAY MEDICAL BILLS? ☐ YES ☐ NO
ADDRESS	IF YES, WE ASK THAT YOU HAVE THAT PERSON SIGN AN AUTHORIZATION FORM.
TELEPHONE NUMBER	RELATIONSHIP TO PATIENT ☐ PARENT/GUARDIAN ☐ SPOUSE ☐ OTHER

EMERGENCY CONTACT
IN THE EVENT OF AN EMERGENCY WHO SHOULD WE CONTACT

NAME OF EMERGENCY CONTACT	RELATIONSHIP TO PATIENT ☐ PARENT/GUARDIAN ☐ SPOUSE ☐ OTHER
TELEPHONE NUMBERS HOME WORK CELL	

BILL AND PAYMENT POLICY

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT AND THE RESPONSIBILITY OF THE PATIENT. OUR STAFF WILL ASSIST YOU IN COMPLETING ANY FORMS NECESSARY TO EXPEDITE REIMBURSEMENT FROM INSURANCE CARRIERS AT NO ADDITIONAL CHARGE.

IF A PERSON OTHER THAN PATIENT (PATIENT'S SPOUSE OR PARENT) HAS ACCEPTED FINANCIAL RESPONSIBILITY FOR MEDICAL BILLS, A SIGNED CONSENT TO THAT AFFECT MUST BE ON FILE. OUR STAFF WILL GLADLY EXPLAIN OR ASSIST YOU WITH ANY ASPECT TO THIS POLICY.

AUTHORIZATION AND RELEASE

I, _____, HERBY AUTHORIZE CCCC TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED TO ME AND/OR MY DEPENDENTS.

FINANCIAL INFORMATION

CCCC RESERVES THE RIGHT TO CHARGE A 30% ATTORNEY FEE AND 15% INTEREST, IF REFERRED TO COLLECTIONS. IF I PAY FOR SERVICES WITH A CHECK, TELECHECK WILL REFER THE AVAILABILITY OF MY FUNDS. I UNDERSTAND THAT I WILL BE CHARGED A $25.00 RETURN CHECK FEE, IF MY CHECK IS RETURNED BY MY FINICIAL INSTITUTION/BANK. I ALSO UNDERSTAND THAT THERE IS A CANCELLATION FEE OF $75.00 FOR BROKEN OR MISSED APPOINTMENTS UNLESS A TWO DAY (48-HOUR) NOTICE IS GIVEN. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. EITHER THE ABOVE-NAMED CARRIER OR I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

SIGNATURE

I CERTIFY THAT ALL THE INFORMATION ON PAGE (1) ONE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND I ALSO AGREE TO THE INFORMATION IN THE BILL AND PAYMENT POLICY, AUTHORIZATION AND RELEASE AND FINANCIAL INFORMATION SECTIONS OF THIS FORM. I ALSO AUTHORIZE THIS SIGNATURE FOR CLAIMS SUBMISSIONS.

SIGNATURE OF PATIENT (PARENT/GUARDIAN IF MINOR CHILD: **DATE:**

PROVIDER SIGNATURE:	**DATE:**

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HIPAA Notification – Notice of Clinician's Policies & Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGIAL & MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- PHI refers to information in your health record that could identify you.
- Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychotherapist.
- Payment is when I obtain reimbursement for your health care. Examples of payment include when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations include quality assessment and improvement activities, case management, care coordination, and business-related matters such as audits and administrative services.
- Use applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- Authorization is your written permission to disclose confidential mental health information. All authorizations to disclose information must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. Under circumstances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information.

I will also need to obtain an authorization before releasing your Psychotherapy Progress Notes, which are notes that I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization (of PHI or Psychotherapy Progress Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

(1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization under any of the following circumstances:

- Child Abuse – If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being mentally abused, physically abuse, sexually abused, or neglected, I must immediately report such knowledge or suspicion to the appropriate authorities.
- Adult and Domestic Abuse – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must report this belief to the appropriate authorities.
- Health Oversight Activities – If the D.C. Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under D.C. law, and I will not release information without the written authorization of you or you legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious threat to Health or Safety – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose the PHI to the appropriate authorities and/or individuals.
- Worker's Compensation – If I am treating your for Worker's Compensation purposes, I must provide periodic developmental reports, treatment records, and bills upon request to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer, or their representatives.

Your signature below serves as an acknowledgement that you have received the HIPAA notice.

Printed Name

Signature Date

TM

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Consent for Treatment Agreement

Please read and initial beside each section indicating that you are aware and understand the policies of our office. If you have questions, please discuss with your clinician.

I. Evaluation and Diagnostic Procedures

_____ INITIALS

a. The initial evaluation and diagnostic process may take up to 3 – 4 sessions. All sessions, including intake, are 45-53 minutes long depending on your provider.
b. The initial evaluation will consist of clinical interview and may also include interviews with significant others, psychological testing and/or referrals to other specialists.
c. Treatment will consist of individual, group, couple, and/or family psychotherapy, as well as possible adjunctive psycho-educational or skill building services. Frequency is determined by the clinician's recommendation, scheduling availability, and the nature of the problem. Session frequency is typically weekly, and this may increase or decrease over the course of treatment.
d. Treatment may also consist of referral to a psychiatrist for psychopharmacological recommendations. CCCC does NOT have a psychiatrist on staff; a referral list is available. Collaboration with your primary care physician is desirable and other specialists will be referred to and collaborated with on an as needed basis.
e. Because therapy is the process of dealing with feelings, thoughts, and behavior it may feel worse before it gets better. If I believe I am in crisis, I will contact my clinician or designee, or go to my nearest hospital emergency room for evaluation.

II. Confidentiality

_____ INITIALS

a. I understand that my insurance company or other payment source for my treatment require diagnostic and treatment planning information in order to pay for services rendered. In addition, I understand that it is generally desirable for my clinician to provide clinical information to other professionals I am involved with to coordinate care.
b. The office will not release any information without my knowledge and consent, except in the following circumstances, as applicable:
    1. In the event of a subpoena, or if a judicial system mandates the release of records.
    2. When clinicians have information indicating that a child under age 18 or adult over age 65 is (or has been depending on jurisdictions) abused or neglected, the clinician is a mandated reporter and legally required to report to child/adult protective services.
    3. If I am a danger to myself or others, my clinician will do whatever is ethical to protect me or others. This may include hospital admission, notification of emergency contacts, relatives, and/or police. I also understand that my clinician has a duty to warn individuals identified who are at risk to be harmed.

III. Communication Outside of Session

_____ INITIALS

a. Texting and email communication are not confidential and are not meant to be therapeutic methods of communication, but can be useful for scheduling purposes.
b. Please circle below to authorize the following methods of communication:

Home Phone Cell Phone Office Phone

Email Text Facsimile Other:_____

Please note that billing statements will be sent through the mail if you accrue an outstanding balance

IV. Clinician Consultation and Supervision

_____ INITIALS

a. CCCC clinicians often consult with each other when they may benefit from clinical support and feedback from colleagues at CCCC, or when working with the same clients (e.g. couples, DBT referrals, family, etc.). CCCC clinicians will only share information that benefits the client(s), and the client and clinician have agreed upon the information that will be shared.
b. Some of our clinicians are under clinical supervision and will share client information with their supervisors. Clients will be informed of this when they first meet with the clinician.

V. Scheduling and Fees

_____ INITIALS

a. Payment is expected at the time services are rendered and paid before my sessions begin. This includes co-pays, deductibles, self-pay fees, etc.
b. I am responsible and not my insurance company for co-payments, coinsurances, and deductibles. I am also responsible for services not covered or denied by my insurance company, such as, but not limited to: psycho-educational services, workshops, paperwork for school or work, letters, and legal matters. The clinician will inform me of the time and cost of the non-covered services and make arrangement with you for payment. Costs for services not covered by insurance are my responsibility, including payments expected from my insurance carrier which have been denied. Payments not made at the time of service are subject to a 1.5% fee increase every 30 days of non-payment and will be sent to collections after 90 days unless a payment agreement is adhered to.
c. Appointments are scheduled through administrative staff in collaboration with clinicians. If I need an emergency appointment, I will contact the office or instructions given by my clinician.
d. Services beyond those covered by my insurance company are provided on a self-pay basis, workman's compensation, or other agreed upon payment source.

VI. Missed Appointments

_____ INITIALS

a. There is a charge of $100.00 for missed appointments or late cancellations. We require a 48-business hour notification to avoid this fee (calls must be placed during business hours, and Tuesday cancellations need to be called by Saturday). Medicaid clients and Military personnel are not subject to this fee.

VII. Attendance Policy

_____ INITIALS

a. The practice's policy around late cancellations and no shows is as follows: after 3 late cancellations or no shows, clients can lose their standing appointment on their clinician's schedule; 3 more after that and they can lose their ability to stay in the CCCC practice. Clinicians have discretion regarding how and in what way they manage this expectation.

VIII. Reasons for Non-Compliance Termination

_____ INITIALS

a. My clinician may terminate treatment at CCCC under the following circumstances:
    1. Failure to comply with the treatment plan/recommendations by the clinician.
    2. Failure to maintain my financial responsibilities.
    3. Several cancellations or no shows for scheduled appointments.

IX. Couples, Family, Group Psychotherapy

_____ INITIALS

a. I will keep information revealed by others confidential.
b. Group clinicians may have a separate consent form for their specific group.
c. Medical records from couples therapy cannot be released without both parties' consent.

I, _____ have read and understand the various aspects
(name of patient or parent of minor child)

of psychotherapy such as evaluation and method of treatment for myself or my child,

_____.
(name of minor child, if applicable)

DO NOT SIGN UNTIL YOU HAVE DISCUSSED THESE POLICIES WITH YOUR CLINICIAN

_____

Patient/ Parent/Legal Guardian's Signature Date

_____

Clinician Signature Date

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Informed Consent for Psychological Testing

PLEASE READ AND INITIAL BESIDE EACH SECTION INDICATING THAT YOU ARE AWARE AND UNDERSTAND THE POLICIES OF OUR OFFICE. IF THERE IS SOMETHING YOU DO NOT UNDERSTAND, PLEASE ASK FOR ASSISTANCE.

I. Psychological Assessment:

a. Overview: Psychological testing consists of various standardized measures that assess cognitive, emotional, social, and neuropsychological areas of functioning.

b. Purpose: Psychological assessment can serve a variety of purposes, which include but are not limited to diagnostic clarification, treatment planning, and special services.

c. Scheduling: Psychological assessment involves the following three general steps:

   i. Intake evaluation: Your first appointment will be an initial evaluation, in which your clinician will discuss the reasons for referral for psychological testing. The intake evaluation may take on average two 1-hour appointments.

   ii. Psychological testing: Psychological testing is a lengthy process involving administering several assessment measures. One testing session may last between 2-5 hours. Although testing could be completed in one testing session, it is possible that testing may occur over several days depending on the nature of the referral question and individual differences.

   iii. Feedback: After testing data is analyzed and interpreted, a testing report will be written. The results of testing will then be discussed during a 45-minute feedback session. In addition, a testing report can be provided to all interested parties with proper consent.

d. Some clients experience difficult emotional reactions to the testing process or content. We encourage clients to discuss such reactions with their testing examiner.

Client Initials: _____

II. Limits of Confidentiality:

a. All information obtained throughout the course of your psychological evaluation is confidential and will not be shared with any person, organization, or third party without your written authorization. The following exceptions are as follows:

   i. In the event of a subpoena or court-order requesting the release of your records, the office may have to provide information regarding your evaluation.

   ii. If any information indicating that a child is abused or neglected, the clinician is required to be reported to child protective services. Additionally, any information indicating that an individual over the age of 60 is being abused or neglected is required to be reported.

   iii. If you are in danger to yourself or others, your clinician is required to report this information and to notify any parties necessary to ensure the safety of the individual at risk.

Client Initials: _____

III. Fees & Insurance

a. While our goal is to provide specific and accurate information regarding your benefits and eligibility for psychological testing, your coverage may differ from the quote communicated to us by your insurance company. As such, we encourage you to independently inquire into your benefits and eligibility for psychological testing. You are responsible for all fees not reimbursed by your insurance plan.

a. Services on a self-pay basis are available for individuals who do not want to use their insurance, who do not have health insurance, or in cases in which insurance does not cover or only partially covers psychological testing. Ask your clinician about fees and a financial agreement if this option applies to you.

b. Payment is expected at the time services are rendered, and paid in full prior to the final feedback session.

c. I am responsible and not my insurance company for co-payments, coinsurances, and deductibles. The co-payment reflects the number of units/hours required for testing, scoring, interpretation, and report writing.

Client Initials: _____

IV. Clinicians in Training and Under Supervision

a. Capitol Hill Consortium for Counseling and Consultation LLC is a training site for doctoral students and post-doctoral students in clinical psychology who operate with a master-level or doctoral level of clinical experience. Testing administration may be completed by pre-doctoral externs or post-doctoral residents. All post-doctoral clinicians and pre-doctoral externs are closely supervised by at least one licensed clinical psychologist.

V. Reasons for Termination

a. My clinician may terminate testing at CCCC under the following circumstances:
   i. Failure or inability to comply with the testing process.
   ii. Failure to maintain my financial responsibilities.
   iii. Failure to show to any of your testing appointments can result in delay or termination. Termination can result from several missed appointments with or without notice.

Client Initials: _____

I, _____ have read and understand the various aspects of Patient Name (Parent name if a minor child) Psychological Testing, such as evaluation and method of treatment for myself or my child (circle one).

Name of Minor Child	

All information is confidential with the following exceptions: minors, court ordered patients and those who pose a risk of danger to themselves or others. Insurance companies and other agents paying for treatment may also receive information as requested. In addition, clinical information may be shared with other professionals for the purpose of coordination of care.

DO NOT SIGN UNTIL YOU HAVE DISCUSSED THESE POLICIES WITH YOUR CLINICIAN

_____

Patient/Parent/Legal Guardian's Signature Date

_____

Clinician's Signature Date

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Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I _____ _____ _____ _____
(Member Name) (Insurance Name) (Policy Number) (Date of Birth)

authorize _____, to release protected health information related to my evaluation and treatment to
(Provider Name - Please Print)

PCP Name: _____ **PCP Phone:** _____

PCP Address: _____ _____ _____ _____
(Street Number, Street Name, Building & Suite Number) (City) (State) (Zip Code)

Information Below to be Completed by Behavioral Health Provider

I saw _____ **on** _____ **for** _____
(Patient Name - Please Print) (Date(s) of Service) (Reason or Diagnosis)

Summary: _____

_____

The following medication was or will be started: _____
(indicate medication name and dosage/frequency)

If no medication is indicated, check the following as appropriate:

_____ Medication Not Prescribed _____ Patient Refused Medication _____ Try Psychotherapy Before Trying Medication

Treatment Recommendations:

Lab Tests for the Following: _____ CBC _____ Thyroid Studies _____ Chemistry Panel _____ EKG

Other Treatment Recommendations: _____

_____

If you have any questions or would like to discuss this case in greater detail, please call me at: _____
(Phone Number)

_____ _____ _____
(Provider Signature) (Provider Printed Name) (Licensure)

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting: _____ .
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire on the date specified below, within one (1) year or less from the date of signature. I have read and understand the above information and give my authorization: **PATIENT PLEASE CHECK ONE**

_____To release any applicable mental health / substance abuse information to my primary care physician.
_____To release only medication information to my primary care physician.
_____To release the date of my first visit following my hospitalization from _____ through _____ to my primary care physician.
_____I DO NOT give my authorization to release any information to my primary care physician.

_____ _____ _____ _____ _____
(Patient Signature) (Date) (Expiration Date) (Signature of Patient's Authorized Rep.) (Date)

IF SIGNED BY PATIENT'S AUTHORIZED REPRESENTATIVE, DESCRIBE RELATIONSHIP TO PATIENT: _____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PCP AND KEEP THE ORIGINAL IN THE TREAMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Patient Information Release Authorization
Communication and/or Records

Patient Name	Date of Birth	Social Security Number

I hereby authorize the following Physician/Organization or Facility to release my records and or to communicate with_____ at CCCC.
(Name of Therapist)

Physician/Organization or Facility to receive this release

Organization	
Contact Person	
Street	
City	
State / Zip Code	
Telephone Number	
Fax Number	

The information should include the diagnosis and records of any treatment or examination rendered to me during the period of _____ to _____.

The patient (parent/guardian, if minor child) in writing may end this authorization at any time.

_____

Printed Name of Patient (Parent or Guardian if minor child) | Signature | Date

_____

Witness Name | Witness Signature | Date

Mail records to: Capitol Hill Consortium for Counseling & Consultation
650 Pennsylvania Avenue, SE
Suite 240
Washington, DC 20003
Attn: Medical Records

NOTE TO THE PARTY RECEIVING INFORMATION; This information has been disclosed to you from records whose confidentiality is protected by federal law which prohibits you from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. (This form meets the requirements of Federal Regulations 42 CFR).

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Psychological Testing - Background Form

CLIENT'S BACKGROUND INFORMATION		
CLIENT'S NAME:		
DATE OF BIRTH:	**AGE:**	**GENDER:**

BIOLOGICAL FATHER	
NAME:	
AGE AT TIME OF BIRTH:	**CURRENTLY LIVING?**
OCCUPATION:	**EDUCATION:**
SPECIAL EDUCATION / LEARNING PROBLEMS:	
MEDICAL PROBLEMS:	
MENTAL HEALTH PROBLEMS (IF ANY):	
LIST PATERNAL RELATIVES THAT HAVE OR DO EXPERIENCE THE SAME PROBLEMS THE CLIENT IS FACING	

BIOLOGICAL MOTHER	
NAME:	
AGE AT TIME OF BIRTH:	**CURRENTLY LIVING?**
OCCUPATION:	**EDUCATION:**
SPECIAL EDUCATION / LEARNING PROBLEMS:	
MEDICAL PROBLEMS:	
MENTAL HEALTH PROBLEMS:	
LIST MATERNAL RELATIVES THAT HAVE OR DO EXPERIENCE THE SAME PROBLEMS THE CLIENT IS FACING	

NAME OTHER SIBLINGS & THEIR GENDER	AGE	MEDICAL, SOCIAL, SCHOOL PROBLEMS

PREGNANCY & DELIVERY HISTORY

DID ANY OF THE FOLLOWING OCCUR DURING PREGNANCY:	YES	NO	WHAT / WHEN / HOW MUCH
excessive vomiting			
threatened miscarriage			
hospitalization			
toxemia			
operations			
excessive blood loss			
smoking			
drinking			
drug use (Rx and Illicit)			

DELIVERY INFOMRATION

DURATION OF PREGNANCY:	DURATION OF LABOR:

TYPE OF LABOR: ◯ spontaneous ◯ induced

TYPE OF DELIVERY: ◯ normal ◯ breech ◯ caesarean

COMPLICATIONS: ◯ cord around neck ◯ hemorrhage ◯ injury

DESCRIBE OTHER COMPLICATIONS:

POST-DELIVERY PERIOD

Child discharged after how many days:

Child had: ◯ jaundice ◯ cyanosis (turned blue) ◯ infection ◯ other:

INFANCY PERIOD

Were any of the following present for this child:

◯ did not enjoy cuddling ◯ difficult to comfort ◯ difficult to nurse ◯ difficulty sleeping
◯ overly active ◯ difficult to calm ◯ excessive irritability
◯ colic ◯ head banging ◯ overly passive/inactive

Temperament of infant/toddler:	Describe infant/toddler behavior (low, moderate/normal, excessive)
How active were they?	
How distractible were they?	
How adaptable to change were they?	
Ability to deal with new situations?	
Intensity of emotional expression?	
Predictable sleeping, eating, excretion?	
Describe mood?	

CURRENT MEDICAL STATUS

Current height:	Current weight:

Describe current medical conditions and treatment:

List current medications (dosage, condition):

MEDICAL HISTORY

Provide age, type, and description of medical problem

Childhood Disease:
Medical Operation/ Hospitalization:
Head Injury: (lost consciousness, how long?)
Convulsions:
Coma:
Persistent high fevers:
Vision/Hearing problems:
Allergies:
Asthma:
Poisoning:
Tics:

SLEEP PATTERNS

settle down to sleep easily	*yes*	*no*	experience night terrors	*yes*	*no*
sleep through the night	*yes*	*no*	experience sleep walking	*yes*	*no*
experience nightmares	*yes*	*no*	experience sleep talking	*yes*	*no*
sleep restlessly	*yes*	*no*	Snore	*yes*	*no*

DEVELOPMENTAL MILESTONES	OCCURRED EARLY	OCCURRED ON TIME	OCCURRED LATE
Smiled			
sat without support			
Crawled			
stood without support			
walked without help			
bladder trained during day			
bladder trained during night			
rode tricycle			
rode bike w/o training wheels			
buttoned clothing w/o help			
tied shoe laces w/o help			
spoke first words			
spoke in phrases			
spoke in sentences			
named colors			
said alphabet			
began to read			

PHYSICAL COORDINATION	POOR	AVERAGE	GOOD
walking			
running			
throwing			
catching			
shoelace tying			
buttoning			
writing			
athletic abilities			

Does client have more accidents than their peers?

ACADEMIC HISTORY

Most Recent Higher Education - School Name:

Year started at this School:	**Currently Enrolled, Graduated, or Did not complete?**

Preschool Name:

Describe any academic difficulties:

Kindergarten Name:

Describe any academic difficulties:

Elementary School Name:

Describe any academic difficulties:

Middle School Name:

Describe any academic difficulties:

High School Name:

Describe any academic difficulties:

ACADEMIC FUNCTIONING

ACADEMIC AREA	GOOD	GRADE LEVEL	BELOW GRADE LEVEL	VERY DEFICIENT
intelligence relative to others same age				
comprehend & follow directions				
reading				
spelling				
mathematics				
other:				

ACADEMIC FUNCTIONING *(This Section for Child Cases Only)*

Type of classroom in which child is currently placed:

Accommodations child receives:

Does child utilize school counseling/resource rooms:

In what ways does your child learn best?

Child's favorite subject and why:

Child's least favorite subject and why:

How do you see your child's academic future? Why?

How could your child be best helped at school? Why?

PROBLEM BEHAVIORS

Circle "H" for behaviors occurring at home and "C" for behaviors in school classroom

HOME/CLASSROOM BEHAVIORS	**NEVER**		**HARDLY EVER**		**MODERATE**		**OFTEN**		**USUALLY**	
interrupts	H	C	H	C	H	C	H	C	H	C
learns from experience	H	C	H	C	H	C	H	C	H	C
destroys property	H	C	H	C	H	C	H	C	H	C
fights	H	C	H	C	H	C	H	C	H	C
easily frustrated	H	C	H	C	H	C	H	C	H	C
disturbs others	H	C	H	C	H	C	H	C	H	C
overly sensitive	H	C	H	C	H	C	H	C	H	C
short attention span	H	C	H	C	H	C	H	C	H	C
doesn't follow directions	H	C	H	C	H	C	H	C	H	C
excessive energy	H	C	H	C	H	C	H	C	H	C
sullen/sad	H	C	H	C	H	C	H	C	H	C
immature for age	H	C	H	C	H	C	H	C	H	C
extreme mood changes	H	C	H	C	H	C	H	C	H	C
doesn't complete chores	H	C	H	C	H	C	H	C	H	C
poor memory	H	C	H	C	H	C	H	C	H	C
immediate rewards work	H	C	H	C	H	C	H	C	H	C
delayed rewards work	H	C	H	C	H	C	H	C	H	C

PEER BEHAVIOR *(check one)*	**NEVER**	**HARDLY EVER**	**MODERATE**	**OFTEN**	**USUALLY**
isolates from others					
inconsiderate/selfish					
not accepted by others					
influences others to misbehave					
easily influenced					

RESPONSE TO AUTHORITY	**NEVER**	**HARDLY EVER**	**MODERATE**	**OFTEN**	**USUALLY**
tries hard to please					
fearful					
anxious					
openly defiant					
passively uncooperative					
physically aggressive					

DISCIPLINE HISTORY AND CHILDHOOD

Describe behavior management strategies used with Client and effectiveness of each:

Spanking:

Loss of Privileges:

Time out:

Other:

Describe injuries resulting from corporal punishment during childhood, if any:

Did your parent(s) participate in parenting classes or training:

ACTIVITES/HOBBIES

(list activities and how well child performs each)

OTHER PROFESSIONAL(S) INVOLVED WITH CLIENT'S CARE

PROFESSIONAL/INSTITUTION	DATES	SERVICES PROVIDED