ANDREA BIEBERICH, PH.D., LP, PLLC
LICENSED CLINICAL PSYCHOLOGIST
4101 PARKSTONE HEIGHTS DRIVE, SUITE 260, AUSTIN, TX 78746
(512)627-6259

Dear Potential Client,

First, let me thank you for choosing my professional services! To make our first meeting more efficient, I provide the following documents for you to read and fill out ahead of time:

(1) DISCLOSURE STATEMENT

(2) An AGREEMENT AND INFORMED CONSENT FOR TREATMENT, which outlines my policies and the services agreement. If you agree to these terms, please sign and date the document. If you would like a copy for your records, please print two copies.

(3) A NOTICE OF PRIVACY PRACTICES, which explains my practices and the federal regulations regarding the use and disclosure of your health information. After reviewing this document, please sign and date the CONSENT FOR TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE AND PRIVACY PRACTICES.

(4) A PAYMENT CONTRACT FOR SERVICES, which further explains my payment policies. If you agree to these terms, please sign and date the document.

(5) The INTAKE FORM, which will help me to better understand your child and make our first session more productive.

Please complete these documents and bring them to your first appointment. If you have any questions about these documents, please feel free to contact me by phone. We can also discuss your questions during our first meeting.

Paperwork aside, it is common for new clients to feel nervous about seeing a psychologist, and I understand how stressful it can be. Fortunately, most people begin to feel more comfortable with the process in just a few sessions. In the meantime, it might be helpful (for both of us) if you would take some time to think about what you want to get from therapy. You might even make some notes about your goals and what is most important to you, so that we can discuss these together during our first session.

I look forward to meeting with you and your child!

Sincerely,

Andrea Bieberich, Ph.D.

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DISCLOSURE STATEMENT

Andrea A. Bieberich, Ph.D., LP
Licensed Clinical Psychologist
512-627-6259
www.drandreabieberich.com

Education/Degrees

1998-Internship in Professional Psychology, Children's Hospitals and Clinics, Minneapolis, MN
1998-Doctor of Philosophy (Ph.D.) in Clinical Psychology, University of Memphis, Memphis, TN
1995-Master of Science (M.S.) in Psychology, University of Memphis, Memphis, TN
1992-Bachelor of Science (B.S.) in Psychology and Business, Bemidji State University, Bemidji, MN

Department of Regulatory Agencies

You have the right to direct concerns or complaints regarding the practice of psychotherapy to the Texas State Board of Examiners of Psychologists, located at 333 Guadalupe, Suite 2-450, Austin, TX 78701.

Fees

My basic fee is $150 per hour for individual and family therapy and testing services. The fee for an initial evaluation, lasting up to 90 minutes, is $200.

Insurance Reimbursement

I do not accept insurance but I will provide you with an invoice that includes all billing codes required to obtain reimbursement from your insurance company if you have out-of-network benefits you would like to access.

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AGREEMENT AND INFORMED CONSENT FOR TREATMENT

Welcome to my practice. This agreement contains important information about my professional services and office policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. **You should be aware that this Agreement will be in effect for one year from the date of signing unless you specifically request that it remain in effect for a shorter time. This contract, or any provision of this contract, can be revoked by you at any time, except to the extent that I have relied on it.**

PSYCHOLOGICAL EVALUATION
A psychological evaluation usually involves an initial consultation, the administration of a battery of tests, and a follow-up meeting to discuss results and recommendations. The initial consultation is for the purpose of discussing concerns, reviewing the client's history and other records, and developing an assessment plan. Evaluations may include cognitive, adaptive, and behavioral assessments targeted at identifying individual strengths and weaknesses. Some parts of the evaluation may be interesting and stimulating, while some area may be more boring or frustrating. Clients may experience negative emotion, particularly when asked to complete tasks that are difficult. Ample opportunities for breaks will be given and testing may be broken down into smaller sessions if necessary.

PSYCHOTHERAPY
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures or your progress, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

SCHEDULED SESSIONS
I will start out by conducting a diagnostic interview, lasting up to 90 minutes. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Following our initial meeting, I will usually schedule one 50-minute psychotherapy session per week (or every other week) at a time we agree on.
****Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control].

PROFESSIONAL FEES
You will be expected to pay in full with cash or credit card at the beginning of each session. The fee for an initial consultation for psychotherapy or evaluation services is $200.00.

- My hourly fee is $150.00 for psychotherapy services (ranging from 50-60 minutes in length). In addition to weekly therapy appointments, I charge this amount for other professional services you may need, though I will pro-rate the hourly cost if I work for periods of less than one hour. Other professional services include report or letter writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, and preparation of records or treatment summaries upon your request.
- My hourly fee for psychological assessment (or testing) is $150.00 per hour, including test scoring, interpretation, report writing, and feedback time.
- If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the added challenges of legal work, I charge $400.00 per hour for preparation and attendance at any legal proceeding.

While it is important for us to set realistic treatment goals and priorities, it is also important to evaluate what resources you have available to pay for your treatment. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT
At this time, I am not an "in network provider" for any insurance groups or panels. I am considered an "out of network" provider" and depending on your individual insurance plan, you may receive partial reimbursement for sessions attended and paid for. In this case, you may submit your receipt of fees paid to your insurance company. You are responsible for billing your insurance company. In order for you to be reimbursed, I will need to include dates and types of service, fees, and diagnoses.

CONTACTING ME
I am not able to guarantee 24-hour emergency care. If you believe you need 24-hour care and/or crisis intervention, I will be happy to refer you to a therapist or clinic that provides this service. Please discuss this with me immediately, so that an appropriate referral can be made.

I am often not immediately available by telephone. When I am not available, my telephone is answered by voice mail that I check daily. If you are experiencing an emergency call 911 or go to the nearest emergency room. For mental health emergencies you may also contact the confidential Travis County 24-hour HOTLINE at 472-HELP (472-4357).

SOCIAL MEDIA AND NETWORKING
I do not accept "friend" requests from current or former clients on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

LIMITS ON CONFIDENTIALITY
Your privacy is very important to me. The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other medical or mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also

legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- If you sign a "Release of Information" form, I can provide to and receive information from the identified person or agency any and all information you have authorized.
- If I were suddenly incapacitated and unable to continue this practice, authorization has been given to another psychologist to gain access to my records in order to contact clients and properly protect the confidentiality of records. I can provide you with the name of this psychologist if you wish.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

If any of the above situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In certain situations, I may charge a copying fee of 75 cents per page. There may also be additional expenses that I will charge for. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

CONSUMER PROTECTION

If you question whether your therapy is of real benefit to you, I encourage you to talk about your concerns with me. You have the right to seek outside consultation with other professionals, and I support you in getting other opinions about your problems and/or about what you are experiencing in your relationship with me.

TERMINATION OF THERAPY

You make the ultimate decision about how long you or your child may continue in therapy. I will certainly consult with you about that decision if you ask me to do so. Our work is a resource for your use; it is your right to feel free to stop using that resource when you decide it is in your best interest (or that of your child). I do hope that the decision to end counseling will be discussed candidly and thoroughly with me. Endings often proceed in a growth-enhancing manner when they are fully discussed and a sense of closure is achieved.

I look forward to the work we are about to undertake together. I hope you will find your experience meaningful and helpful. A decision to seek professional counseling for problems of living is always a difficult and important one – one that is never made lightly. I will strive to use my best professional skills to aid in the search for solutions to your concerns.

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(512)627-6259

NOTICE OF PRIVACY PRACTICES

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

Understanding the contents of your Clinical Record and how that information is used will (1) help you to better understand when others may have access to your health information and (2) assist you in making more informed decisions when authorizing disclosures. Your record is the physical property of Dr. Andrea Bieberich; the information within the record belongs to you. In using and disclosing your health information, it is my policy to be in compliance with the Privacy Standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

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 *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  – *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 psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are 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 are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations with your consent. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization (Consent for Release of Confidential Information) from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes 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 medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy 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, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I know or have reason to believe a child is being neglected or physically or sexually abused, or has been neglected or physically or sexually abused within the preceding three years, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse**: If I have reason to believe that a vulnerable adult is being or has been maltreated, or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, I must immediately report such to the Department of Protective and Regulatory Services.

  "*Vulnerable adult*" means a person who, regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:
  - (i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and
  - (ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.
- **Abuse by a Therapist**: If I have cause to believe that you have been the victim of sexual exploitation by a mental health professional during the course of treatment, I will report this to the appropriate State Examining Board.
- **Health Oversight Activities:** If a complaint is filed against me with the appropriate State Board overseeing me – The Texas State Board of Examiners of Psychologists – they have the authority to subpoena confidential mental health information from me relevant to the complaint.
- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party (i.e., custody study) or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety**: If you communicate a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim, I must make reasonable efforts to communicate this threat to the potential victim or to a law enforcement agency. I must also do so if a member of your family or someone who knows you well has reason to believe you are capable of and will carry out the threat. I also may disclose information about you necessary to protect you from a threat to commit suicide.
- **Worker's Compensation**: If you file a worker's compensation claim, a release of information is not needed from you in order for me to release information to your employer, insurer, the Department of Labor and Industry.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- **Right to Request Restrictions** –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send information to another address.)
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI and

psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide written Notice to you at our next session or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, talk to me about these concerns.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The agencies listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 15th, 2014. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice at your next visit.

ANDREA BIEBERICH, PH.D., LP, PLLC
LICENSED CLINICAL PSYCHOLOGIST
4101 PARKSTONE HEIGHTS DRIVE, SUITE 260, AUSTIN, TX 78746
(512)627-6259

CONSENT FOR TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE AND PRIVACY PRACTICES

I hereby grant my permission for any psychotherapy, testing, or diagnostic evaluation that may be deemed necessary by Dr. Andrea Bieberich. I understand that therapy is a joint effort between the psychologist and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances. I agree that I will be responsible for the payment of all professional fees. I know that I can end therapy at any time I wish and that I can refuse any requests or suggestions made by my psychologist.

I have read, understand, and agree to the AGREEMENT AND INFORMED CONSENT FOR TREATMENT, and I have reviewed this office's NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION. I voluntarily agree to participate in mental health and/or consultation services with Andrea Bieberich, Ph.D., LP, PLLC.

Please initial the following:

____I have been provided a **DISCLOSURE STATEMENT** which includes my psychologist's degrees and credentials. I have read the preceding information and been informed and understand my rights as a client.

____I have been provided a copy of the **AGREEMENT AND INFORMED CONSENT FOR TREATMENT** of Andrea Bieberich, Ph.D., LP, PLLC. I have read and agree to these policies.

____I have been provided a copy of the **NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION (HIPAA)**. I understand and agree to these policies noted in this document.

Client signature:_____ Date:_____
Client Name Printed:_____

If under 18 – Guardian signature(s):_____ Date:_____
If under 18 – Guardian name(s) printed:_____

Psychologist signature:_____ Date:_____
Psychologist name printed:_____

PAYMENT CONTRACT FOR SERVICES

This document is intended to clarify the payment policies for services contracted with Dr. Andrea Bieberich. The Person Responsible for Payment is required to sign this document before any services are provided.

PAYMENT POLICY:
My practice is organized on a cash payment basis. Payment in full is due at the time of service in the form of cash or credit card. Parents are responsible for payments for a minor at the time of service. If you do not abide by the payment agreements, I reserve the right to refuse further service.

My fees are as follows:

*Initial consultation session is billed at $200.00.

*Psychotherapy sessions lasting 50-60 minutes are billed at $150.00 per hour.

*Psychological evaluation is billed at $150.00 per hour. The evaluation time billed will vary based on the diagnostic question and number of assessment measures used. When planning for a psychological evaluation, a fee amount will be discussed following the initial consultation. This will allow me to assess what assessment measures will be needed and the length of time required. Evaluation fees will be agreed upon prior to the start of testing and will include not only face-to-face contact time, but also test scoring and interpretation, and report writing time. One half of the total evaluation fee is due at the first testing appointment and the remainder is due at the feedback session.

CANCELLED APPOINTMENTS
Appointments cancelled with less than a 24 hour notice will incur a cancellation fee of $25, and scheduled appointments that are missed without any notice may incur a no-show fee of $50. Repeated cancellations and missed appointments may result in termination of the therapeutic relationship. A letter reflecting termination will be mailed to you should this occur.

SUPPORT SERVICES:
A charge for phone calls of longer than 15 minutes will incur the regular hourly psychotherapy fee. Phone calls made to collateral contacts will not be charged for initial contacts or for case planning unless these phone calls become extensive. Other professional services such as report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries and time spent performing any other services you may request of me will be charged at the hourly psychotherapy fee.

INSURANCE REIMBURSEMENT:
I am considered an "out-of-network provider" and you are responsible for billing your insurance company, should you choose to seek any reimbursement. In order for you to be reimbursed, the dates and types of service, fees, and diagnoses need to be included on your invoice.

If you have any questions regarding this document, please be sure to ask me. YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTOOD, AND AGREED TO THE TERMS OF THIS DOCUMENT.

Client Name: _____

_____ _____

Signature of person responsible for payment Date

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INTAKE FORM FOR CHILD AND ADOLESCENT CLIENTS

Client Name: _____ Client age: _____ Date of birth: _____

Information supplied by: _____ Relationship: _____ Today's date: _____

	PARENT	PARENT
Name		
Street address City, State, Zip		
Home Phone		
Work Phone		
Cell Phone		
Education		
Occupation		
Employer		
Age		

What is the relationship between the child and his/her custodial parent(s)? Check all that apply.

___Parents married
___Single parent mother
___With mother and stepfather
___Other, describe: _____
__ Single parent father
__ Parents divorced
__ W/Father & Stepmother
__ Parents never married
__ Parents separated
__ Child Adopted

SIBLINGS

Name	Age	Gender	Where living?	Quality of relationship with client
		F M	Home Away	Poor Average Good
		F M	Home Away	Poor Average Good
		F M	Home Away	Poor Average Good
		F M	Home Away	Poor Average Good

OTHERS IN HOUSEHOLD

Name	Age	Gender	Where living?	Quality of relationship with client
		F M	Home Away	Poor Average Good
		F M	Home Away	Poor Average Good
		F M	Home Away	Poor Average Good
		F M	Home Away	Poor Average Good

SCHOOL INFORMATION

Name:	Grade:
Address:	Contact Person:
City, State, Zip Code	Homeroom Teacher:
Phone number:	

REFERRAL INFORMATION

Primary physician:	Referred by:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:

Has this child been involved in therapy before?

❑ Yes ❑ No

If yes, please describe: _____

Why is this child coming for therapy/assessment at this time? _____

_____

_____

_____

_____

How long have these concerns existed? _____

Under what conditions do the problems usually get worse? _____

_____

Under what conditions are the problems usually improved? _____

_____

FAMILY HISTORY

Is there a history or recent occurrence(s) of child abuse to this child?

❑ No ❑ Yes--verbal ❑ Yes-- physical ❑ Yes--sexual

Comments: _____

_____

Please check all medical conditions that have occurred in this child's immediate relatives (parents, grandparents, siblings, aunts, uncles, cousins). Indicate whom in the space provided. If you are unsure, put a "?".

	Birth Mother's Family	BirthFather's Family
Learning disability		
Attention Deficit Disorder		
Mental retardation		
Autism		
Pervasive Developmental Disorder		
Speech or Language Disorder		
Hearing loss/deafness		
Tourette's or Tic disorder		
Obsessive compulsive disorder		
Congenital syndrome		
Thyroid disease		
Chronic illness (e.g., asthma, diabetes,)		
Depression		
Anxiety		
Schizophrenia		
Hospitalization for psychological problem		
Alcohol dependency		
Drug dependency		
Other		

MEDICAL HISTORY

Does your child take any medications or vitamin supplements on a regular basis?

❑ No ❑ Yes – please complete the table below

Name of medication/supplement	**Dosage and how often taken?**	**For how long?**
1.		
2.		
3.		
4.		
5.		

List any major illnesses and/or operations: _____

_____

List any physical concerns occurring at present: (e.g., high blood pressure, headaches, dizziness):

_____

List any physical concerns experienced in the past (e.g., head trauma, seizures): _____

On average how many hours does the child sleep daily? _____
Does the child have trouble falling asleep at night?

- ❑ No
- ❑ Yes - for how long has this been a problem?_____

Current health status of child:

❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Don't know

DEVELOPMENTAL HISTORY

Please indicate if any of the following complications occurred during pregnancy with this child.

- ❑ Fertility medications
- ❑ Excessive vomiting
- ❑ Measles
- ❑ X-rays
- ❑ Bleeding
- ❑ Abnormal emotional stress
- ❑ Amniocentesis
- ❑ Maternal injury
- ❑ Infections
- ❑ Toxemia
- ❑ Gestational diabetes
- ❑ Preterm labor
- ❑ Anemia
- ❑ hypertension

Were any of the following used during the pregnancy? If so, please describe.

- ❑ Alcohol
- ❑ Cigarettes
- ❑ Prescribed medications
- ❑ Illegal drugs

Did any of the following complications occur **during** labor or delivery.

- ❑ Labor induced
- ❑ General anesthesia
- ❑ Fetal distress
- ❑ Prolonged labor (how many hours?)_____
- ❑ Premature/overdue delivery
- ❑ Cesarean
- ❑ Breech delivery
- ❑ Forceps delivery
- ❑ Multiple birth
- ❑ Other

How many pregnancies has the child's mother had? _____
Length of pregnancy: _____weeks
Child's birth weight: _____
Child's condition at birth:

❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Don't know

Length of hospital stay: Infant _____ Mother_____
Please check any of the following that may have occurred **after** delivery.

- ❑ Infection/fever
- ❑ Incubator
- ❑ Jaundiced
- ❑ Breathing problems
- ❑ Respirator
- ❑ Bleeding in the brain
- ❑ Difficulty sucking/breathing
- ❑ Heart problem

Please indicate which of the following concerns were noted within each age range.

CONCERN	1 TO 3 YEARS OF AGE	3 TO 5 YEARS OF AGE
Excessive temper tantrums		
Developmental delays		
Toileting problems		
Separation problems		
Recurrent ear infections		
Sleep problems		
Ear tubes inseted		
Behavior problems		
High activity level		
Short attention span		
Difficulty with transitions		
Difficulty with structured activity		
Difficulty getting along with peers		

Please fill in when the following developmental milestones took place. Please indicate age in months (e.g., 16 mo)

_____Rolled over
_____Sat alone
_____Crawled
_____Walked alone
_____Bowel trained
_____Bladder trained
_____Dry at night
_____Spoke first words
_____Spoke 2-3 words together

Please rate your child's development (as compared to others the same age) in the following areas:

	Below average	About average	Above average
Social	_____	_____	_____
Physical	_____	_____	_____
Language	_____	_____	_____
Intellectual	_____	_____	_____
Emotional	_____	_____	_____

List your child's three greatest strengths:

1) _____
2) _____
3) _____

List your child's three greatest areas of need:

1) _____
2) _____
3) _____

Has your child shown any developmental regression? If so, please describe._____

_____

Briefly describe the child's hobbies and interests: _____

_____

EDUCATION/INTERVENTION HISTORY

Please describe your child's preschool experience._____

_____

Please indicate below which of the following education programs your child has participated in.

- ❑ Early childhood special education
- ❑ Learning Disabilities programming
- ❑ Emotional/behavioral disorders programming
- ❑ Program for Other Health Impaired
- ❑ Speech/Language Therapy
- ❑ Occupational Therapy
- ❑ Physical Therapy
- ❑ Autism Services
- ❑ Friendship/Social skills group
- ❑ Tutoring
- ❑ Home schooling
- ❑ Gifted/talented programming

Does your child have an Individualized Education Plan (IEP)?

- ❑ Yes (last updated on_____)
- ❑ No

Does your child have a 504 Plan?

- ❑ Yes (last updated on_____)
- ❑ No

Has your child had a school evaluation for learning or behavior concerns?

- ❑ Yes (Year completed_____)
- ❑ No

The following questions apply only to school-age children:

Has your child ever experienced any of the following? If so, please indicate grade and reason.

- ❑ Grade retention_____
- ❑ School suspension_____
- ❑ Expelled_____

What grades does the child usually receive? _____

Have these changed lately? _____Yes ____ No If Yes, how? _____

I certify that the above information is accurate. I understand that this information will be included in my child's Clinical Record and will be used and disclosed only as described in the AGREEMENT AND INFORMED CONSENT FOR TREATMENT and the NOTICE OF PRIVACY PRACTICES.

_____	_____	_____
Name	Signature	Date