

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems.

PARENTS / GUARDIANS AND FAMILY INFORMATION:

Marital Status (circle one): Married Remarried Divorced Separated Widowed Single Cohabitants

If divorced, who has physical custody? _____ Is it full or joint? _____

Who has legal custody? _____ Is it full or joint? _____

Please provide a copy of the custody agreement.

Mother's Name: _____ Age: _____

Occupation: _____ Education Completed: _____

Health: ___ Excellent ___ Good ___ Fair ___ Poor

Father's Name: _____ Age: _____

Occupation: _____ Education Completed: _____

Health: ___ Excellent ___ Good ___ Fair ___ Poor

If married, how long have you been married? _____

If divorced, how long have the biological parents been divorced? _____

Has either parent been married before or since? Mother: _____ Father: _____

If yes, provide dates of other marriage(s), names, and ages of children from these marriages:

Mother: _____ Children and ages: _____

Father: _____ Children and ages: _____

Is there a birth parent living outside the home: (circle one) MOTHER FATHER

Where does this parent live? _____

If birth parent(s) do/does not live in the child's home, how much contact does the child have with the parent(s) not having custody, with stepsiblings, etc.?

How would you rate the quality of your present marriage?

Mother: _____Great _____Very Good _____Good _____Fair _____Poor _____Very Poor

Father: _____Great _____Very Good _____Good _____Fair _____Poor _____Very Poor

Does either parent's job require him/her to be away from home long hours or extended periods? If yes, explain:

Who supervises the child's care when not in school?

Siblings: List IN ORDER OF AGE siblings of child/adolescent for whom you are seeking services.

<u>Sibling Name</u>	<u>Age</u>	<u>School</u>	<u>Grade Placement</u>	<u>Grade Average</u>	<u>Conduct*</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

*(Please indicate good, fair, or poor conduct)

In general, how would you say the child for whom you are seeking services gets along with these siblings?

_____Great _____Very Good _____Good _____Fair _____Poor _____Very Poor

Describe: _____

Others: List any other people who currently, or in the child's lifetime, have lived in your home (other family members, caregivers, nannies, etc.).

Name	Age	Relationship to Child	Years Living in Home
_____	_____	_____	From _____ to _____
_____	_____	_____	From _____ to _____
_____	_____	_____	From _____ to _____
_____	_____	_____	From _____ to _____

Are there other relatives who have a significant impact on how this child is raised?

FAMILY STRESS LEVEL

Please rate the overall level of FAMILY stress:

____ Very Low ____ Low ____ Average ____ High ____ Very High

What is the greatest source of stress for the family at this time?

Please rate the overall level of stress in the mother's life:

____ Very Low ____ Low ____ Average ____ High ____ Very High

What are the greatest sources of stress in the mother's life?

Please rate the overall level of stress in the father's life:

____ Very Low ____ Low ____ Average ____ High ____ Very High

What are the greatest sources of stress in the father's life?

How would you rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY)

Mother: _____ Father: _____

FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorders?

<u>Yes</u>	<u>Condition</u>	<u>Family Member</u>
_____	General Developmental Delays or Cognitive Delay	_____
_____	Mental Retardation	_____
_____	Speech or Communication Disorder	_____
_____	Attention-Deficit / Hyperactivity / Impulsivity	_____
_____	Learning Problems / Disabilities	_____
_____	Autism Spectrum / Asperger's Disorder	_____
_____	Sleep disorders	_____
_____	Generalized Anxiety (across many situations)	_____
_____	Social Anxiety	_____
_____	Obsessive-Compulsive Disorder	_____
_____	Phobias	_____
_____	Depression	_____
_____	Manic-Depression / Bipolar Disorder	_____
_____	Suicide attempts / Suicide	_____
_____	Schizophrenia or other psychosis	_____
_____	Alcohol / Substance Abuse	_____
_____	Seizures or other neurological disorder	_____
_____	Genetic Disorder (e.g., Down Syndrome, Fragile X)	_____
_____	Other: _____	_____
	_____	_____

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:

DEVELOPMENTAL HISTORY

Any difficulties during the pregnancy or delivery of this child? Please list any medications, periods of bed rest, etc.

Child was born: _____ premature _____ at full term _____ late

Birth Weight _____ lbs, _____ oz

Difficulties following delivery?

Nursery (check all that apply): _____ Well-baby _____ Transitional _____ Intensive Care _____ Other

Describe your child's temperament as an infant (e.g., easy-going, irritable, passive, difficult to soothe, etc.)

Any medical problems diagnosed in infancy? _____

As an infant, did this child seem:

_____ less active than average _____ average _____ overly active

As a toddler, did this child seem:

_____ less active than average _____ average _____ overly active

As a preschooler, did this child seem:

_____ less active than average _____ average _____ overly active

As the child entered school, did this child seem:

_____ less active than average _____ average _____ overly active

At what age did your child accomplish these developmental tasks. If your child has not met one or more milestones, leave those items blank or write "not yet."

	Early	On-Time	Late	Approximate Age
Smile	_____	_____	_____	_____
Coo/babble	_____	_____	_____	_____
Roll over	_____	_____	_____	_____
Sit alone	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Stand alone	_____	_____	_____	_____
Walk alone	_____	_____	_____	_____
Say first word	_____	_____	_____	_____
Put two words together	_____	_____	_____	_____
Speak in phrases	_____	_____	_____	_____
Speak in sentences	_____	_____	_____	_____
Feed self	_____	_____	_____	_____
Toilet train (bladder)	_____	_____	_____	_____
Toilet train (bowel)	_____	_____	_____	_____
Dress self	_____	_____	_____	_____

MEDICAL HISTORY

Name of Child's Primary Physician: _____

Physician's Address: _____

Physician's Phone: _____

List any other physicians or health professionals your child sees for services on a regular basis.

When was your child last seen by a physician?

Rate your child's overall health: _____ Excellent _____ Good _____ Fair _____ Poor

Child's current height: _____ ft, _____ in. Weight: _____ lbs.

Does your child have any vision problems? _____

Date of last vision test and who performed (physician, optometrist, school) _____

Does your child have any hearing problems? _____

Date of last hearing test and who performed (physician, audiologist, school) _____

Is your child: _____ right handed _____ left handed _____ does not favor one hand

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had.

List any medications your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time.

Describe your child's regular diet (i.e, favorite and least favorite foods). Do you have any concerns about your child's eating habits (e.g., aversion to certain tastes, textures, overly restricted eating, overeating, unhealthy eating)?

What is your child's typical bedtime and wake time each day? Do you have any concerns about your child's sleeping habits?

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings?

EDUCATIONAL HISTORY

List in chronological order all schools your child has attended:

Name of School	Dates Attended	Grade Placement	Grade Average	Behavioral Conduct
1. _____	From _____ To _____	_____	_____	_____
2. _____	From _____ To _____	_____	_____	_____
3. _____	From _____ To _____	_____	_____	_____
4. _____	From _____ To _____	_____	_____	_____
5. _____	From _____ To _____	_____	_____	_____

*(Please indicate good, fair, or poor conduct)

Name of current teacher (s): _____

What concerns does your child's teacher have about him/her?

What is your child's favorite subject? _____

What is your child's least favorite subject? _____

Has your child ever repeated a grade? _____ If so, which? _____

Has your child ever skipped a grade? _____ If so, which? _____

Has your child ever had tutoring? _____ Which subjects? _____

When and with whom? _____

Has this child ever been in a Special Education Program? _____ If so, during what years? _____

How much of the school day? _____

What type of program? (LD, Gifted, EBD, ASD, etc.): _____

Child's attitude toward school: _____

Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

<input type="checkbox"/> Football	<input type="checkbox"/> Karate	<input type="checkbox"/> Dance (type): _____
<input type="checkbox"/> Baseball	<input type="checkbox"/> Piano	<input type="checkbox"/> Music (type): _____
<input type="checkbox"/> Basketball	<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Soccer	<input type="checkbox"/> Scouts	<input type="checkbox"/> Other: _____

List any special abilities, skills, strengths your child has.

CURRENT BEHAVIOR AND BEHAVIOR MANAGEMENT

Please indicate if your child is experiencing any of the following emotional or behavioral difficulties:

- School concentration difficulties
- Grades dropping or consistently low
- Hyperactive, difficulty being still
- Impulsive, doesn't think before acting
- Sadness or Depression
- Generalized Anxiety (across many situations)
- Specific fears/phobias (list): _____
- Social Anxiety
- Obsessive-Compulsive / Rigid behavior patterns
- Isolated socially from peers
- Problems making or keeping friends
- Problems with eating
- Problems falling asleep (including hyperactivity at bedtime)
- Problems sleeping through the night (middle of the night waking)
- Trouble waking up
- Fatigue/tiredness during the day
- Nightmares
- Noncompliant, purposely does not obey (not due to language or cognitive deficits)
- Oppositional, defiant behavior
- Problems controlling temper
- Tantrums / "Meltdowns"
- Problems with authority (breaking rules or laws)
- Aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)
- Self-injurious / Self-harm behavior (head banging, scratching, biting, hair pulling, cutting self)

- _____ Wetting accidents (indicate day or night wetting): _____
- _____ Soiling accidents
- _____ History of abuse (emotional, physical, sexual)
- _____ Alcohol/drug use/abuse
- _____ Vocal or motor tics (e.g, grunts, squeals, involuntary movements)
- _____ Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)
- _____ Stress from conflict between parents
- _____ Stress due to family financial problems
- _____ Legal situation (anyone in family)
- Other behavior problems: _____

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed: (circle the appropriate number)

	Very Unlikely				Very Likely
Let situation go	1	2	3	4	5
Take away a privilege (ex., no TV)	1	2	3	4	5
Assign an additional chore	1	2	3	4	5
Take away something material (ex., no dessert)	1	2	3	4	5
Send to room	1	2	3	4	5
Physical punishment	1	2	3	4	5
Reason with child	1	2	3	4	5
Ground child	1	2	3	4	5
Yell at child	1	2	3	4	5
Send to time out	1	2	3	4	5
List anything else you may do:					
_____	1	2	3	4	5
_____	1	2	3	4	5

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Then, please circle the strategy that is LEAST effective.

Please rate what percentage of discipline is handled by each of the following:

Father: _____% Mother: _____% Other: _____% (Please specify): _____

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Would like Child to do More Often	Would like Child to do Less Often
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

LEGAL HISTORY

Have you every filed or been involved in any litigation? Please explain

Is there anything else we should know about your child that was not covered by this form?



NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

Welcome to the Behavioral Institute of Atlanta (BIA). This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your doctor/therapist is considered privileged and confidential. We will not release any information without your written release. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes. The only exception to these conditions may occur in situations such as child abuse, danger to life, or workers' compensation where by law other action is permitted. Please discuss this with your doctor/therapist.

OFFICE HOURS

The office staff are typically available from 9:00 a.m. to 5:00 p.m. Monday through Friday. When the office staff are not available, please call your therapist's extension and either leave a message or contact him/her through their cell phone or pager. The first priority and our primary concern is your well being. In an emergency, please go to the nearest hospital emergency room (ER) for help with your problem, and contact us by saying "This is an emergency!"

If your doctor/therapist is out of town or unavailable for some other reason, one of our other doctors/therapists will be on-call.

SCHEDULING APPOINTMENTS

An appointment can be scheduled by either your doctor/therapist or our office staff.

APPOINTMENT LENGTH:

Individual, couples, and family therapy are billed on the basis of a 45-50 minute hour. Group therapy is based on a 90-minute session. If an appointment runs longer, you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

The first session involves assessment and usually lasts for one to one and one-half hours. Your doctor/therapist will discuss with you any further assessment or testing that they feel is appropriate and necessary. The fees for these services will also be discussed at this time.

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from someone else in need.

Therefore, except in the case of an acute emergency, we require a 24 hour notice of any cancellation; otherwise, your account will be charged for the visit. In addition, because we are unable to bill insurance for missed appointments, you will be held financially responsible for these charges. If our office is closed, leave a message on your therapist’s voice mail to inform us of your cancellation so the time may be used appropriately.

FEES:

FEES FOR PROFESSIONAL SERVICES ARE DUE AND PAYABLE AT THE TIME THEY ARE RENDERED. ALL CLIENTS ARE EXPECTED TO TAKE CARE OF THEIR FEES AS SERVICES ARE RENDERED. ANY OTHER ARRANGEMENT IS CONSIDERED A SPECIAL ARRANGEMENT AND MUST BE DISCUSSED IN ADVANCE WITH YOUR THERAPIST. DELINQUENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY.

VISA AND MASTERCARD ARE ACCEPTED:

For some therapists, collection of insurance benefits or any other arrangement regarding third party payment is the responsibility of the client (parent or guardian, if the client is a dependent child). An insurance receipt is available for your convenience in submitting your insurance claim. Additional copies can be made for you on request.

ASSESSMENT AND/OR TESTING:

Testing is billed on the basis of the type of test and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with information about the type of test and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. The written report, if requested, is generated after payment in full for testing services is received.

REPORTS:

Reports not included in assessment and/or testing fees will be billed as a separate procedure. Requests for such reports and the fees will be discussed with you in advance.

I have read and understand these policies. I acknowledge responsibility for all fees incurred.

Date: _____

Client’s Name

Signature of Responsible Party



INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to psychological services by _____.
(practitioner’s name)

This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of receiving psychological services may include obtaining a professional opinion, reduction of psychological symptoms, and an increased understanding of psychological issues. I understand that potential risks may include possible disagreement with the professional opinions offered, possible emotional distress when addressing my child’s difficulties, and limitations in the ability to make predictions based on results of psychological assessments (when applicable). I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with my services.

I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

1. where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. where the validity of a will of a former patient is contested
3. where such information is necessary for the practitioner to defend against a malpractice action brought by the client
4. where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the practitioner
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order.

I hold _____ harmless for releasing information under the above conditions.
(practitioner’s name)

Child’s Name: _____ Date of birth: _____

Parent/Guardian (print name) _____

Parent/Guardian Signature: _____ Date: _____



PERMISSION TO RELEASE AND OBTAIN INFORMATION

I do hereby authorize _____ to release and discuss the results of my child's
(practitioner's name)

____ Psychological Evaluation/Testing

____ Treatment/Therapy

with the following individuals. I give those listed below my permission to discuss and release
information regarding my child to _____.
(practitioner's name)

This release of information is valid from _____ (date) to _____ (date).

Individual	Agency	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Child's Name: _____ Date of birth: _____

Parent/Guardian (print name) _____

Parent/Guardian Signature: _____ Date: _____