Developmental Assessment and Counseling Center

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LICENSED SCHOOL PSYCHOLOGIST

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Please complete this questionnaire as thoroughly and accurately as possible prior to your child's first appointment. Comments may be added any place you feel clarification would be helpful.

Identifying Information:

Today's Date: ______________________

Child's Name: ____________________________________ **Birth date:** _________________________

Child's Home Address: ____

____

Current school: ____ **Grade:** ____________

If a College Student, email address: ____

Family History:

Father's name: ____ Age: ________

Highest level of education completed: __________ Occupation/Employer: ______________________

Home phone number: _______________________ Work/cell phone number: ____________________

Email Address: ____

Mother's name: ____ Age: ________

Highest level of education completed: __________ Occupation/Employer: ______________________

Home phone number: _______________________ Work/cell phone number: ____________________

Email Address: ____

Parents are: _____ married _____ separated _____ divorced ______ deceased _____other

If so, the child lives with (check all that apply)

_____ Mother Stepmother______ Grandparents _____
_____ Father Stepfather ______ Other______________________

Does the child have any siblings?
If yes, please complete the following:
Brother(s) ____ Age __________

____ Age __________

____ _Age __________

Sister(s) ____ Age __________

____ Age __________

____ Age __________

Source of Referral: ____

Areas of Concern: Please list the areas of concern or problems with which you want help for your child.

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Has he/she been evaluated previously? ______ **Yes** _______ **No**
If yes, please provide when, where, and why the evaluation(s) was conducted. If possible, please attach any available reports from the previous evaluation(s).

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Has he/she received any therapy/treatment outside of school (speech/language therapy, physical or occupational therapy, psychological counseling, tutoring, etc.)? _____ Yes _____ No
If yes, please explain.

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Pregnancy and Delivery History:

Length of pregnancy: ________________________________

Delivery (i.e. natural, induced, cesarean, forceps used, breech) ______________________________

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Please check and explain all complications **DURING** the pregnancy of the child to be assessed.

____ Had bleeding during pregnancy
___First 3 months ___ Second 3 months ___Last 3 months

____Had toxemia/preeclampsia. If yes, which months? ____________________________________

____ Used Alcohol. If yes, approximate number of drinks per week ___________________________

____ Smoke Cigarettes. If yes, approximate number of cigarettes per day _______________________

____ Took prescription medications. If yes, list type and duration of meds. ______________________

____ Took illegal drugs

____ Illnesses during pregnancy. If yes, describe ____

____ Other Complications. Please explain: ____

List complications *immediately following* the child's birth (ex. jaundice):

____

____

____

Developmental History

Please indicate at *approximately* what age your child first began each milestone listed below. If unable to remember the approximate date please state whether the milestone was met at an EARLY, NORMAL or DELAYED rate.

Sat alone without support ____________________________

Crawled __________________________

Walked alone (10-15 steps) ____________________________

Spoke 3 words _______________________________

Combined 2-3 words together regularly (i.e., "want milk") _________________________

Spoke clearly enough for strangers to understand ___________________________

Began toilet training ______________________

Fully bladder trained (daytime) ___________Fully bladder trained (nighttime) _____________

Fully bowel trained _________________

Able to dress self without supervision ______________________

Able to tie shoes ___________________________

Able to separate easily from caregiver ________________________________

Began to read __________________________________

Please describe your child's personality as a preschooler (ages 2-5)

During your child's first 3 years of life, were there any significant sources of stress, unhappiness, or anxiety within the family? If yes, please explain.

Health Problems

Please indicate all which apply and the approximate age(s) to the right of the condition.

Ear infections
Chronic (more than 6 per year) _________ or Occasional _________

Eye problems: Type _______________________________________
Corrective lenses ___________ or Surgery _____________________

Meningitis or Encephalitis __________________

Seizures: Type ____

Pneumonia ___________________

List any allergies: ____

____

Asthma _______________

Frequent upper respiratory infections _________________________

Bowel problems
Constipation ________________ or Diarrhea _____________

Surgery
(reasons)____

____

Hospitalization
(reasons)____

____

____

Serious injuries
(describe)____

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____

Anemia ____

Poisoning or overdoes (indicate substance)

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____

Heart problems (describe)

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____

Kidney or Urinary Problems (describe)

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____

Became ill after an immunization ______________________

Other important illnesses (specify)

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List previous and current medications and dosages

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Functional problems. Please indicate the degree of the problem by a check mark in the correct column for your child and write the age(s) during which a behavior was problematic within an approximate rage.

mild= once a week or less
moderate= several times a week
definite =daily

	Age of onset	Definite Problem	Moderate Problem	Mild Problem	Not a Problem
Feeding Difficulty.					
Colic.					
Very unpredictable appetite					
Extreme hunger.					
Constipation.					
Stomach aches.					
Difficulty keeping to a schedule (feeding or sleeping) (circle which).					
Trouble falling asleep.					
Difficult to get or keep in bed until asleep. . . .					
Very heavy sleeper.					
Very unpredictable length of sleep.					
Overactive or very restless and squirmy.					
Head banging.					
Rocking in bed.					
Difficulty in adapting to changes in routine. . . .					
Very sensitive to sounds, lights, smells, or pain (circle those that apply).					
Sudden shifts in mood (normal to very upset). .					
Very loud-whether crying or happy.					

mild= once a week or less
moderate= several times a week
definite =daily

	Age of onset	Definite Problem	Moderate Problem	Mild Problem	Not a Problem
Stiffness or rigidity.					
Looseness or floppiness.					
Shyness with strangers (whether adult or children)					
Irritability.					
Extreme reaction to noise or sudden movement ...					
Trouble getting satisfied.					
Failure to be affectionate to parents.					
Tendency to make odd sounds, grunts, or snorts (describe below).					
Tendency to twitch, jerk arm or head often. . . . . . (describe below).					
Protest/withdraws in a new situation (food, places, people, clothes).					
Temper tantrums or “fits” of temper.					
Cry often and easy.					
Difficulty in being comforted or consoled.					

Add any comments, descriptions, etc. , for clarification purposes:

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Attention, Impulsivity, and Activity Characteristics.
Please rate each with a check mark in the appropriate column. Try to compare your child with children of the same age as best you can.

	Does Not Apply	Once a Week	Several Times a Week	Several Times a Day
Can concentrate for only a short time unless things are very interesting.				
Gets tired or seems to "burned out" too easily when Expected to sustain concentration for more than 10-15 min.				
Has trouble concentrating in a large group of children.				
Is a poor listener.				
Seems to be looking around or staring a lot.				
Confused, seems to be in a fog.				
Daydreams often, seems to be in his/her own world. .				
Makes comments about unimportant or irrelevant things (for the topic being discussed at the moment).				
Is distracted by noise or sights within the building or own thought process (circle all that apply).				
Does work or performs tasks carelessly Without thinking.				
Is in a hurry to complete work or chores quickly Instead of doing them well.				
Acts before thinking, acts on impulse.				
Does not seem to plan or organize.				
Blurts out answers to questions before they have been Completed or before others can have a turn.				
Has difficulty waiting turns in games.				
Often interrupts or intrudes into other's conversations, games, etc.				
Can't keep hands or feet to himself/herself.				

	Does Not Apply	Once a Week	Several Times a Week	Several Times a Day	
Mind is overactive.					
Is restless, easily bored.					
Keeps thinking about what's ahead.					
Seems to want things right away (attention/ toys, privileges, etc); Impatient.					
Talks excessively.					
Body is in a constant motion (fidgets or up and the go).					on
Behavior is variable and hard to predict.					
Gets into trouble without really meaning to..					
Doesn't do much better after correction					
Seems to not realize when he/she is disturbing someone.					
Is able to remember minor details or trivia for periods of time..					long
Learns a new skill one day and then can't seem do it a few days later.					to
Receives very unpredictable (inconsistent) quality of work, grades, or test scores in school...					
Understands the main idea of things but misses important details.					
Needs a lot of supervision.					
Often shifts from one uncompleted activity to another. ..					
Body is underactive.					
Not getting along with teachers					
Acting like the class clown.					

	Does Not Apply	Once a Week	Several Times a Week	Several Times a Day
Difficulty getting started.				
Feels overwhelmed.				
Difficulty setting priorities.				
Procrastination.				
Difficulty getting organized.				
Slow to react.				
Perfectionist.				
Misunderstands directions.				
Hard to wake up.				
Spaces out when reading.				
Needs to reread.				
Seems out of it.				
Appears not be listening.				
Seems sleepy during the day.				
Seems to be lazy.				
Slow to understand a new concept.				
Not working to potential.				
Effort fades quickly.				
Needs reminder to work.				
Doesn't finish task.				
Repeats/restarts in writing.				

School Adjustment and Performance:

Please list all daycare centers and schools attended in chronological order. If daycare is currently used, specify the days and hours the child attends.

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Please list the subjects and grades in your child's most recent report card (or attach a photocopy). ***Photocopy all report cards for kindergarten through last year and attach (or bring in originals and they will be returned to you). Also, bring some current samples of school work, if available.***

Subject	Grade

Has your child ever repeated a grade?__ Yes ___ No

If yes, which one(s)________________________

Please list your child's favorite subject(s).

____

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____

Put a check mark in the column which best describes your child's current ability:

	Has Significant Difficulty	Has Mild Difficulty	Does Pretty Well	Excels
Figuring out new words.				
Reading fast enough.				
Understanding what he/she reads.				
Handwriting.				
Writing fast enough.				
Writing sentences or paragraphs.				
Spelling accurately.				
Learning new math skills.				
Remembering math fact.				
Remembering assignments.				
Completing homework.				
Knowing what and how to study.				
Learning new vocabulary words.				
Memorizing things for school.				

Please describe any strong academic skills and weak academic skills.

Strong: ____

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Weak: ____

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What are your child's main hobbies, interests, activities, collections, etc.?______________________

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General Behavior/Symptoms Checklist. Listed below are behaviors that many children show at one time or another during their lives. Think about your child and put a check mark in the column that you feel best describes his/her **behavior during the past six months.** If a particular behavior happened earlier, but it has not been shown in the past six months please check the past problem column and put in the age or age span when the behavior was a concern to you.

	Does Not Apply	A Past Problem	Applies a Little	Applies Often	Definitely Applies
Loses temper.					
Argues with adults.					
Defies adult rules or refuses adult requests. .					
Deliberately does things that annoy other people.					
Blames others for his/her own mistakes.					
Is touchy or easily annoyed by others.					
Is angry or resentful.					
Behaves in a spiteful or vindictive way.					
If any of the group of behaviors are present, when did these problems begin?___________ ______________________________					
Clings to adults or is too dependent.					
Is shy or timid with others.					
Has frequent nightmares.					
Seems fearful or anxious.					
Allows self to be pushed around by others.					
Worries more than his/her peers, e.g. , about death, illness, being alone.					
Is afraid of new situations or places.					
Is afraid of going to school.					

	Does Not Apply	A Past Problem	Applies a Little	Applies Often	Definitely Applies
List any other fears and rate them. . . . . ______________________________ ______________________________ ______________________________					
If any of the above group of behaviors are present, when did these problems begin?______________ ____________________________________ ____________________________________ Is in a depressed or irritable mood most of the day nearly every day.					
Shows diminished pleasure or interest in activities most of the day nearly every day.					
Seems to be fatigued or to have a loss of energy nearly every day.					
Has trouble concentrating nearly every day.					
Expresses feelings of worthlessness or excessive guilt..					
Shows an increase or decrease in appetite.					

Please list any history of learning disabilities, speech delays, emotional difficulties, ADHD or other medical conditions that your **child's extended family (parents, grandparents, aunts, uncles, cousins, etc.)** may have had.

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Signature of party responsible for child's bill:

I have read the Office Policy Statement from the Developmental Assessment and Counseling Center and agree to the specified terms and fees.

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Parent or Guardian Signature

ACKNOWLEDGEMENT OF RECEIPT OF DEVELOPMENTAL ASSESSMENT AND COUSELING CENTER'S "NOTICE OF PRIVACY PRACTICES" TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

The Federal Government has mandated that as of April 14, 2003, all health care patients are to receive from their clinicians a notice (which is hereafter referred to as "The Notice") regarding the protection of their private health care information. This keeps us, as clinicians, in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") privacy rule (45 C.F.R., Parts 160 and 164).

Your signature below acknowledges that you have received "The Notice". HIPAA covers what is call "Protected Health Information" (PHI) which is used for treatment, payment and healthcare operations. PHI is information in your health record that might identity you.

"The Notice" contains basic information about:

1. How your PHI may be used and disclosed for treatment, payment and healthcare operations (these terms are defined in "The Notice").
2. Which uses of PHI and which disclosures require authorization from you, and which do not.
3. How you may revoke an authorization that you have already made.
4. Certain rights that you may have to restrict the use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records, and to have an accounting of disclosures.
5. A list of the psychologist's duties to protect the privacy of your PHI.
6. What you can do if you have complaints about violations of your privacy rights, about decisions that your psychologist may make about access to your records.
7. Any restrictions or limitations that you or your psychologist wishes to put on the use and disclosure of your PHI.

The full Privacy Notice is several pages in length. Generally, a brief Notice is given to you on your first visit, unless there is some good reason for delay. A full copy of "The Notice" is available in the waiting room and also appears on Developmental Assessment and Counseling Center's website (www.foutzpsychologicaltesting.com). You can also ask your psychologist for a copy. Any later revision(s) of "The Notice" will be available at these same locations.

This page is documentation that you have received a copy of "The Notice", as required by the Federal Government's HIPAA legislation.

Date: ________________

Print Client's Name: ____________________ Signature: ____________________

___________________________________ Signature: ______________________
Print Name of Parent or Legal Guardian if Client is a Minor, or the Designated Personal Representative for the Client, if applicable

If you are the Personal Representative of the client, describe your role in regards to the client and/or authority by which you are signing for the client.

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**Parent Copy

Developmental Assessment and Counseling Center
NOTICE OF PRIVACY PRACTICES
"NOTICE OF DEVELOPMEMTAL ASSESSMENT AND COUNSELING CENTER PSYCHOLOGIST'S POLICIES AND PRACTICES"—SHORT VERSION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Commitment to Your Privacy

Developmental Assessment And Counseling Center's psychologists are dedicated to maintaining the privacy of your "personal health information". We are also required by law to do this. These laws are complicated, but we must provide you with important information. These pages are a short version of the full, legally required Notice of Developmental Assessment and Counseling Center's Privacy Practices, which is available at (www.foutzpsychologicaltesting.com). You may view the full Notice posted in the lobby, download it from our website, or ask your psychologist for a copy. However, we cannot cover all the possible situations nor anticipate all of your questions, so please talk to your psychologist about any questions of problems you may have.

We use your "health information", which we get from your or from others, mainly **to provide you with treatment, to arrange payment for our services**, or for some **other business operations,** which are called, in the law, health care operations. **After you read this Notice of Privacy Practices, we will ask you to sign a consent form,** in order to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any purposes other than treatment, payment, or health care operations, we discuss this with you and ask you to sign a specific authorization, allowing this disclosure.

Of course, we will keep your healthcare information private, but there are times when the laws require us to share it, such as the following conditions:

1. When there is serious threat to your health or safety, or the health and safety of another individual or the public. We will only share information with the person or organization that is able to help prevent or reduce the threat.
2. Some law suits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For worker's compensation and similar benefit programs.

There are some additional situations like these, but this is rare. They are described in the longer version of the NPP.

Your rights regarding Your Health Information:

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, but not at work to schedule or cancel an appointment. We try our best to do just as you ask us to do. You must tell us in writing using the form we will provide you, upon request.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or in the payment of your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement, except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You understand that this does not apply to your "psychotherapy notes". This distinction is covered in the longer NPP. You can get a copy of your medical records, but we may charge you for this service.
4. If you believe the information in your medical records is incorrect or incomplete, you can ask your psychologist to make some kind of changes (called "amending") to your health information. You have to make this request in writing to your psychologist and send it directly to your psychologist. You must tell your psychologist the reasons why you want to make the changes. A form is available, upon request. For this purpose.
5. You have the right to a copy of this Notice. If we change this NPP, we will post it in the lobby, as well as on our website. You can always get a copy of the NPP, by requesting it from your psychologist.
6. You have the right to file a complaint, if you believe your privacy rights have been violated. You can file a complaint with your psychologist or the Secretary of the Department of Health and Human Services. All complaints must be made in writing. Filing the complaint will not change the health care we provide to you in any way. We request that you tell us first about the problem, using the form we provide.

If you have any question regarding this Notice or our health care information privacy policies, please contact your psychologist and raise your questions directly with her.

The effective date of this Notice is November 1, 2011