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New Patient Intake Form-CHILD

_____
Today's Date

Patient Name: (Last)_____(First)_____(MI):___

Age:_____Birthdate:_____Gender: M / F

Grade:_____ School:_____

Parents/Guardian

MOTHER (Last)_____(First)_____
Home Address:_____City_____Zip _____
Place of Employment:_____ Occupation:_____
Is the mother living with the family: **Yes/No**
She is: Birthmother___, Stepmother_____, Other_
She is: Separated___, Divorced__,Remarried__,Other___
Mother's Education:_____Language(s) Spoken:_____
Any History of Behavioral, Psychological, Academic, or Legal difficulties **Yes or No** If **Yes**, Explain:
_____

FATHER (Last)_____(First)_____
Address:_____City_____Zip_____
Place of Employment:_____ Occupation:_____
Is the father living with the family: **Yes/No** He is: Birthfather__, Stepfather___, or Other__
He is: Separated__,Divorced__,Remarried__,Other_
Father's Education:_____Language(s) Spoken:_____
Any History of Behavioral, Psychological, Academic, or Legal difficulties: **Yes or No** If **Yes**, Explain:
_____
Child's Current living arrangements:_____

PHONE NUMBERS:
Mother: (Hm):_____(Wk):_____(Cell):_____

Father: (Hm):_____(Wk):_____(Cell):_____

E-Mail Addresses:_____

Other Contact Person:(Name)_____(Relation)_____(Ph)_____

Pediatrician:_____(Phone):_____

Who referred you to this office:_____

Reason for Visit:_____

List all other Children living in the home and their ages: _____

_____

List all other adult living in the home: _____

How well does the child get along with others in the household?_____

Child's Responsibilities at Home:_____

Who administers discipline?_____

What form of discipline is used? _____

Is it effective? _____ Explain: _____

Usual **Bedtime** School Nights:_____Weekends:_____

How many **Hours** of sleep usually?_____

Quality/Characteristics of Sleep? Sleeping independently? **Yes/No**

Sleep is … -**Good -Poor -Disrupted -with Nightmares -with Night Terrors**

Does child wake up easily and rested in morning? Y/N Explain:_____

Prenatal/Developmental History

Pregnancy: Normal_____ Not Normal_____ Baby's Birthweight_____

Were there any complications or difficulties with the pregnancy? _____, If "Yes"

Explain: _____

Was medication, alcohol or drugs used during the pregnancy? _____, If "Yes"

Explain: _____

Child was born: _____Full Term _____Premature _____Overdue Born at ____Weeks

Early Developmental Milestones: *Please estimate at what **ages** did your child first….*

Sit up? _____ Crawl? _____ Walk? _____ Say first words? _____
Speak in Sentences? _____ Become Toilet Trained?_____
Have there been any delays? ____ Explain:_____

Early feeding history? _____Breastfed, or _____Formula fed

Any problems with early feeding? _____ Explain:_____

*How long was child breast or bottle fed?*_____*Currently still breast or bottle fed?*_____

Early reactions to feeding? _____*Any current eating problems?*_____ *Difficulty with solid foods?*_____

Explain _____

Early Temperament: ___quiet ___colicky ___irritable __easy to console ___difficult to console

Medical/Health History

Is child in good health now?_____ If "no," Explain: _____

Date of last Physical Examination?_____ Findings? _____

Is child currently taking Medications? _____ List Type and Dose:_____

Has child ever been treated by any one of the following:

_____*Neurologist* _____*Orthopedic Surgeon* _____*Psychologist* _____*Counselor*

_____*Psychiatrist* _____*Ear, Nose, Throat Specialist* _____*Other Professional*

*Explain:*_____

Has child been Hospitalized? ____ For what reason?_____When?_____

Does child have problems with any of the following?

___Vision ___Language ___Speech ___Social Skills ___Other

___Gross Motor Skills (walking, jumping)___Fine Motor Skills (pencil grasp, Handwriting)

Explain:_____

Check conditions/illness that apply to Child and the ***age*** at which they occurred:

❑Allergies_____ ❑Anemia_____ ❑Asthma_____ ❑Diabetes____ ❑Fainting____
❑Tuberculosis____ ❑Ear Aches____ ❑Head Injury____ ❑Heart Disease____
❑Frequent Colds___ ❑High Fever____ ❑Epilepsy_____ ❑Pneumonia_____
❑Rheumatic Fever__ Coma _____ ❑Meningitis____ ❑Other_____
❑ **Anxiety Issues/excessive worry please explain**_____

Social Development

List child's interests and hobbies*:* _____

How many same-age friends does child have at School?_____ at Home?_____

Do you feel that child is happy with his/her friendship and social life?_____ Explain

_____

Describe any concerns you might have about child's social development and/or friendships: _____

_____

Any events that might have been stressful or anxiety provoking for your child (deaths, accidents, divorce, etc)?

_____

Three characteristics you like best in your child: _____

_____

Three characteristics you would like to see changed: _____

_____

Educational History

List all schools Child has attended and for which *Grade levels*: _____

_____

Has child ever had any **social or academic** problems in school? _____

Explain specific **academic** problems: _____

Explain specific **social** problems: _____

Has child ever been retained of repeated a grade? _____Which grade: _____

Reason:_____

Has child ever been **Expelled or Suspended** from School: **Yes / No** Reason ?

_____

How would you characterize your child's academic performance: (**Check all that apply**)

❑ Consistent ❑ Inconsistent ❑ Poor motivation ❑Dislikes School ❑Incomplete Work (hw/cw)

❑ Excellent (no academic problems) ❑ Good ❑ Poor ❑ Works Slowly ❑ Inattentiveness

❑Lack of Organization ❑ Poor Memory (does not retain information) ❑Poor Study Habits

Please Explain:_____

Are grades? ❒Below Average (D) ❒Average (C) ❒High Average (B) ❒Superior (A/B)

Has child ever tested (Psychological, Intellectual or Speech evaluation?)_____

Reason for Testing and by Whom_____

History of Learning Problems? **YES / NO**

If YES, What type of learning problems?_____

_____

Patient Payment Responsibility Agreement Authorizations

Patient's Name:_____Birthdate: _____

Consent to Treat

I, (name of parent/guardian)_____, hereby authorize Dr. Joseph C. Mallet, Licensed Psychologist, to provide psychological evaluation and/or treatment to my child _____ as deemed warranted following the initial consultation.

Initial Each Below:

_____I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that **payment is due at the time services are rendered** unless special arrangements have been made. Lengths of time for therapy sessions are 1.25 hour for an initial consultation and 50 minutes for follow-up sessions. The Initial Consultation rate is $225. The rate for psychological services provided is $190/hour or part thereof. Psychological testing services are billed at $225/hour.

_____In order to be flexible and responsive, I am available for phone sessions and to speak with you at times when necessary. Please be advised, however, that all calls exceeding **ten minutes** will be billed in a pro-rated fashion on the basis of your session fee.

_____I understand that charges will be added to my account for other professional services rendered. This charge will be in increments of 15 minutes and I will always discuss additional charges with you. Other professional services include extended contact via email, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

_____Because my time has been reserved exclusively for me and/or my family members, I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment late cancellation fee of $100. We may make exceptions and waive the fee, at our discretion, for emergency or unusual circumstances.

_____ Repeated missed appointments might result in termination of therapy. There may be a time when I may need to cancel your appointment for an emergency; I will make every effort to reschedule you in an appropriate time frame.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient/Parent/Guardian

Signatures:_____ / _____

Printed Names:_____ / _____

Date:_____