

Central Iowa Psychological Services

Psychological History Initial Information/Evaluation for Children and Adolescents

Please complete the following form about your child or adolescent to assist me in having the most complete information possible to best help you and your child. If certain questions do not apply, please write NA in the blank.

Child's name: _____ Date: _____ Gender: ___ F ___ M

Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client) & relationship to client: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (cell): _____ (work): _____ Ext: _____

Email: _____

Primary reason(s) for seeking services: _____

Emergency Contact Information: Name: _____ Phone #: _____

Address: _____ Spirituality/Religious Affiliation: _____

Your Child's Family History

Parents

With whom does your child live at this time? _____

Are parent's divorced or separated? _____ If yes, is there joint custody? _____

Is there any information about the parents' relationships with your child that might be beneficial in counseling? ___ Yes ___ No

If Yes, describe: _____

Client's Mother

Name: _____ Age: _____ Occupation: _____ ___ Full-Time ___ Part-Time

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ___ Yes ___ No

Does the child live with ___ Biological parent ___ Step-parent ___ Adoptive parent ___ Foster home Other: ___

Is there anything notable about your child's relationship with their mother?

___ Yes ___ No If Yes, please explain: _____

How is your child disciplined by their mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name: _____ Age: _____ Occupation: _____ ___ FT ___ PT

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? ___ Yes ___ No

Is there anything notable about your child's relationship with their father?

___ Yes ___ No If Yes, please explain: _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

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Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender		Lives		Quality of relationship with the 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
_____	_____	___ F	___ M	___ home	___ away	___ poor	___ average	___ good

Others living in the household

Relationship
(e.g., cousin, foster child)

_____	_____	___ F	___ M	_____	___ poor	___ average	___ good
_____	_____	___ F	___ M	_____	___ poor	___ average	___ good
_____	_____	___ F	___ M	_____	___ poor	___ average	___ good
_____	_____	___ F	___ M	_____	___ poor	___ average	___ good

Comments: _____

Family Health History

Have any of the following medical/emotional problems occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Attention-deficit disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cleft lip | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Migraines | _____ |

Your Child's Developmental/Medical History

Pregnancy/Birth

What was the length of pregnancy with your child: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number ___ of ___ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? Yes No If Yes, what amount: _____

Did the mother use drugs or alcohol? Yes No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)

Yes No If Yes, describe: _____

Length of labor: _____ Induced: Yes No Caesarean? Yes No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

Describe any complications for the mother or the baby after the birth: _____

Length of hospitalization: Mother: _____ Baby: _____

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Infancy/Toddlerhood Check all which apply:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Breast fed | <input type="checkbox"/> Milk allergies | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bottle fed | <input type="checkbox"/> Rashes | <input type="checkbox"/> Colic | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Not cuddly | <input type="checkbox"/> Cried often | <input type="checkbox"/> Rarely cried | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Resisted solid food | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Irritable when awakened | <input type="checkbox"/> Lethargic |

Major Developmental Milestones Please note the age at which the following behaviors took place:

- | | |
|------------------------|------------------------------|
| Sat alone: _____ | Dressed self: _____ |
| Took 1st steps: _____ | Tied shoe laces: _____ |
| Spoke words: _____ | Rode two-wheeled bike: _____ |
| Spoke sentences: _____ | Toilet trained: _____ |
| Weaned: _____ | Dry during day: _____ |
| Fed self: _____ | Dry during night: _____ |
- Compared with others in the family, child's development was: slow average fast

Have there been any issues that could have affected your child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.) Yes No If yes, please describe: _____

Medical/Physical Health: Please place a check beside all of the following medical issues your child has had.

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hives | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Influenza | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Severe colds |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Severe head injury |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Wearing glasses |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Whooping cough |

List any current health concerns: _____

List any recent health or physical changes: _____

Does your child have any vision difficulties? Yes No If yes, describe _____

Does your child have any hearing difficulties? Yes No If yes, describe _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Chemical Use History

Does your child/adolescent use or have a problem with alcohol or drugs? Yes No

If Yes, describe: _____

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Your Child's Educational History

Current school: _____ School phone number: _____
Type of school: Public Private Home schooled Other (specify): _____
Grade: _____ Teacher: _____ School Counselor: _____
In special education? Yes No If Yes, describe: _____
In gifted program? Yes No If Yes, describe: _____
Has your child ever been held back in school? Yes No If Yes, describe: _____
Which subjects does your child enjoy in school? _____
Which subjects does your child dislike in school? _____
What grades does your child usually receive in school? _____
Have there been any recent changes in your child's grades? Yes No If Yes, describe: _____
Has your child received psychological testing or testing from the AEA? Yes No
If Yes, describe: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

Anxious Passive Enthusiastic Fearful
 Eager No expression Bored Rebellious
 Other (describe): _____

Approach to School Work:

Organized Industrious Responsible Interested
 Self-directed No initiative Refuses Does only what is expected
 Sloppy Disorganized Cooperative Doesn't complete assignments
 Other (describe): _____

Performance in School (Parent's Opinion):

Satisfactory Underachiever Overachiever
 Other (describe): _____

Child's Peer Relationships

Spontaneous Follower Leader Difficulty making friends
 Makes friends easily Long-time friends Shares easily
 Other (describe): _____

Your Child's Counseling/Prior Treatment History

Has your child ever received psychological or psychiatric help or counseling of any kind before? If yes, please give details, including dates or time period of the previous counseling, the problems for which your child was seen, where and by whom they were treated, the nature of the therapy, and any other additional information that might be relevant to our work.

How would you rate this previous help? Very Somewhat Not Very Useless Harmful
 Helpful Helpful Helpful

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Behavioral/Emotional Functioning

Please check any of the following problems that are typical for your child at this time:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Aggressive/angry | <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Over active | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Over weight | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Head banging | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Phobias | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Quarrels | <input type="checkbox"/> Suicidal threats, attempt |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Irritable | <input type="checkbox"/> Sad | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Selfish | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Separation anxiety | <input type="checkbox"/> Thumbsucking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loner | <input type="checkbox"/> Sets fires | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Sexual acting out | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Moody | <input type="checkbox"/> Sick often | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Short attention span | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Often sick | <input type="checkbox"/> Shy, timid | <input type="checkbox"/> Worries excessively |

Please describe any of the above (or other) concerns: _____

How are problem behaviors generally handled? _____

Has your child/adolescent experienced death? (friends, family pets, other) Yes No

At what age? _____ If Yes, describe your child's/adolescent's reaction: _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

Yes No If Yes, describe: _____

Any additional information that would assist us in understanding current concerns or problems?

What are your goals for your child's therapy? _____

What family involvement would you like to see in the therapy? _____

PAYMENT FOR TIME AND SERVICES

PLEASE NOTE: WHILE INSURANCE OR ANOTHER PERSON MAY BE PAYING FOR ALL OR PART OF OUR CHARGES, OUR AGREEMENT IS WITH YOU RATHER THAN THE INSURANCE COMPANY. YOUR SIGNATURE BELOW INDICATES YOUR UNDERSTANDING AND WILLINGNESS TO ABIDE BY OUR OFFICE POLICIES REGARDING:

- PAYMENT OF ALL REASONABLE CHARGES INVOLVED IN THE RENDERING OF SERVICES.
- PAYMENT IS DUE AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. PLEASE NOTE WE ACCEPT MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS.
- OUR FULL SERVICE FEE IS CHARGED FOR TIME RESERVED WHEN APPOINTMENTS ARE FAILED OR CANCELLED WITHOUT SUFFICIENT NOTICE (ONE DAY.)

IF YOU BELIEVE YOUR MEDICAL INSURANCE MAY COVER THE COSTS OF ALL OR PART OF YOUR VISITS HERE, PLEASE GIVE US A COPY OF YOUR INSURANCE CARD AND COMPLETE THE FOLLOWING INFORMATION:

POLICY HOLDER	INSURANCE COMPANY OR PLAN	GROUP OR POLICY NUMBER
EMPLOYER OF POLICY HOLDER	RELATIONSHIP TO CLIENT	POLICY HOLDERS DATE OF BIRTH
POLICY HOLDERS SSN	POLICY HOLDERS ADDRESS (If different)	

While we will file your insurance claim for you, WE SUGGEST YOU CALL YOUR INSURANCE COMPANY to get information concerning your co-pay and deductible. We suggest you do this before your 1st or 2nd visit and ask them about your coverage for "out patient mental health services". This will help you to determine the appropriate payment for your counseling sessions. In lieu of this information we suggest a payment of at least 50% of the initial fee for the session. We will reimburse any excess amount once your insurance company pays us. All co-payments must be paid at the time of each session unless you make other arrangements with your therapist. Mastercard, Visa, Discover and American Express are accepted. If your plan requires a physicians referral, please contact your family doctor before treatment begins.

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION AND AGREEMENT TO PAY

I, _____ on my own behalf or as legal representative of _____
YOUR NAME (FOR ADULTS) FOR A CHILD LESS THAN 18 (OR SOME OTHERS)

authorize CENTRAL IOWA PSYCHOLOGICAL SERVICES (CIPS) and/or it's representatives to release mental health information to my insurance Company to the full extent specified under any or all Federal laws and Iowa Code Chapter 228, or as subsequently amended, to provide utilization review or quality assurance service for the administration of claims for benefits. I further authorize CIPS to directly receive all payment of benefits due.

This authorization allows (CIPS) and/or it's representatives to release information to my Insurance Company, to administrator claims submitted, or to be submitted for payment, to conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or to conduct an audit of claims paid.

I acknowledge that I am aware that I may inspect the information disclosed at any time, and may revoke this authorization at any time it I furnish written revocation to (CIPS) and/or it's representatives and thus, I agree to accept financial liability, for mental health care services provided if insurance should deny claims for benefits because of the inability to examine my mental health records or the mental health records of the person named in this authorization.

I certify that all the information is true, accurate, complete and I agree to be personally responsible for all reasonable charges not paid by my Insurance company.

DATE _____ PATIENT SIGNATURE _____