Central Iowa Psychological Services

Psychological History Initial Information/Evaluation for Children and Adolescents

Please complete the following form about your child or adolescent. If certain questions do not apply, please write NA in the blank.

Child's name:____________________ Date:____________________ Gender: ___ F ___ M ___ Other

Date of birth:____________________ Age:____________________ Grade in school:____________

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

Parent 1 Address:____________________ City: ____________ State: _____ Zip: ____________

Phone (home): ____________ (cell):____________ (work): ____________ Ext: ________

Email: ____

Which phone numbers can we leave a message on? **Home** _____Yes _____ No I **Cell** _____Yes _____ No I **Work** _____Yes _____ No

Parent 2 Address:____________________ City: ____________ State: _____ Zip: ____________

Phone (home): ____________ (cell):____________ (work): ____________ Ext: ________

Email: ____

Which phone numbers can we leave a message on? **Home** _____Yes _____ No I **Cell** _____Yes _____ No I **Work** _____Yes _____ No

Primary reason(s) for seeking services: ____

____

Emergency Contact Information: Name: ____________________ Phone #: ____________________

Address: ____________________________ Relationship to child: ____________________

Child's Living Arrangements (mark all that apply):

Are parents divorced or separated? _____Yes _____ No If yes, is there joint custody? _____Yes _____ No

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

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

If yes, describe: ____

<u>Parent 1</u>

Name: ____________________ Age: _______ Occupation: ____________ _____ Full-Time _____ Part-Time

Where employed: ____________________ Parent 1's education: ____________________

Is the child currently living with this parent? _____Yes _____ No

Is there anything notable about your child's relationship with this parent? _____Yes _____ No

If Yes, please explain: ____

How is your child disciplined by this parent? ____

For what reasons is the child disciplined by this parent?____

<u>Parent 2</u>

Name: ____________________ Age: _______ Occupation: ____________ _____ Full-Time _____ Part-Time

Where employed: ____________________ Parent 2's education: ____________________

Is the child currently living with this parent? _____Yes _____ No

Is there anything notable about your child's relationship with this parent? _____Yes _____ No

If Yes, please explain: ____

How is your child disciplined by this parent? ____

For what reasons is the child disciplined by this parent?____

If there is other parental information to note, please use the back of this page.

Client's Siblings and Others Who Live with Child/Adolescent

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

Others living in the household (including step-parents)			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: ____

Additional Demographic Information:

Family Spirituality/Religious Affiliation (if any): ________________________

Please specify your child's ethnicity (mark all that apply):

____ Asian or Pacific Islander ____Black or African-American ____Caucasian or White ____Hispanic or Latino/a Other: ______________

Family Health History

Please note any major medical and/or mental health diagnoses in the child's biological family? This includes birth parents, siblings, grandparents, aunts or uncles).

Medical or Mental Health Diagnosis:	Relationship to Client:

Your Child's Developmental/Medical History

Pregnancy/Birth

What was the length of pregnancy with your child: ____

Biological mother's age at child's birth: ______________ Biological father's age at child's birth: ____________

Child number ___ of ____ total children born to biological mother.

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: _______________

Infancy/Toddlerhood Check all which apply:

_____Breast fed	_____ Bottle fed	_____ Milk allergies	_____ Vomiting	_____Diarrhea
_____Rashes	_____Colic	_____Constipation	_____Not cuddly	_____Very cuddly
_____Rarely cried	_____Cried often	_____Good sleeper	_____Trouble sleeping	_____Irritable when awakened
_____Lethargic	_____Overactive	_____Resisted solid food	_____ Other: ______________________	

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.

_____Asthma	_____Hay fever	_____Pneumonia	_____Bronchitis	_____Heart trouble
_____Polio	_____Cerebral Palsy	_____Hepatitis	_____Multiple sclerosis	_____Chicken Pox
_____Hives	_____Scarlet Fever	_____Croup	_____Severe head injury	_____Lyme Disease
_____Seizures	_____Diabetes	_____Lead Poisoning	_____Severe colds	_____Diphtheria
_____Measles	_____ Influenza	_____Dizziness	_____Muscular Dystrophy	_____STD's
_____Ear aches	_____Mumps	_____Rheumatic Fever	_____Thyroid disorders	_____Ear infections
_____Meningitis	_____Wearing glasses	_____Nose bleeds	_____Whooping Cough	_____Other: __________

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 ______________________________

Primary Care Physician: ____________________ Clinic: ____________________ Date of last physical exam: _________________

Is your child up-do-date on all vaccinations? _____Yes _____ No

Current prescribed medications	Dose	Dates	Purpose	Side effects
____________________	________	__________	______________	______________
____________________	________	__________	______________	______________
____________________	________	__________	______________	______________

If your child is prescribed mental health medication(s) (i.e., for ADHD, anxiety, depression, etc.) please include that provider's information here, if different than PCP:

Physician/ARNP Name: ____________________ Clinic: ____________________ Date of last medication check: _________________

Chemical Use History

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

If yes, describe: ____

____

____

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, please check ______504-plan ______ IEP ______Title I Reading ______ Title I Math

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: ______________________________

Comments: ______________________________

____

Check the descriptions which specifically relate to your child:

<u>Feelings about School Work</u>:

___ Anxious ____ Passive ____ Enthusiastic ____ Fearful

___ Eager ____ No expression ____ Bored ____ Rebellious

___ Other (describe): ______________________________

<u>Approach to School Work</u>:

___ Organized ____ Industrious _____ Responsible _____ Interested

___ Self-directed ____ No initiative _____ Refuses _____ Does only what is expected

___ Sloppy ____ Disorganized _____ Cooperative _____ Doesn't complete assignments

___ Other (describe): ______________________________

<u>Performance in School (Parent's Opinion)</u>:

______ Satisfactory ______ Underachiever ______ Overachiever

______Other (describe): ______________________________

<u>Child's Peer Relationships</u>

___ 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 treatment, 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 Helpful	Somewhat Helpful	Not Very Helpful	Useless	Harmful

Behavioral/Emotional Functioning

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

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

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

____

How are problem behaviors generally handled? ____

____

Has your child/adolescent experienced trauma? (i.e., loss of loved ones, pets, etc.; physical/sexual/emotional abuse) _____Yes _____ No

At what age? _______ If Yes, describe your child's/adolescent's trauma and/or their 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, psychological testing, or medication evaluation?____________________

____

What family involvement would you like to see in the treatment? ____________________________________

____

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 "outpatient mental health services." This will help you to determine the appropriate payment for your 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 treatment provider. Mastercard, Visa, Discover and American Express are accepted. If your plan requires a physician's referral, please contact your family doctor before treatment begins.

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION AND AGREEMENT TO PAY

1, ________________________________on my own behalf or as legal representative of____

PARENT'S NAME 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/GUARDIAN SIGNATURE ____