Achieve Wellness Group, LLC
Tampa Location Address: 13039 W. Linebaugh Ave., Bldg. V, Suite 101, Tampa, FL 33626
Spring Hill Location Address: Medical Arts Building, Unit 6, 10441 Quality Drive, Spring Hill, FL 34609
Phone: 888-531-1313 Fax: 888-551-6035

CHILD/ADOLESCENT -- PATIENT REGISTRATION FORM

Patient Name: _____ SS#: _____
Last First Middle Initial

Sex: ____ Date of Birth: _____ Marital Status: _____ Race: _____ Home Telephone: _____

Street Address: _____ Email: _____

City, State, Zip Code: _____ Mobile Telephone: _____

Patient's Employer: _____ Employer's Telephone: _____

Referring Professional's Name: _____ Telephone: _____

You have my permission to contact the following people regarding my medical care and treatment:

Contact Name: _____ Relationship: _____ Telephone: _____

Contact Name: _____ Relationship: _____ Telephone: _____

Appointment confirmation and other contact from this office may be made to: ☐ Home Phone Cell Phone ☐ Work Phone Email

Responsible Party Information if Patient is a Minor &/or Patient is not the Payer of Services:

Name of Responsible Party: _____ Mobile Telephone: _____
Last First Middle Initial

Street Address: _____ Email: _____

City, State, Zip Code: _____ Home Telephone: _____

Responsible Party's Employer: _____ Business Phone: _____

Street Address, City State, Zip Code: _____

Financial Agreement and Assignment of Benefits: In consideration for services to be rendered to me, I agree to pay for these services. I authorize payment directly to **Achieve Wellness Group, LLC (hereinafter "AWG")** benefits otherwise payable to me for the treatment and understand that I am financially responsible for all charges not covered by this assignment, and assume full responsibility for their payment. Should it become necessary, I shall be responsible for any costs and attorney's fees incurred by AWG in collecting any unpaid and outstanding balances owed. The financial agreements and assignment of benefits shall include all third party carriers, federal and state agencies, worker's compensation organizations or other designated payers.

Professional time not covered by my insurance and time spent outside of the scheduled therapeutic sessions, including, but not limited to, between-session phone calls or email exchanges; consultation with other professionals; writing, and reading or reviewing documents, will be billed on a prorated basis. If my doctor is required to attend meetings outside of the office, I will pay for all time spent traveling to the location of such meetings**. I also understand that recordings of any kind are not permitted in the session.**

Consent For Treatment: Permission is given to AWG and my doctors to render psychological evaluation and treatment deemed necessary. I understand that I will be informed of the nature and purpose of the evaluation or treatment; alternative treatments; approximate length of care; and that the consent can be revoked orally or in writing prior to or during the treatment period. I have read and understand the foregoing. No guarantee has been made to me as to the results that may be obtained.

No Show Fee: Remembering the date and time of my scheduled appointment is my responsibility. Reminder calls are a courtesy and do not negate my responsibility for my sessions. **I agree to provide the office a minimum of 48 hours notice if I need to cancel/ reschedule my appointment. I understand I will be billed $75 for any appointment I fail to keep or cancel without 48 hours notice, and that insurance typically does not cover this charge.** I understand that calling after Friday 5pm does not constitute as 48 hours notice if my appointment is for the following Monday.

Confidentiality: I understand that through the course of treatment by my doctor either my family or I may be privileged to confidential information. I agree to maintain the confidentiality in regard to all patients, and will notify all family who may be involved in treatment, the necessity of maintaining this confidentiality in accordance with Florida State Statutes and Federal Regulations. These records may be protected by Federal Regulations (42 CFR Part 2) which govern alcohol/drug abuse patients.

Limitations of Services Provided: Although my doctor's responsibility may require involvement in conflicts between my family member or other persons and me, I agree that my involvement will be strictly limited to that which will benefit me therapeutically. This means, among other things, that I will treat anything that is said in session as confidential. I will not attempt to gain advantage in any legal proceeding from my involvement in psychological treatment. In particular, I agree that in any such legal proceedings, I will not ask my doctor to testify in court, whether in person, or by affidavit. I also agree to instruct my attorneys not to subpoena my doctor or to refer in any court filing to anything said or done during treatment.

_____

Patient Name (Print) Patient Signature (if unable to sign, then Legal Guardian) Date

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Patient Name: _____ DOB: _____

PRIMARY INSURANCE	SECONDARY OR SUPPLEMENT INSURANCE
Insurance Company Name:	Insurance Company Name:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Subscriber Name:	Subscriber Name:
Patient Relation to Subscriber: __Self __Spouse __Dependent __ Other _____	Patient Relation to Subscriber: __Self __Spouse __Dependent __ Other _____
Policy/Contract/Member ID#	Policy/Contract/Member ID#
Group #	Group #
Plan #	Plan #

Profession Services Assignment: To the extent that fees for professional services rendered to the patient are payable, the undersigned hereby assigns to said professionals and authorizes payment directly to said professionals all insurance benefits, including major medical, for professional services rendered to the patient. The undersigned is financially responsible to the physicians for fees not paid pursuant to this agreement.

Acknowledgment: I understand and agree that AWG, (1) may at its discretion make contact with an insurance company regarding insurance benefits, (2) does not in any way guarantee any insurance health benefits, (3) has not and does not guarantee that the professional services charges are covered by insurance.

This will authorized AWG to release general medical as well as psychiatric, alcohol, drug abuse, HIV and/or AIDS information from my health record in accordance with Florida statutes 394.459.90.503, 396.112, and/or 381.609 (3) (F) and Federal Regulations (42 CFR Part 2) to the above names insurance companies if necessary for the payment of insurance claims.

A general medical authorization and subpoena duces tecum without a specific authorization to release psychiatric, alcohol, drug abuse, HIV and/or AIDS information must have this waiver from the patient or his/her empowered representative.

I understand that I have the right to refuse this authorization. If I approve, the facility named above is released from all legal liability that may arise from the release of the information requested.

Prohibition and redisclosure: This information has been disclosed from records whose confidentiality is protected by State/Federal law. State/Federal law prohibits any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by State/Federal law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it.

_____ _____
Patient's Signature Date

_____ _____
Empowered Representative Signature (If patient is minor or unable to sign) / Guarantor or policy holder Date

_____ _____
Witness Signature Date

Achieve Wellness Group, LLC

PATIENT ACKNOWLEDGEMENT

Please initial each section.

_____ Remembering the date and time of my scheduled appointment is my responsibility. Reminder calls are a courtesy and do not negate my responsibility for my sessions. I agree to provide the office a minimum of 48 hours notice if I need to cancel/reschedule my appointment.

_____ This office does it best to stay on schedule. As such, we do not overbook appointments. Scheduling an appointment fills a slot on the doctor's schedule. Missing appointments or arriving late not only disrupts the flow of the schedule, but also is not fair to other scheduled patients or to those who may need to be seen on an urgent basis. I understand that if I am late for my appointment, my appointment may need to be rescheduled and/or I may be charged a late cancellation fee of $75.00.

_____ I understand I will be billed a late cancellation/no show fee of $75.00 for any appointment I fail to keep or cancel without 48 hours notice. I understand that calling on Friday does not constitute as 48 hours notice if my appointment is for the following Monday. I give my permission to keep my credit card information on file and I understand my card will be billed in the event of the aforementioned.

_____ My portion of payment for services is due at the time services are rendered in the form of cash or check. If for any reason I do not bring payment at the time services are rendered, I give permission for my credit card to be billed.

Type of Card: ☐ Visa, ☐ MasterCard, ☐ Discover, ☐ Medical Flex/Savings

Credit Card Number _____ - _____ - _____ - _____,

CVV Number _____ (A 3-digit number in reverse italics on the **back** of the credit card)

Expiration Date _____

Credit Card Billing Address Zip Code _____

Charges will appear on the credit card statement as Achieve Wellness Group or some abbreviated form of it.

My signature below and initials above indicate that I have read and understand and I agree to comply with all the above.

_____

Signature of Responsible Party **Date**

_____

Printed Name of Responsible Party **Date**

Achieve Wellness Group, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Version of Notice of Privacy Practices Provided 9/16/13

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how my health information may be used and/or disclosed, and how I may obtain access to this information.

_____ _____

Signature of Patient or Authorized Personal Representative Date

_____ _____

Printed Name of Patient or Representative Relationship (e.g., parent, legal guardian, etc.)

For Office Use Only - Do Not Write Below This Line

_____

DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The patient presented for his/her service on this date and was provided a copy of the Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgment of receipt of the Notice. However, an acknowledgement of receipt was not obtained because of the following reasons:

- Patient refused to sign Acknowledgement of Receipt
- Patient was unable to sign or initial the Acknowledgment of Receipt

_____ _____

Signature of employee completing the form Date

_____

Printed name of employee

Achieve Wellness Group, LLC

NOTICE OF PRIVACY PRACTICES

Effective Date: September 16, 2013

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

MY OBLIGATIONS:

I am required by law to:

- **Maintain the privacy of protected health information (PHI).**
- **Give you notice of my legal duties and privacy practices regarding health information about you.**
- **Follow the terms of the notice that is currently in effect.**

HOW I MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI): The following categories describe the more common or routine ways I can use or disclose information.

TREATMENT: I may use and disclose your PHI for coordination of treatment with other health providers, e.g., other psychologists, physicians, nurses, medical residents or trainees, or other health care personnel treating you.

PAYMENT: I may use and disclose PHI so that others or I may bill and receive payment from you, an insurance company, or a third party for the treatment and services you have received from me.

HEALTH CARE OPERATIONS: I may use and disclose PHI for health care operation purposes. These uses and disclosures are necessary to make sure that all my patients receive quality care, to operate and manage the office, and to evaluate the performance of my staff in caring for you. I may also share information about you to other entities that have a relationship with you (e.g., your health plan) for their health care operations activities.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, BENEFITS AND SERVICES: I may use and disclose PHI to contact you and remind you of your appointment. I may also use and disclose information to tell you about treatment alternatives, or health related-benefits and services that may be of interest to you.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE: When appropriate, I may share PHI with a person who is involved in your medical care or payment for you, such as family or close friend. I may also notify your family about your location or general condition or disclose such information to an entity (e.g., The Red Cross) assisting in a disaster relief effort.

RESEARCH: Under certain circumstances, I may use and disclose PHI for research, e.g., in a comparison of one treatment with another. Before I use or disclose PHI for research, the project will go through a special review process. In certain cases, your written authorization may be required. Your information may be used in a way that does not specifically identify you. Finally, the law allows me to use very limited information about you for research and public health studies and to give other health care providers and health researchers access for their own research and operations, but only if they pledge to never use the information to identify you.

SPECIAL SITUATIONS: As required by law, I disclose PHI when required to do so by international, federal, state, or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: I may use and disclose PHI to prevent serious threat to your health and safety, or the health and safety of the public or another person. For example, this might include suicidal or homicidal risk. Disclosures, however, will only be made to someone who may be able to help prevent the threat.

ORGAN AND TISSUE DONATION: If you are an organ donor or eligible recipient, I may disclose PHI to medical personnel or to an organization that handles such issues, as necessary, to facilitate organ, eye, or tissue donation or transplantation.

MILITARY AND VETERANS: If you are a member of the armed forces, I may release PHI as required by military command authorities. I may also disclose PHI about foreign military personnel to the appropriate foreign military authority.

WORKERS' COMPENSATION: I may release your PHI for workers' compensation or similar programs. These programs provide benefits for the work-related injuries or illnesses.

BUSINESS ASSOCIATES: I may disclose PHI to my business associates that perform functions on my behalf or provide me with services if the information is necessary for such functions and services. For example, I may use a company or individual to perform billing or transcription services on my behalf. All of my business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

PUBLIC HEALTH RISKS: I may disclose PHI to authorized public health officials, or a foreign government agency collaborating with such officials, so that they may carry out their public health activities, generally, to prevent or control disease, injury, or disability, report births or deaths, report child abuse or neglect, report reactions to medications or problems with product, inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, and report to the appropriate government authority if I believe someone has been the victim of abuse, neglect, or domestic violence. I will only make this disclosure if you agree or when required by law.

HEALTH OVERSIGHT, LICENSING, ACCREDITATION, AND REGULATORY ACITIVITIES: I may disclose your PHI to health oversight agencies authorized to conduct audits, investigations, and inspections of the facilities. These activities are necessary for the government to monitor the health care system, government programs (e.g., Medicare) and compliance with civil rights laws.

LAWSUITS AND DISPUTES: If you are involved in a lawsuit or legal dispute, I may disclose PHI in response to a court or administrative order. Mental health information is not typically disclosed in response to subpoena, discovery request, or other lawful process by someone else involved in the dispute. If necessary to do so, all efforts will be made to notify you about the request and obtain your permission or to obtain an order protecting the information requested.

LAW ENFORCEMENT: I may disclose your PHI to law enforcement officials if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime, even if, under very limited circumstances, I am unable to obtain the person's agreement; 4) about a death I may believe may be the result of criminal conduct; about criminal conduct on the premises; 6) in an emergency to report a crime, the location of a crime victim or the identity, description, or location of a person who committed a crime.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIEDS OR PROTECTIVE SERVICES FOR THE PRESIDENT OR OTHERS: I may release PHI to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President of the United States or other officials.

INMATES OR INDIVIDUALS IN CUSTODY: If you are an inmate in a correctional institution or in the custody of a law enforcement official, I may disclose PHI to the correctional institution or law enforcement official.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS: In the unfortunate event or your death, I may release PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. I may also disclose PHI to funeral directors as necessary to carry out their duties.

SPECIAL PROTECTION FOR MENTAL HEALTH, SUBSTANCE ABUSE, AND HIV INFORMATION: Special privacy protection applies to mental health, substance abuse, or AIDS/HIV related information. Since your records at my facility contain such information, this information will be handled and disclosed only as permitted by law.

I WILL ALSO OBTAIN AN AUTHORIZATION FROM YOU BEFORE USING OR DISCLOSING: (a) protected health information (PHI) that is not described in this notice; and (b) psychotherapy notes.

YOUR RIGHTS: You have the following rights regarding health information I have about you:
RIGHT TO INSPECT AND COPY: You have the right to receive a copy of a summary of your PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, but not necessarily copies of psychotherapy notes. To request a summary of your health information, you must make a request in writing. I may charge a fee for this service. See below.

RIGHT TO AMEND: If you feel that the PHI is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information to be amended was created by me, is inaccurate, and the amendment and health information remains in my office. The request must be in writing and state the reason for the request. See below.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request a list of certain disclosures I have made of your PHI for purposes other than treatment, payment, and health care operations, or for which you provided written authorization. To request an accounting of disclosures, you must make your request in writing. See below.

RIGHT TO REQUEST RESTRICTIONS: Although there are already restrictions on mental health information, you have the right to request restrictions or limitations on your PHI that I use for disclosure for treatment, payment, health care operations, as well as to family members. I are not required to agree to your restrictions and, in some cases, your request may not be permitted by law. Requests for restrictions must be specific and in writing. See below.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION: You have the right to request that I communicate with you in a confidential manner, e.g., if you do not want messages left at home or work, or have a specific way to reach you. I will do my best to accommodate reasonable requests in attempting to reach you, but must have a way to contact you in emergencies. To request confidential communication as indicated, you must clearly and specifically request it in writing. See below.

RIGHT TO RESTRICT DISCLOSURES WHEN YOU HAVE PAID FOR YOUR CARE OUT-OF-POCKET: You have the right to restrict disclosures of your PHI to a health plan when you pay out-out-pocket in full for my services.

RIGHT TO BE NOTIFIED IF THERE IS A BREACH OF YOUR UNSECURED PROTECTED HEALTH INFORMATION: You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

CHANGES TO THIS NOTICE: I reserve the right to change this notice and make the new notice apply to health information I already have as well as any information I receive in the future. I will post a copy of this notice at my office. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe that your privacy rights have been violated, you may file a complaint with my office or the Department of Health and Human Services. All complaints must be in writing. You will not be penalized for making a complaint. To make a complaint, please contact: Privacy Officer: Lisa I. Correa, Psy.D., M.B.A., 13039 W. Linebaugh Ave., Bldg. V, Suite 101, Tampa, FL 33626, Phone: 888-531-1313, Fax: 888-551-6035.

ACHIEVE WELLNESS GROUP, LLC

Patient Questionnaire

Date: _____ Patient Name: _____ DOB: _____ Age: _____

Name of person completing this form and relationship to child: _____

Presenting Problem:

Describe the problem(s) your child is having and when they began: _____

_____

_____

Rate the severity of your concerns (with 1 being minimal and 10 being very severe): _____

What seems to make the problem better: _____

_____

What seems to make the problem worse: _____

_____

If applicable, describe what you have done to try to improve this problem: _____

_____

Previous Mental Health Treatment, Provider, and Date Range:

_____

_____

_____

Medical History:

Sex: □ M □ F Height: _____ Weight: _____

Name and phone number of your child's Primary Care Physician: _____

Date of last physical: _____ Date of last visit: _____

Are your child's immunizations up to date? Yes No

Pregnancy and Birth History:

Pregnancy was ___ planned or ___ unplanned. Was it full term? Yes No

How did the mother feel about the pregnancy? _____

How did the father feel about the pregnancy? _____

Were any drugs, alcohol, or medications used during the pregnancy? Yes No

If yes, please describe: _____

Describe any problems with the pregnancy: _____

Describe any problems with the birth: _____

Developmental History:

Was the baby ___ breast fed, ___ bottle fed, or ___ both?

Who was the primary caregiver for the child? _____

Estimate months of age when the child first:

Smiled: _____ Ran: _____

Sat up on own: _____ Said first words: _____

Stood: _____ Said phrases: _____

Crawled: _____ Fed self: _____

Walked: _____ Toilet Trained: _____

Describe any illnesses, behavioral difficulties, or discipline problems during early childhood: _____

_____

_____

If the child had temper tantrums, please describe when, how often, and about what: _____

_____

_____

Describe discipline techniques used and consistency of parental discipline: _____

_____

_____

List current prescribed and over-the-counter medications:

Medication	Dosage	Date Started	Condition Prescribed for	Prescribing Doctor

Does your child have any drug allergies? Yes No If yes, please describe: _____

_____

Is your child taking any supplements (e.g., vitamins & minerals)? □ Yes □ No If yes, please list: _____

_____

How often does your child exercise: weekly (_____ days / week) monthly (_____ days / month) occasionally rarely never

Does your child have any physical limitations? □ Yes □ No If yes, please explain: _____

_____

Is your child sexually active? Yes □ No □ N/A Is your child using contraception? □ Yes □ No □ N/A

Is your child your pregnant? Yes □ No □ N/A

Does your child have a history of any of the following?				**Is your child under a doctor's care for this problem?**	
Diseases	**Yes**	**No**	**Describe, including age of onset**	**Yes (write name of doctor)**	**No**
Depression					
Anxiety					
Memory Problems					
Substance Abuse					
Psychiatric Hospitalization					
Legal Problems					
Suicide Attempt					
Arthritis					
Chronic Pain					
Migraines					
Headaches					
High Blood Pressure					
Stroke					
Asthma					
Cancer					
Diabetes					
Hypoglycemia					
Emphysema					
Glaucoma					
High fevers					
Head Injury w/ loss of consciousness					

Head Injury without loss of consciousness					
Heart disease					
Heart Attack					
Hypertension					
Hepatitis					
HIV					
Seizures					
Meningitis					
Kidney Disease					
Liver Disease					
Lung Disease					
Thyroid Disease					
Tuberculosis (TB)					
Sexually Transmitted Disease					

Have your child experienced any of the following symptoms within the past 12 months?				**Is your child currently under a doctor's care for this problem?**	
Symptoms	**Yes**	**No**	**Describe**	**Yes (write name of doctor)**	**No**
Allergies					
Bladder problems or Enuresis					
Bronchitis					
Change in hearing					
Chest Pain					
Cough					
Dizziness					
Edema (swelling)					
Encopresis					
Fainting spells					
Gastrointestinal problems					
Chronic or severe headaches					
Light headedness					
Numbness (location)					
Seizures					
Shortness of breath					
Tingling (location)					
Weakness (location)					
Significant weight gain or loss					
Other:					

List hospitalizations and surgeries:

Year: _____ Location: _____ Nature of Illness: _____

Year: _____ Location: _____ Nature of Illness: _____

Year: _____ Location: _____ Nature of Illness: _____

Year: _____ Location: _____ Nature of Illness: _____

Year: _____ Location: _____ Nature of Illness: _____

Check all that are problems for your child:

Sleeping too much___
Difficulty falling asleep___
Difficulty staying asleep___
Waking up too early & cannot fall back asleep___

Excessive appetite___
Loss of appetite___
Low energy___
Excessive energy/agitated/restlessness___

Feeling anxious or uptight___
Being afraid of things___
Not being able to stop worrying___
Not being able to relax___
Racing thoughts___
Panic attacks___

Having been traumatized___
Having nightmares___
Having flashbacks___
Avoiding people, places, or things___
Feeling constantly on guard or vigilant___

Depressed or low mood___
Sadness/Tearfulness___
Feeling empty inside___
Irritable or angry mood___
Loss of interest or pleasure___
Excessive or inappropriate guilt___
Apathetic___
Death thoughts___

Feeling helpless or hopeless___
Feeling worthless or being self-critical___
Indecisiveness___
Difficulty concentrating or thinking clearly___
Memory problems___
Withdrawal___
Low motivation___
Suicidal thoughts___

Aggression or anger outbursts___
Impulsivity___
Mood Swings___

Hallucinations___
Elevated mood___
Self harm (i.e., cutting) ____

Not getting along with others___
Acting rude or overbearing___
Being suspicious of others___
Being shy___
Being uncomfortable when talking to people___
Being bullied___

Bullying others___
Not fitting in with peers___
Feeling like people are against me___
Feeling lonely___
Feeling uncomfortable in social settings___

Being overweight___
Having physical handicap___
Being noticed for physical appearance___

Feeling unattractive ___
Other problem with appearance: _____

Refusal to go to school___
Difficulty following school rules___
Receiving detentions at school___
Being afraid of failing at academics___
Feels like teacher being critical or unfair___
Difficulty completing work___

Refusal to do homework___
Not turning in completed assignments___
Being suspended from school ___
Being bored at school___
Homework is taking excessive amount of time to complete___
Failing exams___

Misbehaving___
Argumentative___
Difficulty following rules in general___
Stealing___
Manipulating others___

Destroying property___
Lighting fires___
Cruel to animals___
Lying___
Unusual sexual behavior___

Computer / gaming addiction___

Sexual addiction___

Child consuming caffeine____. If yes, amount of daily consumption: _____

Child using tobacco___. If yes, age of first use:____
Frequency of use: weekly (__ days / week) monthly (___days / month) occasionally rarely past use only

Child drinking alcohol___. If yes, age of first use: ____ □
Frequency of use: weekly (__ days / week) □ monthly (___days / month) □ occasionally □ rarely past use only

Child using illicit drugs___. If yes, age of first use: ____ □
Frequency of use: weekly (__ days / week) □ monthly (___days / month) □ occasionally □ rarely past use only

Any odd or unusual habits: _____

Any habits that bother other people: _____

Educational History:
Indicate grade your child attends: _____. Name of school: _____
What kind of student is your child? _____
List any special educational services your child receives: _____
_____
_____
How does your child get along with teachers and peers: _____
List any discipline problems your child has in school: _____
_____
What your child's strengths: _____
_____
What are the areas that most need to be developed and strengthened: _____
_____

Social History:
Place of birth: _____ Where did your child grow up? _____
If your child is adopted, at what age? _____
If your family moved around, please describe: _____
_____
Please list all members of the household, age, and relationship to child: _____
_____
_____
Which family member(s) is the child close to? _____
List any trauma your child may have suffered (physical, sexual, emotional): _____
_____
_____
Describe the child's relationship with the father: _____
Describe the child's relationship with the mother: _____
Describe any significant conflicts the child has with family members: _____
_____
Whom does the child rely on for emotional support? _____
Describe any losses, changes, or transitions that have occurred in the child's life: _____
_____
_____
Describe spiritual, cultural, and/or religious beliefs have influenced the child: _____
_____

Relationship History:
How does the child make and maintain friends? _____
How does your child get along with others? _____

Family History:
Ethnicity: _____ Religion: _____

Marital status of child's primary caregiver: □Married □Separated □Divorced □Widowed □Single □Domestic Partner

Familial problems and stressors:
Violence in the household___
Arguing in the household___
Parental discord___
Parental disagreement on how to raise children___
Recent major loss or change (i.e,, parent job, home) ___
Death or loss of loved one___
Recent move to new home or school ___
Financial difficulties___
Other family member having medical problems___
Other family member having emotional problems___
Other family member having problems with drugs/alcohol___
Lack of time spent together as a family___
Other: _____
_____

Are there family members with any of the following problems (indicate relation, i.e. brother):

□ Depression: _____ □ Psychiatric Hospitalization: _____

□ Anxiety: _____ □ Legal Problems: _____

□ Substance Abuse: _____ □ Suicide Attempt/Completion: _____

□ High Blood Pressure: _____ □ Thyroid Problem:_____ _____

□ Diabetes: _____ □ Liver Problem: _____

□ Stroke: _____ □ Kidney Disease: _____

□ Heart Attack: _____ □ Alzheimer's: _____ _____

□ Cancer (Type): _____

Legal History:
Have you been court ordered to bring your child in for psychological treatment? Yes No
List any current involvement you or your child has with the criminal or civil legal system: _____
_____
List any past involvement you or your child has with the criminal or civil legal system: _____
_____

Anything you would like to add which you have not already:
_____
_____
_____

_____ _____
Signature of Patient or Authorized Personal Representative Date