SPENCER H. GELERNTER, PH.D.& ASSOCIATES
CHILD . ADULT . FAMILY . COUPLES

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CHILD INFORMATION FORM

Date: _____ Referred by: _____

Child's name: _____ Home Phone: (____)_____
Street: _____ Date of Birth: _____ Age: _____
City: _____ State: _____ Zip: _____ Religion: _____
School: _____ Grade: _____ Teacher: _____
E-mail Address_____ E-mail Address_____
(Mother) (Father)

List schools child previously attended and dates:

School	City	Grade Level	Dates

Mother's Name: _____ Religion: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Phone: (___)_____ Work Phone: (___)_____Cellular (___)_____
Level of Education: _____ Profession: _____
Mother's Employer: _____ Social Security # _____

Father's Name: _____ Religion: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Phone: (___)_____ Work Phone: (___)_____Cellular (___)_____
Level of Education: _____ Profession: _____
Father's Employer: _____ Social Security # _____

Stepfather's Name: _____
Step-siblings' Names, Ages, Grades Enrolled:
_____
_____
_____
_____
_____

Stepmother's Name: _____
Step-siblings, Names, Ages, Grades Enrolled:
_____
_____
_____
_____
_____

Child currently lives with: Percent of Time:
_____ Mother and Father _____ Other: _____
_____ Mother without Father _____ _____
_____ Father without Mother _____

Child is in legal custody of: Percent of Time:
_____ Mother and Father _____ Other: _____
_____ Mother without Father _____ _____
_____ Father without Mother _____

This is Father's _____ marriage. This is Mother's _____ marriage.
Father has_____children from a previous relationship. Ages: _____
Mother has _____children from a previous relationship. Ages: _____

FAMIY MEMBERS
Please list all family members, including parent(s) and siblings.

NAME	BIRTHDATE	AGE	RELATIONSHIP TO CHILD	HIGHEST GRADE COMPLETED	IN/OUT OF HOME

Nearest relative not living with you:
Name: _____ Phone Number: (____)_____

HELPFUL ADDITIONAL INFORMATION:

(1) A photograph of your family for our files. (We can make a copy).
(2) A report of previous medical or psychological evaluations of your child.
(3) Report cards and notes with a teacher's observations or comments about your child.

REASONS FOR REFFERAL:

Parent Concerns: List all concerns with those of greatest importance first:

_____
_____
_____
_____
_____
_____
_____

Attempted Solutions:

_____
_____
_____
_____
_____
_____
_____
_____

Teacher Concerns: List all concerns with those of greatest importance first:

_____
_____
_____
_____
_____

Attempted Solutions:

_____
_____
_____
_____
_____

Compared to others his/her age, how well does your child:

	Worse	About Average	Better
Gets along with his/her brothers & sisters?	_____	_____	_____
Get along with other kids?	_____	_____	_____
Behave with his/her parent?	_____	_____	_____
Play and work alone?	_____	_____	_____

ADHD
- ☐ hyperactive
- ☐ impulsive
- ☐ under achievement
- ☐ non-compliant
- ☐ inattentive
- ☐ poor concentration
- ☐ disorganized
- ☐ self-control

Depression
- ☐ sad
- ☐ sleep problems
- ☐ negative thinking
- ☐ poor concentration
- ☐ hopeless/worthless
- ☐ mood swings
- ☐ guilt
- ☐ fatigue/lethargy

Anxiety
- ☐ excessive worry
- ☐ panic attacks
- ☐ irrational fear
- ☐ obsessions
- ☐ social isolation
- ☐ phobias
- ☐ compulsive
- ☐ shyness

Relationship
- ☐ too clingy/dependent on adults
- ☐ too attention seeking
- ☐ bullying/teasing
- ☐ difficulty with friends
- ☐ work/school problems
- ☐ personal growth
- ☐ grief/loss
- ☐ sexual behavior

Anger
- ☐ short-fused
- ☐ temper tantrums
- ☐ impulse control
- ☐ violent/assaultive
- ☐ runaway risk
- ☐ fighting
- ☐ irritable
- ☐ oppositional
- ☐ refuses to go to bed

Addictions
- ☐ alcohol
- ☐ drugs
- ☐ gambling
- ☐ relationships/sex
- ☐ eating disorders
- ☐ cyber/internet
- ☐ stealing
- ☐ tobacco

Abuse
- ☐ physical
- ☐ emotional
- ☐ domestic violence
- ☐ rape
- ☐ sexual
- ☐ dissociative

Other
- ☐ agitated
- ☐ mania
- ☐ paranoia
- ☐ delusions
- ☐ tics/Tourettes
- ☐ cutting behavior
- ☐ appetite changes
- ☐ nightmares/flashbacks
- ☐ adjustment to parents divorce
- ☐ bed wetting
- ☐ acts too young for his/her age

INSURANCE

Remember we do not file insurance:
Primary Insurance Company: _____ Effective Date: _____
Policy Holder: _____ Birthdate: _____
Relationship to patient: _____ Patient Birthdate: _____
Policy Holder's Social Security or Policy No: _____ Group No: _____
Claims Telephone No: _____ Claims Address: _____

FAMILY STRESSORS:

On a 1 – 10 Scale (poor-great) please answer the following questions.

	Mother	Father
How would you rate your marriage?	_____	_____
How would you rate your job?	_____	_____
How would you rate your school?	_____	_____
How would you rate your support network	_____	_____

What are your routine work hours?

Husband_____ Wife _____

Who takes care of the child(ren) when he/she is not in school? _____

_____

_____

Are any children living in the household adopted? If so, at what age were they adopted and how long ago?

_____

Have there been any deaths in the immediate family? If so, whom, relationship to child, and when?

_____

_____

Has any relative attempted or committed suicide? _____

_____

Please list the family's greatest sources of stress and concerns:

_____

_____

_____

_____

PSYCHOTHERAPY:

Please name child or family's previous therapist(s), location and approximate dates seen:

_____

_____

_____

PSYCHOLOGICAL TESTING:

Please name previous person or agency testing child, the location, dates:

_____

_____

_____

MEDICATIONS:

Is your child or anyone in your family currently on medication (for other than minor, brief illnesses)? If so, please name the person, list medication, dosage, and how often it is taken.

_____

_____

_____

_____

HEALTH CONCERNS:

Please list any major health problems of any member(s) of your family:

_____
_____
_____
_____

EDUCATIONAL CONCERNS:

Please list any major educational problems experienced by any family member (parents and siblings), including Attention Deficit Disorder and Learning Disability.

_____
_____
_____

ADDICTION CONCERNS:

Does your child, or any other family member, have/or had a problem with addictions
(e.g.. alcohol, drugs, prescription medicine, gambling or sexual?) No ____ Yes ___
If yes, please describe _____
_____
_____

Please tell us anything you think might be important for us to know about your child, your family, or any exceptional circumstances that might directly or indirectly affect your child.

_____
_____
_____
_____
_____
_____

This form was completed by: _____ *Date* _____

PERMISSION TO TREAT:

I am legally authorized as the ( ) parent ( ) guardian of _____ to enroll him/her in Psychological services. I hereby authorize clinicians/physicians at Spencer H. Gelernter, Ph.D. and Associates to provide Psychological/Medical treatment and/or evaluation for_____.

Signature: _____ *Date:* _____

APPOINTMENT POLICY:

I understand that when an appointment is scheduled for me, a specific period of time is set-aside just for me. If I am late, my session cannot be extended beyond the time reserved for me, because it would infringe on the next patient's appointment time. I understand that I will be charged the full amount.

I understand that I am responsible for providing at least a 24-hour notice to cancel an appointment. I understand that I will be responsible for paying fully for all missed appointments not canceled at least 24 hours in advance.

Signature: _____ *Date:* _____

PAYMENT POLICIES:

I understand that I am fully responsible for payment on my (or my child's) account. I agree to pay fully for all services at the conclusion of each session. I understand that I will file for insurance benefits and any reimbursement by my insurance company is a negotiation between my insurance representative and myself.

Signature: _____ *Date:* _____

Authorizations and Consent to Treat: Client Rights and Responsibilities

A Person Receiving Services is entitled to:

1. Mental Health/Chemical Dependency services in accordance with standards of professional practice appropriate to his/her needs and designed to give him/her a reasonable opportunity to improve his/her condition.
2. Humane care, protection from harm, and to be treated with dignity and respect.
3. The right to participate in the development and review of his/her treatment plan, including the known effects of receiving and not receiving such treatment, or alternative treatment, if any.
4. The right to receive treatment in the least restrictive settings
5. The right to review his/her own record in the presence of the primary therapist, unless the primary therapist's professional judgment deems this to be potentially detrimental to the person.
6. The right to confidential maintenance of all his/her identifying treatment information; no disclosure of such information without his/her written authorization, except in cases of medical emergency, by court order, or when otherwise dictated by law.
7. The right to register complaints and to have his/her complaints heard and action taken, if required, promptly
8. The right to waive any of his/her rights, if the waiver is given voluntarily, knowingly, and in a competent state of mind. The waiver may be withdrawn at any time.

Consumer Consent for Use/Disclosure of Health Care Information

I understand that the consumer's health information is private and confidential. I understand that the therapist/physician works very hard to protect the consumer's privacy and preserve the confidentiality of the consumer's personal health information. I understand that therapist/physician may use and disclose the consumer's personal health information to help provide health care to the consumer, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Examples would be if a consumer threatened to hurt someone or if child abuse is reported.

The therapist/physician has a detailed document called the "Notice of Privacy Practices", that is available for me to read. It contains more information about the policies and practices protecting the consumer's privacy. I understand that I have the right to read the "Notice" before signing this agreement. The therapist/physician may update this "Notice of Privacy Practices". If I ask, he will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask the therapist/physician to limit how the consumer's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that the therapist/physician does not have to agree to my request. If the therapist/physician does agree to my request, I understand that therapist/physician would follow the agreed limits. Requests must be made in writing and therapist/physician will provide a form for this purpose by request at any office.

I may cancel this consent in writing at any time by doing one of the following:

● Signing and dating a form that the therapist/physician can give me called "Revocation of Consent for Use and Disclosure of Health Care Information".

● Writing, signing, and dating a letter to the therapist/physician. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the consumer's personal health information for treatment, payment, and health care operations. If I revoke this consent, the therapist/physician does not have to provide any further health care services to the consumer or may require that the consumer pay directly for any service rendered.

My signature below indicates that I have been given the chance to review a current copy of the therapist/physician's "Notice of Privacy Practices". My signature means that I agree to allow the therapist/physician to use and disclose the consumer's personal health information to carry out treatment, payment, and health care operations

If my insurance company contacts Spencer H. Gelernter, Ph.D. & Associates

Do not release any information.	*yes*	*no*
Release only dates of appointments, clinicians' names and diagnostic code	*yes*	*no*
Release any information requested by my insurance company	*yes*	*no*

Signature of Consumer/Legal Representative: _____ *Date:* _____

Medication History for: _____ (Name of Child/Teen)

Please tell us about **ALL** drugs/medications your child/teen takes. **Include** "over-the-counter" medications (aspirin, antihistamines, cough syrup, vitamins, etc.) and homeopathic/herbal products.

Medication Name (brand or generic?)	Doctor's Name, Medical Specialty	Date Started	Condition for which medication is taken	Dose each time	Times per day	Time(s) of day taken?	Side effects?	Is the medication working?

1. Does your child/teen have any nutritional/recreational practices that could impact the medicine's effectiveness? Yes □ No □

   If so, please describe: _____

2. Has your child/teen taken medication (prescription or otherwise) that belonged to family members or friends? Yes □ No □

3. Has your child/teen ever had alcohol or any illegal/illicit drugs, such as marijuana? Yes □ No □

   If so, please describe: _____

4. Does your child/teen use any form of nicotine? Yes □ No □

   If so, please describe: _____