Rock Landing Psychological Group

Child/Teen Client Information

Please Print

Name: _____ Age: _____

Name your child prefers to go by: _____

Date of Birth: _____ □ Female □ Male Ethnicity: _____

Address: _____

City/State/Zip: _____

Your Relationship to Client: □ Parent □ Guardian

Name: _____ Date of Birth: _____

Address: _____

□ Female □ Male Social Security #: _____

Employer: _____ Occupation: _____

Preferred Contact Number: _____

The Other Parent is:

Name: _____ Phone Number: _____

Insurance Information

Primary Insurance: _____ Subscriber Date of Birth: _____

Subscriber Name: _____ Subscriber SSN: _____

Policy ID #: _____ Group #: _____

Subscriber's Employer: _____ Work Phone: _____

Secondary Insurance: _____ Subscriber Date of Birth: _____

Subscriber Name: _____ Subscriber SSN: _____

Policy ID #: _____ Group #: _____

Subscriber's Employer: _____ Work Phone #: _____

Treatment Contract

Insurance and Financial Policy Statement

Thank you for choosing Rock Landing Psychological Group for counseling. As part of providing high-quality services, we need to clarify our financial policies. Should you have any questions regarding the practice policies, please ask a member of the staff for clarification.

If you are using your health insurance benefits, we will bill your insurance company. To do so, we need you to provide us with accurate and timely information regarding your insurance. **All co-pays, deductibles, and denied payments are your responsibility.** Your health insurance company may require you to make a co-payment and/or satisfy a deductible. The co-payment is determined by your health insurance company and is due at the time of service. If you have a deductible which has not been met, then the full fee is due until the deductible has been met.

I authorized a release of information to my health insurance company and I assign all benefits to Rock Landing Psychological Group.

Late Cancellation/No Show Fee

Rock Landing Psychological Group requires 24 hour notice for routine cancellations. Late cancellations and no shows will incur a **$65.00 charge for a missed appointment with your therapist and a $75.00 charge for missed appointment with your psychiatrist** to be paid at your next scheduled session. Please note that your health insurance company will not cover this fee. The practice has a 24 hour voice mail system to take your cancellations. Please call (757) 873-1736 and speak to a staff member or if it is after hours leave a message for he scheduling staff on the voice mail system. At the time of check out you are given a card with the date of your next scheduled appointment. Our office will make every effort to remind you of your scheduled appointment. However, it is your responsibility to be aware of your appointment. Repeated cancellations and/or missed appointments may result in being disengaged from this practice.

Late Cancellation/No Show Fee for Psychological Testing

The psychologist requires 72 hours for cancellation for testing. Late cancellations and no shows will incur a **$65.00 charge for each hour** the individual was scheduled for testing. Please note the health insurance company will not cover this fee. Please be aware it will be at the discretion of the examiner as to whether or not the individual will be rescheduled for testing.

Parent/Guardian Signature: _____ Date: _____

Name of Child: _____ Date: _____

Consent to Treatment

I do hereby seek and consent to take part in the treatment of my child provided by Rock Landing Psychological Group.

I understand that developing a treatment plan for my child with the provider(s) of care, and regularly reviewing the work towards meeting the treatment goals are in my child's best interest. I agree to play an active role in this process.

I am aware that no promises have been made to me regarding the outcome of treatment rendered by my child's provider(s) of care.

Parent/Guardian Signature: _____ Date: _____

Coordination of Treatment

If my child is referred to any other clinician or physician at Rock Landing Psychological Group, I give my consent for those clinicians to obtain and release pertinent information to each other for the purpose of coordinating the care of my child.

Parent/Guardian Signature: _____ Date: _____

Agreement

I hereby attest that all information contained in these pages is current and correct. I understand that I am responsible for informing Rock Landing Psychological Group of any changes. Failure to do so may delay processing of insurance claims, in which case I will incur responsibility for those unpaid claims. Falsification of this information is punishable under Federal Law.

I have received a copy of the Notice of Privacy Information Practices (HIPAA) pertaining to this practice.

Parent/Guardian Signature: _____ Date: _____

Name of Child: _____ Date: _____

Permission to Call

We may need to reach you to verify or discuss an appointment. Please indicate below how you would prefer us to contact you.

I DO ____ DO NOT ____ Give permission to call my home and/or leave a message there.

I DO ____ DO NOT ____ Give permission to call my place of employment and/or leave a message.

I DO ____ DO NOT ____ Give my permission for my _____ to coordinate any appointments for my child.

Referral Information

Who referred you to this practice? _____

May we have permission to thank them for your referral? □ Yes □ No

Has your child been seen here before? □ Yes □ No If "yes" please give approximate date and reason for seeking counseling: _____

Legal Information

Are you and/or your child currently involved in the legal system: Check all which apply:

□ Arrest for _____ □ Child Custody

□ DUI/DWI □ Disability □ Lawsuit

Others in the home: 1._____ 2._____
3. _____4._____

Parent/Guardian Signature: _____ Date: _____

Name of Child: _____ Date: _____

Brief Health Information

List all prescription medications your child takes.

Medication/Drug	Dose	Taken For

Has your child experienced any diseases, illnesses, significant accidents, injuries, hospitalizations, surgeries, periods of loss of consciousness, other medical conditions.

Age	Illness	Treatment	Treated By	Result

Is your child now being treated for any medical condition? □ Yes □ No
If "yes" name or describe condition: _____

When was your child's last medical exam? _____

Your child's health is: □ Excellent □ Good □ Fair □ Poor

Does your child have any allergies? □ Yes □ No If "yes" please list below:

To What	Reaction	Allergy Medications Taken

Name of Child: _____ Date: _____

Health Habits

Does your child smoke cigarettes or use tobacco products? □ No □ Do not know
□ Yes # of packs per day: _____

Does your child drink alcohol? □ No □ Do not know □ Yes

Does your child use street drugs? □ No □ Do not know □ Yes Which ones? _____

Does your child drink beverages containing caffeine? □ No □ Yes
If so, list type of beverage and amount consumed daily: _____

Does your child take any over-the-counter medications? □ No □ Yes
□ Aspirin/Tylenol/Ibuprofen □ Antihistamines □ Antacids □ Laxatives □ Sleeping pills

Does your child take vitamins/food supplements? □ No □ Yes What? _____

Does your child engage in any of the following: □ Restrict food intake □ Binge eating □ Over-eat
□ Use laxatives □ Self-induced vomiting

Does your child complain of feeling sick a lot? □ No □ Yes

How often does your child exercise? □ Never □ ____ times a week □ ____ times a month

Mental Health History

Has your child ever had mental health counseling? □ No □ Yes
Date: _____ Counselor: _____
Did it help? □ Yes □ No

Has your child ever been under the care of a psychiatrist? □ No □ Yes
Date: _____ Psychiatrist: _____

Did it help? □ Yes □ No

Has your child ever thought about trying to harm or kill himself/herself? □ No □ Yes □ Do not know
If yes, what thoughts did they express? _____

Has your child ever tried to harm or kill himself/herself? □ No □ Yes
When: _____ How: _____

Child & Teen Checklist of Characteristics

Name: _____ Date: _____

Age: _____ Person Completing This Form: _____

Mood

□ Affectionate
□ Complains
□ Fearful
□ Moody
□ Nervous
□ Sad, unhappy
□ Stubborn
□ Worry
□ Angry rages
□ Concern for others
□ Cries easily, feelings are easily hurt
□ Friendly, outgoing, social
□ Likes to be alone, withdraws, isolates
□ Mute, refuses to speak
□ Shy, timid
□ Suicide talk or attempt
□ Thumb sucking, finger sucking, hair chewing
□ Under active, slow-moving, lethargic

Attention

□ Dawdles, procrastinates, wastes time
□ Distractible, inattentive, poor concentration, daydreams
□ Interrupts, talks out, yells
□ Lack organization, unprepared
□ Low frustration tolerance, irritability
□ Over active, restless, fidgety, noisiness

Family

□ Difficulties with parents's partner/new marriage/new family
□ Disrupts family activities
□ Recent move, new school, loss of friends
□ Relationships with sisters/brothers or friends/peers
□ Death in the family/bereavement

School

□ Failure in school
□ Complains of teachers not liking her/him?
□ Behavioral problems at school
□ Learning problems
□ Developmental delays

Child & Teen Checklist of Characteristics (continued)

Name of Child: _____ Date: _____

Behavior

□ Argues, "talksback"
□ Cruel to animals
□ Dependent, immature
□ Fire setting
□ Independent
□ Lying
□ Nail biting
□ Obedient
□ Pouts
□ Responsible
□ Truant, avoiding school
□ Uncoordinated, accident prone
□ Runs away
□ Bullies, intimidates, teases
□ Swearing, foul language
□ Conflicts with parents over rules of the home
□ Legal difficulties-truancy, vandalism, stealing, drugs
□ Extra curricular activities interfere with academics
□ Fighting, hitting, violent, aggressive, hostile
□ Immature, has only younger playmates
□ Lacks respect for authority
□ Disobedient, uncooperative, refused, defiant
□ Need for high degree of supervision
□ Prejudiced, insulting, name calling, intolerant
□ Rocking or other repetitive movements
□ Sexual: sexual preoccupation, inappropriate sexual behaviors
□ Tics – involuntary rapid movements, noises, or words
□ Teased, picked on, victimized, bullied

Please look back over the concerns you checked off and choose the one which you most want your child to be helped with. Which one is it? _____

Development Milestones

Mothers Pre-Natal Health? □ Drug/alcohol use □ Medications used: _____
□ Complications? _____

At what age did your child:

Sit up? □ 3-6 months □ 6-9 months □ 9-12 months □ Over 12 months

Crawl? □ 6-12 months □ 13-18 months □ Over 18 months

Walk? □ Under 12 months □ 12-18 months □ 18-24 months □ Over 24 months

Make vocal sounds? □ 3-6 months □ 6-9 months □ 9-12 months □ Over 12 months

Put two words together? □ 9-12 months □ 13-15 months □ 16-14 months □ Over 24 months

Speak in multiple work sentences?

□ 12-15 months □ 16-18 months □ 19-24 months □ Over 24 months

Toilet trained?

□ Under 1 year □ 1-2 years □ 2-3 years □ 3-4 years □ 4-5 years □ Over 5 years

Has your child ever had any accidents resulting in injuries? (broken bones, severe cuts or bruises, stomach pumped, head injury, eye injury, lost teeth, had stitches, loss of consciousness, etc.)
□ No □ Yes _____

Do you have any concerns about your child's current health? □ No □ Yes
□ Hearing □ Vision □ Speech □ Gross motor coordination (walking/running/climbing)
□ Fine motor coordination (writing, closing buttons, etc.) _____
□ Sensory processing □ Other: _____

Does your child have bladder control problems? □ No □ Yes

Does your child have bowel control problems? □ No □ Yes

Has there been a history of alleged child abuse for this child's family? (physical, sexual, and /or emotional abuse, neglect)? □ No □ Yes

Have there been any family stressors within the past 12 months? (divorce, separation, change in residence, death in the family, family financial or legal difficulties) □ No □ Yes
If yes please describe: _____

Has your child ever been enrolled in a special education program or received any type of individualized educational services? □ No □ Yes

Comments: _____

_____

_____

_____

Child Name: _____ Date: _____