

Rock Landing Psychological Group
Child/ Teen Client Information

Please Print

Name: _____ Date: _____

Name you prefer to go by: _____ Age: _____

Date of Birth: _____ Female Male Race: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Parent/Guardian Work Phone: _____

School: _____

Emergency Contact: _____ Phone: _____

Relationship to Client: Parent Guardian

Name: _____ Date of Birth: _____

Address: _____

Female Male Social Security #: _____

Employer: _____ Occupation: _____

Insurance Information

Primary Insurance: _____ Effective Date: _____

Subscriber Name: _____ Subscriber SSN: _____

Policy ID#: _____ Group #: _____

Subscriber's Employer: _____ Work Phone: _____

Secondary Insurance: _____ Effective Date: _____

Subscriber Name: _____ Subscriber SSN: _____

Policy ID#: _____ Group #: _____

Subscriber's Employer: _____ Work #: _____

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 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 hours notice for routine cancellations. Late cancellations and no shows will incur a \$45.00 charge 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 answer service to take your cancellations. Please call (757) 873-1736 and the service will take the message and fax to the office. At the time of check-out you are given an encounter form with the date of your next scheduled appointment. Upon request the staff will be glad to give you an appointment card. Our office does not make reminder calls for appointments.

Parent/Guardian Signature: _____ Date: _____

Name of Child: _____ Date of Birth: _____

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 out come 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: _____

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.

I prefer to be contacted at the following number: _____

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
- Divorce
- Disability
- Lawsuit

Brief Health Information

1. List all prescription medications your child takes.

Medication/Drug	Dose	Taken for

2. 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

3. Is your child now being treated for any medical condition? Yes No

If “yes” name or describe condition: _____

4. When was your child's last medical exam? _____

5. Your child's health is: Excellent Good Fair Poor

6. Does your child have any allergies? Yes No If “yes” please list below:

To What	Reaction	Allergy Medications Taken

Health Habits

Does your child smoke cigarettes? No Do not know Yes # of packs per day: _____

Use other tobacco products? No Do not know Yes Use per day: _____

Does your child drink alcohol? No Do not know Yes

Does your child drink beverages containing caffeine? No Yes

If so, list type of beverage and amount consumed. _____

Does your child take any over-the-counter medications? No Yes

Aspirin/Tylenol/Ibuprofen Antihistamines Antacids Laxatives

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

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

Does your child engage in any of the following: Restrict food intake Binge eating Over-eat

Use laxatives Self-induced vomiting

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

Mental Health History

Has your child ever had a psychiatric hospitalization? No Yes

Date: _____ Facility: _____ Reason: _____

Has your child ever had mental health counseling? No Yes

Date: _____ Counselor: _____

Has your child ever been under the care of a psychiatrist: No Yes

Date: _____ Provider: _____

Has your child ever thought about trying to harm or kill himself/herself? No Yes Do not know

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:** _____

- Affectionate
- Argues, “talks back”, “smart-alecky”, defiant
- Bullies/intimidates, teases, inflicts pain on others, bossy, picks on others
- Cheats
- Cruel to animals
- Concern for others
- Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- Complains
- Cries easily, feelings are easily hurt
- Dawdles, procrastinates, wastes time
- Difficulties with parents's' partner/new marriage/new family
- Dependent, immature
- Developmental delays
- Disrupts family activities
- Disobedient, uncooperative, refuses, non-compliant, doesn't follow rules
- Distractible, inattentive, poor concentration, daydreams, slow to respond
- Dropping out of school
- Drug or alcohol use
- Eating: poor manners, refuses, appetite increase or decrease, odd combinations, overeats, under-eats, binging, vomiting
- Exercise problems
- Extracurricular activities interfere with academics
- Failure in school
- Fearful
- Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- Fire setting
- Friendly, outgoing, social
- Hypochondriac, always complains of feeling sick
- Immature, “clowns around”, has only younger playmates
- Imaginary playmates, fantasy
- Independent
- Interrupts, talks out, yells
- Lacks organization, unprepared
- Lacks respect for authority, insults, dares, provokes, manipulates
- Learning disability
- Legal difficulties-truancy, loitering, drinking, vandalism, stealing, fighting, drugs

Child & Teen Checklist of Characteristics (continued)

- Likes to be alone, withdraws, isolates
- Lying
- Low frustration tolerance, irritability
- Mental retardation
- Moody
- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Obedient
- Obesity
- Overactive, restless, fidgety, noisiness
- Oppositional, resists, refuses, does not comply, negative
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with sisters/brothers or friends/peers are poor-competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors – biting or hitting self, head banging, scratching self
- Speech difficulties
- Sexual: sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics-involuntary rapid movements, noises, or work productions
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Under active, slow-moving, lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothes
- Worry
- Any other characteristics: _____

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? _____

Child Name: _____ Age: _____
Your Name: _____ Relationship to Child: _____

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

Development Milestones

At what age did you 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

Use first words like “mama” or “dada”?

6-9 months 9-12 months 12-15 months 18-24 months Over 24 months

Put two words together? 9-12 months 12-15 months 15-18 months Over 24 months

Speak in multiple work sentences?

12-15 months 15-18 months 18-14 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, 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) _____

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

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

