DEVELOPMENTAL ENHANCEMENT
BEHAVIORAL HEALTH

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Wyoming, MI 49509	Holland, MI 49423	Grandville, MI 49418
P// 616.604.8492	P// 616.499.2218	P// 616.244.2246
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Welcome to Developmental Enhancement Behavioral Health and thank you for scheduling an appointment with one of our professional staff. We appreciate the opportunity to work with you. Our goal is to provide you with the highest quality services possible. This letter confirms your appointment and provides valuable information about our office policies.

Preparing for this visit

Please complete these forms and bring them with you to your appointment. Completing this information ahead of time allows us to see you in a timely manner upon arrival at our office, and ensures we have the information necessary to address your needs.

In addition, please bring the following items:

-Insurance Card

-Copayment or agreed upon payment amount

If you need to cancel or reschedule your appointment, please contact us at least 24 hours in advance to **avoid a no-show fee of $55.00** and allow us the courtesy of offering your appointment time to another patient. Our telephone number is (616) 244-2246.

Your appointment has been scheduled with ___________________________________.

Your appointment date is _________________ at ___________.

☐ This is an initial appointment with parent/guardians only

☐ This appointment is for both parent/guardians and child

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Client Demographics

Client Name: ____ DOB: ______________

Gender: ☐Male ☐Female ☐Other

Home Address: ____

Legal Status: ☐Minor ☐Emancipated Minor ☐Adult ☐Guardianship ☐Ward

Home Phone Number: ____________________ Cell/Work Phone Number:____________________

Legal Custody: ____
Name Phone Relationship

Guardian/Wardship:____
Name Phone Relationship

Insurance Information:

Policy Holder:____ DOB: ______________

Primary Insurance:______________________________ Employer: _______________________

Contract Number____________________________________ Group Number: ______________

Policy Holder's SSN: ______________________________

Home Address: ____

Phone Number on Card: ____________________ Cell/Work Phone Number:___________________

Secondary Insurance Information:

Policy Holder:____ DOB: ______________

Primary Insurance:______________________________ Employer: _______________________

Contract Number____________________________________ Group Number: ______________

Policy Holder's SSN: ______________________________

Home Address: ____

Phone Number on Card: ____________________ Cell/Work Phone Number:___________________

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Developmental Enhancement Payment Policy

Developmental Enhancement, PLC collects all payments and copays for therapy services at the time of service as stated in the Financial Policy and Guarantor Agreement. Payment for evaluations will be collected at the time of the feedback session or last testing session. You have the option of paying by cash, check, or credit card at the front desk. Any exceptions to this policy must be made in advance with the therapist. **Clients with active Medicaid will not be charged co-pays, cancellation fees, or any amount beyond what Medicaid pays. If the client's Medicaid status is considered inactive at any time, the client will be responsible for any balances accrued during that time.**

Clients must **check in at the front desk prior to each appointment** and make payments at that time. Please notify the office staff any time you have a change in insurance coverage.

If you have insurance other than those we are paneled with, you will be responsible for the cost of services. We are able to provide you with a receipt that can be submitted to your insurance company or that can be retained for tax purposes.

We are able to directly bill Traditional and PPO Blue Cross/Blue Shield of Michigan, MESSA, Cofinity, Aetna, Cigna, ASR, Priority Health, and Blue Care Network, among select others. Please remember that if for any reason your insurance carrier does not cover the charges, you will be responsible for the full amount.

We appreciate your cooperation with the payment policy. If you have questions, please discuss them with your therapist.

I understand that I am responsible for any health insurance deductibles and coinsurance and that any amounts not paid by insurance are my responsibility. If this account is delinquent, I agree to pay all expenses including, but not limited to, collection agency fees, along with any court costs and actual attorney fees incurred by Developmental Enhancement, PLC in collecting this account.

____ _______________________

Signature of Guarantor Date

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Financial Policy and Guarantor Agreement

Please read the Financial Policy and Guarantors Agreement carefully so that you fully understand our financial policy, fees for our services, and your financial responsibility. We would be happy to discuss or answer any questions you may have pertaining to this policy. In order to receive services from Developmental Enhancement, PLC, the Guarantor must guarantee payment to Developmental Enhancement, PLC, for all services provided.

The Guarantor agrees to the following:

1. The Guarantor guarantees that Developmental Enhancement, PLC, will be paid for all amounts owed by the client for services provided by Developmental Enhancement, PLC. All payments are due at the time of service.

2. Developmental Enhancement, PLC is able to bill many insurance companies directly. Clients are responsible for paying the copay and/or deductible at the time of services. The Guarantor remains ultimately responsible for any charges not reimbursed by insurance companies for any reason. Self-paying clients are required to pay the full cost of services at the time services are provided unless a payment plan has been previously approved.

3. Developmental Enhancement, PLC's current fee schedule can be found on the following page. Based on the current fee schedule, amounts expected to be paid by the client for services provided are included, but not limited to, this list. Rates may be subject to change by Developmental Enhancement, PLC at any time.

4. Payment in full is due at the time of service, unless otherwise arranged for ahead of time with your clinician. Developmental Enhancement, PLC, is able to accept cash, check, or credit card for payment.

5. Unless otherwise arranged in advance, any balances owed by the Guarantor not paid within 30 days will receive a billing charge of 1.5%. Guarantor agrees to pay all expenses including, but not limited to, collection agency fees, along with any court costs and actual attorney fees incurred by Developmental Enhancement, PLC in collecting this account.

   a. The Guarantor will be billed a **$55 Missed Appointment Fee** for all unexcused sessions that were not canceled or rescheduled within 24 hours of the scheduled time.
   b. There will be a **$35 Returned Check Fee** for any checks returned for insufficient funds.

6. The guarantee contained in this agreement is a continuing and unconditional guarantee and may only be withdrawn by the Guarantor by giving written notice to Developmental Enhancement, PLC. All amounts owed prior to Developmental Enhancement, PLC, receiving the withdrawal of guarantee remain the obligation of the guarantor.

7. If the agreement is signed by more than one person, all persons signing the agreement as Guarantor acknowledge that their obligation is joint and several, that revocation of the agreement by one guarantor does not affect the liability of any other Guarantor, and that Developmental Enhancement, PLC, may proceed against each or any one of the persons signing this agreement as guarantor.

8. This agreement is not revoked by the death of a client or Guarantor and will continue in force until all financial obligations owed by the client are fully paid.

9. This agreement shall be construed and enforced according to Michigan law. The Guarantor consents to the jurisdiction of any Michigan court in the event it becomes necessary to institute legal proceedings to enforce the agreement, and waives any objection to personal jurisdiction or venue in such proceedings.

10. The terms of this agreement cannot be changed unless Developmental Enhancement, PLC, consents to the changes in writing.

By signing below, I agree to be the Guarantor and to accept the conditions of this agreement.

Guarantor: ____ Date: ______________

Home Address: ____

Home Phone Number: ____________________ Cell/Work Phone Number:____________________

Additional Guarantor: ____ Date: ______________

Home Address: ____

Home Phone Number: ____________________ Cell/Work Phone Number:____________________

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Fee Schedule – Developmental Enhancement, PLC's Charges

Mental Health Assessment and Therapy
90791- Initial Assessment/Therapy Intake, $195.00
90832- Individual Therapy (30 minutes), $80.00
90834- Individual Therapy (45 minutes), $110.00
90837- Individual Therapy (60 minutes), $155.00
90846- Family Therapy-patient not present, $110.00
90847- Family Therapy-patient present, $110.00
90853- Group Therapy, $55.00
96130- Psychological Testing (First 60 minutes), $175.00
96131- Psychological Testing (Additional 60 minutes), $175.00
93136/96137-Testing Administration/Scoring (First 30 minutes/Additional 30 minutes), $75.00 per unit

Applied Behavior Analysis (ABA Therapy)-codes vary by insurance
Direct Therapy with Tutor (per 15 minutes), $18.00
BCBA Supervision (per 15 minutes), $32.50
Initial Assessment with BCBA (per hour), $145.00
Re-Assessment, Treatment Plan (per hour), $135.00
Family/Parent Training (per 15 minutes), $25.00

Consultation, Self-Pay Only
15 minutes, $27.50
30 minutes, $55.00
45-60 minutes, $110.00

Additional Charges
Missed Appointment Fee, $55.00
Returned Check Fee, $35.00
Telephone Consultation (per 15 minutes), $30.00
Treatment Summaries/Other Reports (per 15 minutes), $30.00

Additional services may be offered at mutually agreed upon rates. Services and fees agreed upon for this agreement include the following:

____
____

Rates may be subject to change by Developmental Enhancement, PLC at any time. Please contact your insurance company to confirm your actual codes and cost.

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Consent for Treatment

I hereby give consent for staff at Developmental Enhancement, PLC, to provide psychological, developmental, and educational services including treatment, evaluation, and consultation for:

____ ______________________________

Client Name DOB

____ ______________________________

Client or Parent/Guardian Signature Date

Privacy Practices

I have been provided with the Notice of Privacy Practices and take responsibility to review it and seek clarification from Developmental Enhancement, PLC, regarding unclear information.

____ ______________________________

Client or Parent/Guardian Signature Date

Confidentiality

If seeking payment or reimbursement from a third-party payer (e.g., health insurance, flexible spending account), such payers might request disclosure of pertinent information during the course of treatment.

Do you authorize release of necessary information to third-party payers **required to bill insurance?**

☐Yes ☐No

____ ______________________________

Client or Parent/Guardian Signature Date

If staff at Developmental Enhancement needs to reach you by telephone, may they leave a message on your answering machine?

☐Yes ☐No

____ ______________________________

Client or Parent/Guardian Signature Date

If staff at Developmental Enhancement needs to reach you, may they contact you by secure email?

☐Yes ☐No

Email address: ____

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Release of Information - Primary Care Physician - REQUIRED

I, ____, (_______________) hereby authorize Developmental
Client Name DOB
Enhancement, PLC, to ☐ **disclose** and/or ☐ **receive** the following psychiatric and/or medical information to/from:

Name & Organization: ____ Relationship: ______________________

Address: ____

Phone Number: _________________________________Fax number: ___________________________________

Covering the dates of _________________________ through ___________________________

This release includes professional communications, both verbal and written, and/or reports produced during treatment, with the exception of: ____

This authorization shall be in force and effect until______________ (1-year maximum), or event or purpose at which time this authorization to use or disclose this protected health information expires (Ex. termination of treatment with clinician).

I understand that:

- A revocation is not effective to the extent Developmental Enhancement, PLC, has relied on the use or disclosure of the protected health information. The Notice of Privacy Practices outlines privacy issues including revocation of authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Developmental Enhancement, PLC will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Revoke this authorization, in writing, at any time by sending such written notification to Developmental Enhancement at the above address.
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a copy of this authorization containing my signature.

I have been made aware of Developmental Enhancement, PLC's Privacy Practices. The statements included in this authorization are binding on Developmental Enhancement, PLC's service.

____ ______________________
Client/Parent/Guardian Signature Date

____ ____
Client/Parent/Guardian Printed Name Witness/Date

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Release of Information

I, ____, (_______________) hereby authorize Developmental
Client Name DOB
Enhancement, PLC, to ☐ **disclose** and/or ☐ **receive** the following psychiatric and/or medical information to/from:

Name & Organization: ____ Relationship: ______________________

Address: ____

Phone Number: __________________________________Fax number: ___________________________________

Covering the dates of _________________________ through ___________________________

This release includes professional communications, both verbal and written, and/or reports produced during treatment, with the exception of: ____

This authorization shall be in force and effect until______________ (1-year maximum), or event or purpose at which time this authorization to use or disclose this protected health information expires (Ex. termination of treatment with clinician).

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- Refuse to sign this authorization.
- Receive a copy of this authorization containing my signature.

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____ ______________________

Client/Parent/Guardian Signature Date

____ ____

Client/Parent/Guardian Printed Name Witness/Date

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Child Pick Up & Emergency Information

Name: ____ DOB: __________________

Relationship: ____________________________ Phone Number: ______________________

Type of Custody: (☐Legal ☐Physical ☐Sole ☐Joint Legal ☐Joint Physical ☐None)

Emergency Contact: ☐Yes ☐No Address: ______________________________

Consent to Pick Up: ☐Yes ☐No ____________________________________

Consent to Observe: ☐Yes ☐No ____________________________________

Name: ____ DOB: __________________

Relationship: ____________________________ Phone Number: ______________________

Type of Custody: (☐Legal ☐Physical ☐Sole ☐Joint Legal ☐Joint Physical ☐None)

Emergency Contact: ☐Yes ☐No Address: ______________________________

Consent to Pick Up: ☐Yes ☐No ____________________________________

Consent to Observe: ☐Yes ☐No ____________________________________

Name: ____ DOB: __________________

Relationship: ____________________________ Phone Number: ______________________

Type of Custody: (☐Legal ☐Physical ☐Sole ☐Joint Legal ☐Joint Physical ☐None)

Emergency Contact: ☐Yes ☐No Address: ______________________________

Consent to Pick Up: ☐Yes ☐No ____________________________________

Consent to Observe: ☐Yes ☐No ____________________________________

____ ____________________

Parent/Guardian Signature Date

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Child Pick Up & Emergency Information

Name: ____ DOB: __________________

Relationship: ____________________________ Phone Number: ______________________

Type of Custody: (☐Legal ☐Physical ☐Sole ☐Joint Legal ☐Joint Physical ☐None)

Emergency Contact: ☐Yes ☐No Address: ______________________________

Consent to Pick Up: ☐Yes ☐No ____________________________________

Consent to Observe: ☐Yes ☐No ____________________________________

Name: ____ DOB: __________________

Relationship: ____________________________ Phone Number: ______________________

Type of Custody: (☐Legal ☐Physical ☐Sole ☐Joint Legal ☐Joint Physical ☐None)

Emergency Contact: ☐Yes ☐No Address: ______________________________

Consent to Pick Up: ☐Yes ☐No ____________________________________

Consent to Observe: ☐Yes ☐No ____________________________________

Name: ____ DOB: __________________

Relationship: ____________________________ Phone Number: ______________________

Type of Custody: (☐Legal ☐Physical ☐Sole ☐Joint Legal ☐Joint Physical ☐None)

Emergency Contact: ☐Yes ☐No Address: ______________________________

Consent to Pick Up: ☐Yes ☐No ____________________________________

Consent to Observe: ☐Yes ☐No ____________________________________

____ ____________________

Parent/Guardian Signature Date

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Permission to Participate in Active Therapy Areas

Developmental Enhancement, PLC provides active treatment and play areas to enhance treatment. These areas include but are not limited to climbing equipment, trampolines, swings, and other play apparatus. By signing below, I am giving permission for my child to participate in these activities. I will express any concerns relating to my child's participation to the therapist.

____ _____________________

Parent/Guardian Signature Date

Release and Waiver

Acknowledging participation in the activities at Developmental Enhancement, the undersigned, on his or her own behalf, and on behalf of any executors, heirs, successors and assigns, hereby acknowledges and agrees as follows:

1. The undersigned knowingly and fully assumes all risks, known and unknown, associated with participation in activities at Developmental Enhancement, and waives all claims for damage to personal property or injury to person arising from such participation. This release and waiver covers risks of death, serious injury, and property loss whether arising from (a) negligence or carelessness on the part of the persons or entities being released and other participants, or (b) dangerous or defective equipment.

2. The undersigned certifies that the client may participate in the activities available, and has not been advised to the contrary by a qualified medical professional;

3. The undersigned on his or her behalf and on behalf of any executors, heirs, successors and assigns, hereby releases, discharges, and holds harmless Developmental Enhancement, including its officers, agents, employees, representatives, and all affiliates, from any and all claims, damages, or liability arising from death, disability, personal injury, property damage, or theft, or any kind of action;

4. The undersigned acknowledges that this release and waiver of liability form will be used and relied upon by Developmental Enhancement and that it will govern the undersigned's actions and rights.

____ _____________________

Parent/Guardian Signature Date

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Confidentiality Agreement for Shared Treatment Spaces

During the assessment and treatment of children and adolescents, Developmental Enhancement, PLC utilizes both private office space and shared treatment space. Shared treatment space includes treatment areas where other clients, or client family members of Developmental Enhancement, PLC might be present. In some cases, treatment might involve interaction with these other children or parents.

Confidentiality—trusting that communication and information will be kept private—is important to Developmental Enhancement, PLC. While employees at Developmental Enhancement, PLC follow strict confidentiality rules, we also want to ensure that children and parents that may be in shared treatment space also respect confidentiality. Additionally, we want to make sure that both children and parents understand that participation in treatment in shared areas is voluntary. At any time, children and/or parents may request that therapy is provided in a private treatment space for any reason.

I hereby agree that my child may participate in therapy in shared treatment areas at Developmental Enhancement, PLC.

☐**Yes** ☐**No**

____ _________________

Parent/Guardian Signature Date

While in any area utilized by Developmental Enhancement, PLC, both clients and family members of clients agree not to divulge any confidential information which comes to them in relation to any other client or family member of another client at Developmental Enhancement. This shall include:

- Not discussing any information pertaining to any other client or family member of a client with anyone including but not limited to, my own family, friends, or relatives.
- Not discussing any information pertaining to any client or family member of a client in any place where it can be overheard by others.
- Not contacting any individual or agency outside of Developmental Enhancement, PLC to get personal information about any client or family member of a client
- Not releasing any information, in writing or orally, regarding any client or family member of a client to any person(s) or agencies.
- I understand that violation of these confidentiality principals could potentially result in my termination at Developmental Enhancement, PLC. Further, breaching of confidentiality may subject me to civil or criminal liability.

By my signature below, I indicate that I have read carefully and understand this agreement and that I agree to its terms and conditions.

____ _________________

Client/Parent/Guardian Signature Date

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Child and Adolescent Intake Questionnaire

Please fill out this form completely. The information you provide is confidential and protected by law.

Client Name: ____ DOB: ______________________

Gender: ☐Male ☐Female ☐Other

Name of person filling out this form: _________________________Relationship to Client: ________________________

Who referred you/how did you hear about DEBH?:____

Reason for coming to our office:

Behavior Problems:

- ☐ Aggression
- ☐ Alcohol use
- ☐ Compulsiveness
- ☐ Crying spells
- ☐ Dishonesty
- ☐ Disorganization
- ☐ Disrespectfulness
- ☐ Distractibility
- ☐ Drug use
- ☐ Fire setting
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Over-activity
- ☐ Poor attention
- ☐ Seizures
- ☐ Self-harm
- ☐ Sexual behavior
- ☐ Stealing
- ☐ Suicide attempt
- ☐ Temper tantrums
- ☐ Tics
- ☐ Verbal aggression
- ☐ Withdrawal

Emotional Distress:

- ☐ Anger
- ☐ Excessive guilt
- ☐ Hopeless, helpless
- ☐ Irritability
- ☐ Lack of enjoyment
- ☐ Loneliness
- ☐ Moodiness
- ☐ Nervousness/Worry
- ☐ Obsessions
- ☐ Panic Attacks
- ☐ Sadness
- ☐ Suicidal thoughts
- ☐ Thoughts of harming others
- ☐ Perfectionism
- ☐ Sensitive to criticism
- ☐ Rapid mood changes

Functional Problems:

- ☐ Appetite problem
- ☐ Cognitive problems
- ☐ Inadequate energy
- ☐ Irresponsible
- ☐ Learning problems
- ☐ Memory problems
- ☐ Money management
- ☐ Physical pain/injury
- ☐ Poor hygiene
- ☐ Problems with mobility
- ☐ Problems with speech
- ☐ Recognition of danger
- ☐ Sleep problems
- ☐ Social relationships
- ☐ Toileting problems
- ☐ Apathy

Other Issues/concerns:

____
____

Has the client been diagnosed previously with any type of developmental diagnosis?

☐ **Autism Spectrum Disorder (Autism, Asperger's PDD-NOS)?**

What was the diagnosis? ____

When was the diagnosis made? ____________________ Who made the diagnosis? __________________________

What kinds of special education support services were/are utilized? _______________________________

____

☐ **Cognitive Impairment/Intellectual Disability**

What was the diagnosis? ____

When was the diagnosis made? ____________________ Who made the diagnosis? __________________________

What kinds of special education support services were/are utilized? _______________________________

____

☐ **Speech/Language Disorder/Delay**

What was the diagnosis? ____

When was the diagnosis made? ____________________ Who made the diagnosis? __________________________

What kinds of special education support services were/are utilized? _______________________________

☐ **Sensory Integration Problems**

What was the diagnosis? ____

When was the diagnosis made? ____________________ Who made the diagnosis? __________________________

What kinds of special education support services were/are utilized? _______________________________

____

☐ **ADHD/ADD**

What was the diagnosis? ____

When was the diagnosis made? ____________________ Who made the diagnosis? __________________________

What kinds of special education support services were/are utilized? _______________________________

____

☐ **Learning Disability**

What was the diagnosis? ____

When was the diagnosis made? ____________________ Who made the diagnosis? __________________________

What kinds of special education support services were/are utilized? _______________________________

____

☐ **Other/Psychiatric Diagnosis (e.g. anxiety, depression, OCD, genetic disorder)**

What was the diagnosis? ____

When was the diagnosis made? ____________________ Who made the diagnosis? __________________________

What kinds of special education support services were/are utilized? _______________________________

____

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Psychiatric Hospitalization

Cause *Dates/Age:*

____

____

Medical Hospitalization

Cause *Dates/Age:*

____

____

In the past, has the patient been treated by a mental health professional? ☐No ☐Yes

Please list the doctor(s) name and date range of treatment

Psychologist(s):____

Psychiatrist(s):____

Neurologist(s):____

Other:____

Is the patient currently in treatment with a mental health professional? ☐No ☐Yes

Please list the doctor(s) name and date range of treatment

Psychologist(s):____

Psychiatrist(s):____

Neurologist(s):____

Other:____

Significant Trauma *(Include age at time of incident, nature of trauma, and any legal details)*

☐Physical injury by accident ____

☐Notable physical pain caused by medical procedure_____________________________________

☐Physical abuse (client was the ☐victim ☐perpetrator):_______________________________

☐Sexual assault/abuse (client was the ☐victim ☐perpetrator):__________________________

☐Emotional abuse (client was the ☐victim ☐perpetrator):_____________________________

☐Neglect ____

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Psychiatric and Medical History- *Family and Personal*

Paternal (Biological Father's) Family History ☐No paternal history known

☐ADHD, ADD, attention/concentration/activity level problems ☐Depression

☐Alcohol/drug abuse ☐Genetic problems ☐Anxiety, panic attacks ☐Learning Disorder, problems

☐Autistic Spectrum Disorders ☐Major mental illness ☐Bipolar Disorder ("Manic"-depression)

☐Neurological ☐Cardiopulmonary difficulties (e.g., high blood pressure, heart disease, etc.)

☐Other: ____

Maternal (Biological Mother's) Family History ☐No maternal history known

☐ADHD, ADD, attention/concentration/activity level problems ☐Depression

☐Alcohol/drug abuse ☐Genetic problems ☐Anxiety, panic attacks ☐Learning Disorder, problems

☐Autistic Spectrum Disorders ☐Major mental illness ☐Bipolar Disorder ("Manic"-depression)

☐Neurological ☐Cardiopulmonary difficulties (e.g., high blood pressure, heart disease, etc.)

☐Other: ____

Medical History

Has the client ever experienced the following? *If yes, please elaborate.*

☐High fever requiring hospitalization or treatment: ____

☐Unexplained fever or spike in temperature: ____

☐Head injury: ____

☐Concussion: ____

☐Loss of consciousness: ____

☐Seizures *Type*: ☐Petit Mal ☐Grand Mal *Beginning at what age*: ________ *Frequency*: ____________

☐Tics: ____

☐Thyroid or endocrine problems: ____

☐Chronic ear infections/sinus infections *Were tubes required?*: ☐No ☐Yes: At what age(s)_______________

☐Chronic allergies ☐Diabetes/blood sugar problems ☐Meningitis, encephalitis ☐Bronchitis, pneumonia

☐Upper respiratory problems/asthma ☐Hearing problems ☐Vision problems

☐Congenital Conditions: ____

Current/Chronic illnesses: ____

____

Hearing: ☐No problem ☐Conductive Impairment ☐Sensori-neural Impairment

Vision: ☐No problem ☐Nearsighted ☐Farsighted ☐Blind ☐Other:____________________________

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Is the client currently taking any medication?
Please list medication, including dose, frequency and prescribing physician

____
____
____
____

Past medications that have produced a negative reaction or ineffective medications?
Please list medication and reason for discontinuation

____
____
____
____

Has the client had any major surgeries?
Please list procedure, age, outcome and any complications

____
____
____

Substance Abuse ☐No known history of any alcohol or drug use

Please indicate any substance used currently or in the past by the client:

Current	*Past*	
☐	☐	Alcohol
☐	☐	Ecstasy
☐	☐	Marijuana
☐	☐	Huffing (gas, aerosol, etc.)
☐	☐	Other: ________________________________

Please indicate the word(s) that best describe the client's alcohol or drug use:

☐ Experimental ☐Abusive ☐Dependent ☐Minimal/recreational

Has the client ever attended a substance abuse treatment program? ☐Yes ☐No

Current Living Situation

☐	Biological mother and father (parents married or cohabitating)		
☐	Biological mother (parents divorced/separated)	☐ With visitation	☐ Without visitation
☐	Biological father (parents divorced/separated)	☐ With visitation	☐ Without visitation
☐	Biological mother and stepfather	☐ With visitation	☐ Without visitation
☐	Biological father and stepmother	☐ With visitation	☐ Without visitation
☐	Foster family		
☐	Adoptive family		
☐	Other: __________________________		

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Persons living in the home:

Name	Age	Nature of Relationship to Patient	Quality of Relationship
______________________________	______	______________________________________	☐Good ☐Fair ☐Poor
______________________________	______	______________________________________	☐Good ☐Fair ☐Poor
______________________________	______	______________________________________	☐Good ☐Fair ☐Poor
______________________________	______	______________________________________	☐Good ☐Fair ☐Poor
______________________________	______	______________________________________	☐Good ☐Fair ☐Poor

Other important persons in patient's life:

Name	Age	Nature of Relationship to Patient	Quality of Relationship
______________________________	______	______________________________________	☐Good ☐Fair ☐Poor
______________________________	______	______________________________________	☐Good ☐Fair ☐Poor
______________________________	______	______________________________________	☐Good ☐Fair ☐Poor

Quality of Relationships

Client's attitude toward primary male role model: ☐Father ☐Stepfather ☐Grandfather ☐Other ______________________
☐Good/close ☐Antagonistic/hostile ☐Withdrawn ☐Overly close ☐No contact

Primary male role model's (identified immediately above) attitude toward client:
☐Good/close ☐Antagonistic/hostile ☐Withdrawn ☐Overly close ☐No contact

Client's attitude toward primary female role model: ☐Mother ☐Stepmother ☐Grandmother ☐Other ____________________
☐Good/close ☐Antagonistic/hostile ☐Withdrawn ☐Overly close ☐No contact

Primary female role model's (identified immediately above) attitude toward client:
☐Good/close ☐Antagonistic/hostile ☐Withdrawn ☐Overly close ☐No contact

Social Relationships

What words best describe the client?
☐Friendly ☐Withdrawn ☐Shy ☐Popular ☐Socially awkward ☐Few friends ☐Leader
☐Socially "clueless" ☐No friends ☐Used to have more friends ☐Interested in friends ☐Not interested in friends

Birth History – *Please complete for clients under the age of 18. If over 18, please move on to Personal Information sections.*

Number of pregnancies prior to the birth of the client________
Mother's age at time of client's birth:
☐Under 15 ☐15-19 years ☐20-29 years ☐30-34 years ☐35-39 years ☐Over 40

Did any of the following occur during the pregnancy**?** ☐ Yes ☐ No
(If any of the following occurred, please elaborate on condition/treatment)
☐Anemia ☐High stress ☐Mental health diagnosis ☐Excessive vaginal bleeding
☐Gestational diabetes ☐Physical trauma ☐Placenta Preva ☐Preeclampsia
☐Sexually transmitted disease ☐Toxemia ☐Domestic violence

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☐Illicit drug use (*Please include type, frequency & duration):* ____________________
☐Alcohol use (*Please include type, frequency & duration):* ____________________
☐Prescription drug use (*Please include type, frequency & duration):*____________________
☐Other ____________________

Was bedrest required? ☐Yes ☐No
(If yes, please explain time frame and reason): ____________________
Length of pregnancy: ☐Full term ☐Premature – born at how many weeks____________________
Was labor induced: ☐No ☐Yes, please describe reason____________________
Mode of delivery: ☐Vaginal ☐Cesarean ☐Emergency Cesarean

Were there any concerns or complications during/immediately following delivery?
☐Baby's heart rate dropped ☐Cord wrapped around neck ☐Lack of oxygen ☐Breech
☐Low Apgar scores ☐Significant jaundice (bilirubin) ☐Treatment in the NICU – details: ____________________
____

Developmental History
Temperament as an infant: ☐Easy ☐Withdrawn ☐Difficult ☐Other____________________
☐Excessive crying as an infant ☐Absent/minimal crying as an infant ☐Lack of/Difficulty with eye contact as an infant
Bonding: ☐Cuddly/Clingy ☐Withdrawn ☐Other: ____________________
Anxiety at separation from parent: ☐Mild ☐Moderate ☐Severe ☐None
Apprehension with strangers: ☐Mild ☐Moderate ☐Severe ☐None
Activity level: ☐Average ☐On-the-go ☐Destructive ☐Lethargic ☐Accident-prone
Emotionally oversensitive/over-reactive: ☐Yes ☐No *Does this continue to be a problem*: ☐Yes ☐No
Failure to seek comfort when upset or injured?: ☐Yes ☐No
Tantrums/Meltdowns: ☐No ☐Yes, describe behavior ____________________
☐Crying ☐Cursing ☐Head banging ☐Hitting ☐Kicking ☐Running ☐Spitting
☐Throwing things ☐Yelling/Screaming ☐Other____________________

Developmental Milestones
First independent walking: ☐On-time ☐Early ☐Late *Age of first unsupported steps*____________________
First expressive language: ☐On-time ☐Early ☐Late
Age of first word other than "Ma" or "Da": ____________________
Age of first simple sentences (e.g., "I want cookie"): ____________________
Is the client currently self-sufficient in toileting? ☐Yes ☐No
If not, what help is required? ____________________
Approximate age at which toilet training was completed: ____________________
Problems: ☐Refused to cooperate/did not show interest until age: ______________
☐Daytime urinary incontinence ("wetting the pants") until age: ________
☐Nighttime urinary incontinence ("wetting the bed") until age: ________
☐Daytime fecal incontinence ("pooping in the pants") until age: _______
☐Nighttime fecal incontinence ("pooping in the bed") until age: _______
☐Other (e.g., fecal smearing, retaining urine or feces, rituals, etc.): ____________________

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Puberty: ☐No ☐Yes, started at age_____________
If female, first menstruation at age: ________
Cares for self: ☐Yes ☐No ☐With help: ____

Discipline

Physical: ☐Spanking ☐Other: ____
Non-physical: ☐Time outs ☐Yelling/screaming ☐Taking things away ☐Praise
☐Other: ____
Client's response to discipline: ____

Current Sleep**:**

☐Duration in hours: ________________ ☐Requires naps
☐Bedtime rituals: ____
☐Onset problems ☐Mid-night awakening ☐Early awakening ☐Needs too much/too little sleep
Nightmares: ☐Frequency: ________ per week ☐Content: ____

Appetite:

☐No problems ☐Obsessed with food – since____
☐Increased/decreased appetite – since____
☐Weight gain/loss of more than 5 pounds (at ___________________ height)
☐Amount in pounds: ____________________________ Since: ____

Academic ☐No academic history due to age

Current school: ____
Current Grade_____________________________ Started school at age: _________________________
Participated in: ☐ PPI ☐Young Fives ☐Developmental Kindergarten ☐Other: _________________________________
Has the client utilized Special Education support services: ☐No ☐Yes
*Please specify below all classifications that have been used, and **circle any current classification**.*
☐Cognitively impaired ☐Emotionally impaired ☐Hearing impaired ☐Visually impaired ☐Physically impaired
☐Other Health Impairment ☐Speech and Language Impairment ☐Autism Spectrum Disorder
☐Early Childhood Developmental Delay ☐Learning Disabled/Specific Learning Disability ☐Severe Multiple Impairment
☐Oral expression ☐Basic reading expression ☐Listening comprehension ☐Reading comprehension
☐Written expression ☐Mathematics calculation ☐Mathematics reading

Academic Performance:

☐Consistently above average (A's, B's) ☐Consistently average grades (B's, C's) ☐Consistently below average (C's, D's)
☐Consistently below average to failing (D's, E's) ☐Previously strong grades, recent deterioration
☐Previously weak grades, recent improvement ☐Graduated from high school ☐Obtained GED
☐Regular diploma ☐Special Education Certificate ☐Dropped out of school at age____________ grade_____________
☐Other: ____

Has the client been:

☐Held back – What grades? ____
☐Suspended – Reason and how long? ____
☐Expelled – From what grade and why? ____
☐Home-schooled – When and why? ____

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Employment ☐No employment history due to age

Was the client ever employed? ☐Yes ☐No

Was he/she successful at this job? ☐Yes ☐No – details ____________________

Was the client ever fired? ☐No ☐Yes – details____________________

Jobs held: ____________________

Household chores: ____________________

Legal

Please detail any contacts you have had with the courts:____________________

____

Please detail any contacts you have had with the police: ____________________

____

____

Personal Information

What are the client's greatest strengths?

____

____

____

What are the client's most likeable attributes?

____

____

____

Hobbies/Interests *(Please list any changes in interest)*

____________________ ☐No change ☐Decreased ☐Increased

____________________ ☐No change ☐Decreased ☐Increased

____________________ ☐No change ☐Decreased ☐Increased

Goals

What are the immediate and long-term goals for services?

____

____

____

____________________ ____________________

Form Completed By Date