Woodlands Family Institute, P.C.
1610 Woodstead Ct., Suite 420
The Woodlands, TX 77380

(281) 363-4220 Fax: (281) 363-4010
www.wfipc.com

PERSONAL DATA RECORD

Client Name: _____ Date of Birth _____

Address: _____

City/State/**Zip**: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

SSN: _____ TXDL: _____

Employer/School: _____

Referred to Our Office by: _____

May we send a Thank You card to the person who referred you? (Circle One) Yes No
May we mention your name in that Thank You card? (Circle One) Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address/Phone: _____

Please indicate below how we may contact you and whether we can leave a message:

☐ Home Phone May we leave a message (Circle One)? Yes No

☐ Work Phone May we leave a message (Circle One)? Yes No

☐ Cell Phone May we leave a message (Circle One)? Yes No

☐ Unencrypted (normal) email (address):_____

If you would like us to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other (Specify) _____

You may change the above instructions at any time by requesting another one of these forms or otherwise instructing us in writing.

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute (WFI) may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *general consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.
  Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within WFI such as utilizing information that identifies you.
- "*Disclosure*" applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

CONSENT FOR TREATMENT

Client Name: _____ Birthdate: _____

I give full consent for **myself** or my **child/adolescent** to receive outpatient mental health services until I notify WFI of any changes or until it is determined that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself or my child/adolescent.

_____ _____

Signature of *Client, Client's Parent* or *Legal Guardian* Date

AUTOMATIC PAYMENT

If you would like us to automatically charge your credit/debit card for your fee, please provide the information below:

MC/Visa No. _____ Exp. Date _____

Name as Listed on Card: _____

Signature of Authorized User: _____

FINANCIAL RESPONSIBILITY

Name of person(s) financially responsible for this account: _____

Address(es): _____

Signature(s): _____

Relationship(s) to client: _____

ACKNOWLEDGEMENT

I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information** and the **Office Information and Office Policies**. I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above, and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

_____

Client or Authorized Representative Signature Date

☐ Refused to Sign

☐ Unable to Sign (Specify Reason) _____

_____

Signature of Person Documenting Refusal or Inability to Sign Date

Connect, Communicate, and Relate
Lauren Pasqua, Psy.D.
Email: dr.pasqua@woodlandsfamilyinstitute.com | Phone: 281-560-3648

Psychological Services
Psychotherapy is not like a medical doctor visit where you are prescribed a pill to make your symptoms go away. Instead, it requires a very active effort on your part. In order for psychotherapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involved discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

By the end of the first few sessions, I will be able to offer you some first impressions of what our work will include if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. You may terminate your services with me at any time, as long as your account is up-to-date. I would happy to provide other referrals if needed. For any concerns about my services, you can contact the Texas Board of Psychology.

Professional Fees

Service	Description	Fee
Individual or Family Therapy Session	45 minutes	$150 or contracted co-pay
Consultation	Review of records, second-opinion, school advocacy	$150 or contracted co-pay
Psychological Testing	Formal testing for ADHD, autism, diagnostics, learning disabilities, development	Fees dependent on referral questions/needs and are charged per hour at rate of $150. Minimum usually $900
Missed session/late cancellation	Sessions missed or cancelled without 24 hr notice. Not covered by insurance	$150
Returned check	Checks will not be accepted as payment after 2 bounced checks	$35 per check
Unscheduled phone sessions over 10 minutes	I do not give phone or email sessions. The first 10 minutes of a call are free. You will be billed starting at the 11th minute. Not covered by insurance.	2.50 per minute starting at 11th minute
Attorney, provider, teacher, or other invested 3rd party phone sessions		Prorated fee based on time spent
Letters	i.e. letter to CPS, schools, attorneys. Not covered by insurance	Prorated fee based on time spent

Treatment Summary	Clinical note information, treatment dates and times, discharge plan, treatment plan and recommendations, interventions, prognosis, response to treatment, and change in symptoms	Prorated fee based on time spent
Meetings	i.e. ARDs, CPS meetings, parent conferences, school observations. Not covered by insurance.	Billed at rate of $150 per hour, portal-to-portal. From my office to location and return to office.
Legal depositions, testimony, or consultation	Time required for travel, preparation, waiting, & expenditures (e.g. copies, parking). Minimum charge for 1 hour. Deposit for legal appearances	$450 per hour $1500 due 48 hours before appearance
Standby for court	1 day standby for court proceedings- non-refundable and non-transferable fee Includes 2 hours of testimony; does not include travel expenses	$1500 (due before date of standby)

Legal Testimony

I do not consider my practice to include expert or forensic testimony in any area. I do not conduct forensic assessments. I can provide only factual information as documented in my clinical notes. In the event that I am required to testify before any court, arbitrator, or other hearing officer, to testify at a deposition, or to present any or all records pertaining to therapy or assessment to a court official, you will be required to pay for all time expended as outlined above. You will also be billed for any acquired expenses for out of town travel (transportation, meals, lodging, etc.).

I required a deposit of $1500 24 hours prior to the appearance, records, or testimony requested. The balance of charges is to be paid within 7 days of said appearance, presentation, or testimony. The deposit is not transferrable or refundable if your case is dismissed or continued less than 72 hours prior to the scheduled time.

If I am placed on "standby" for court, I cannot schedule appointments for that day. Standby fee is $1500 and is not transferrable to another day and non-refundable. The fee will cover 2 hours in court, but you will be billed at $450 per hour for each additional hour in court.

Billing and Payments

You will be expected to pay for each session at the time that it is held, unless we agree otherwise. I require a deposit at the time of psychological testing with payment in full expected by the time the results are presented in the formal report and feedback session. Fees for no-shows and cancellations will be charged to credit card on file.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. (If such legal action is necessary, its costs will be included in the claim.)

Insurance Reimbursement
If I am a provider for your insurance then I will fill out forms; however **you** (not your insurance company) are ultimately responsible for full payment of my fees. If I am an out-of-network provider, I would be happy to provide you detailed receipts to file for reimbursement.

Although HIPPA protects patient records, insurance companies usually require a clinical diagnosis, dates of service, and type of service. Other companies request treatment plans, detailed reports, or even copies of progress notes. I have no control over the use and distribution of your private health information once it leaves my office.

Contacting Me
Due to my work schedule, I am often not immediately available by telephone. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are unable to reach me and it is an emergency, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

Email
Email and other forms of electronic communication are not secure or confidential. If you choose to communicate with me via email you are agreeing to accept the limits to confidentiality that are inherent in electronic communications. Please **DO NOT** email to cancel appointments as I do not monitor my email for cancellations. Emails are to be primarily used in scheduling and payment discussions. I primarily check and respond to emails once per day at lunchtime.

Confidentiality & Privacy Policy
The law protects the relationship between a client and a psychologist, and I cannot disclose information about you without your written permission; however, there are a few legal exceptions to this rule. 1) when a client is likely to harm himself/herself or others 2) when there is reasonable suspicion of child or elder abuse 3) when there is a valid court order 4) With your permission, to bill third-party payers (insurance). Please read and sign the provided information about privacy and HIPAA laws.

Appointments
I do not usually call to confirm appointments. Your appointment time has been specifically reserved for you. If you cannot keep a scheduled appointment, please cancel the appointment **at least 24 hours in advance**.

Cancellation Policy
If you do not show up for your scheduled therapy appointment or are over 15 minutes late, and you have not notified me at least **24 hours** in advance, you will be required to pay the full cost of the session. Appointment times are set aside specifically for you and missed appointments reduce my capacity to provide services to other clients, as the number of appointment times are limited, especially during peak hours (e.g. after school).

Please note that insurance companies do not pay for missed sessions; therefore, you will be personally responsible for full payment of fees for that time. If you miss or re-schedule several consecutive appointments, we will need to re-evaluate our therapeutic relationship. This may mean that we can no longer work together or that the current time is not right for you to engage in therapy.

By signing below I acknowledge that I have read and agree to adhere to all the policies described above. I agree to pay for the above outlined services provided at the rates described above.

_____ _____

Client's Signature Date

CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY

Identifying Information/Presenting Problem:

Child's Name_____ DOB:_____ Age:_____

Education (grade): _____ Present School: _____

Guardian(s):_____

Who referred your child for services:_____

Primary Reason for Services:_____

How long have these problems occurred? (number of weeks, months, years)

_____

What happened that makes you seek help at this time? _____

_____

Problems perceived to be: ____ very serious _____ serious _____ not serious

What changes would you like to see in your child? _____

_____

What changes would you like to see in yourself? _____

_____

What changes would you like to see in your family? _____

_____

Developmental History:

Prenatal: Child wanted? ___ Yes ___ No Planned for? ___ Yes ___ No

Normal pregnancy? ___ Yes ___ No Was prenatal care received:____ Yes _____ No

Medications, smoking, drugs, or alcohol taken during pregnancy (amount and frequency):

_____

Complications during pregnancy:_____

If mother ill or upset during pregnancy, please explain: _____

Family/Partner reaction to pregnancy: (explain) _____

Father's age at birth _____ Mother's age at birth_____

Birth: Length of active labor: _____ hrs. _____ Easy _____ Difficult

Full term: ____ Yes ___ No Number of weeks _____

Birth weight: _____ lbs. _____ oz. Birth length: _____

Type of delivery: __ spontaneous __induced __pitocin augmentation __ cesarean

__ with instruments__ breech

Any complications for mother or infant after birth? Please explain _____

_____

Number of days in hospital: _____ Postpartum blues or depression? _____

Newborn: Breast or bottle fed? Breast feeding difficulties? _____

Any difficulties connecting to baby? _____

Infant Temperament:_____

Did your child experience any of the following during infancy? How Long?

Irritability ___ Yes ___ No _____
Vomiting ___ Yes ___ No _____
Difficulty breathing ___ Yes ___ No _____
Difficulty sleeping ___ Yes ___ No _____
Convulsions/twitching ___ Yes ___ No _____
Colic ___ Yes ___ No _____
Normal weight gain ___ Yes ___ No _____
Inconsolable crying ___ Yes ___ No _____

At approximately what age did your child do the following activities:

Rolled over: _____ Sat Up: _____
Crawled:_____ First steps:_____
First word:_____ Put 2 words together:_____
Toilet trained:_____ Began daycare/preschool:_____

Where there any delays in development?_____

Does your child have any speech difficulties?:_____

Motor difficulties (e.g. clumsiness) ?:_____

Does you child have difficulties with hygiene?_____

Please describe any other developmental concerns:_____

Medical History:

Has your child ever been hospitalized, had a seizure, head injury, surgery, or major illnesses?:

___Yes (Explain below) ____No

Age	How Long	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has child ever been seen by a medical specialist? ___ Yes ___ No

Age	How Long	Reason
_____	_____	_____

Child Health Information: Note all health problems the child has had or has now.

__ High fevers	__ Dental problems	__Pneumonia	__ Weight problems
__ Flu	__Allergies	__ Encephalitis	__ Skin problems
__ Meningitis	__ Asthma	__ Seizures	__ Headaches
__Unconsciousness	__ Stomach	__ Concussions	__ Accident-prone
__ Head injury	__ Anemia	__ Fainting	__ Dizziness
__ Sinus	__ Tonsils out	__ Heart	__ Vision
__ Hearing	__ Earaches	__ Infectious diseases	__ Other illnesses (explain)

_____

What medications does your child currently take? (include over-the-counter and supplements)

Name	Dose	Frequency	Reason
_____	_____	_____	_____

_____ _____ _____ _____

Has child been to dentist? _____ Name pediatrician: _____

Date and results of last vision screen: _____

Date and results of last hearing screen: _____

Describe child's appetite_____ Any weight concerns? _____

Circle and describe any Feeding Challenges: Pickiness Overeating/Stuffing Gagging Choking Vomiting _____

Describe the child's sleeping patterns:_____

(include problems falling asleep, staying asleep, not enough sleep, oversleeping and sleepwalking) Bedtime: _____

Approximate Number of Hours of Sleep Per Night: _____

Is there a history of nightmares or night terrors? _____ (Describe):

_____

Is there a history of bedwetting? (Describe):_____

Mental Health History:

Has the child received therapy services or counseling in the past? (circle) Yes No

Current Services:_____

Past Services:

Name of provider:_____ Dates:_____ Type of Service_____

Name of provider:_____ Dates:_____ Type of Service_____

Is your child seeing a psychiatrist for medication? Or in the past? (circle) Yes No

Name of Psychiatrist:_____ Dates of treatment:_____

Medication the Psychiatrist Prescribed:_____

Would you allow Dr. Pasqua to consult with (speak to) the Psychiatrist? Yes No

Has your child ever received psychological testing (paper and pencil) in the past?_____

Date/s:_____Who conducted the testing?_____

Do you have a copy of the report?_____

Results of testing:_____

List any previous mental health diagnoses:_____

Is there a history of self-harm or suicidal thoughts, threats, or attempts? _____

Explain:_____

Circle which mental health services you feel would assist in addressing the child's current difficulties? Individual Therapy Group Therapy Family Therapy Medication Management Psychological Testing Hospitalization

Does anyone in the family have similar difficulties that the child? _____

(Describe)_____

List any mental health medications that family members are taking or have taken in the past (who):_____

Has anyone in the family received mental health services?

(Describe):_____

Family

Mother: Relationship to child __ natural parent __ relative __ stepparent __ adoptive

Occupation: _____ Education: _____

Religion: _____ Birthplace: _____ Age: _____

Father: Relationship to child- __ natural parent __ relative __ stepparent __ adoptive

Occupation: _____ Education: _____ Religion: _____ Birthplace: _____ Age: _____

Marital History of Parents:

Parents: __ married when _____ age _____ _____
__ separated when _____
__ divorced when _____
__ deceased M or F _____

Stepparents:
__ married when _____
__ married when _____

Current Members of the Household:

Name	Age	Relationship	How do they get along
1			
2			
3			
4			
5			
6			

Siblings or other immediate family members NOT in the home:

Name	Age	Relationship	How do they get along
1			
2			

_____

If father is not actively involved, have there been other father figures? (e.g. stepfather, boyfriend, relatives) Explain:_____

Describe how everyone typically gets along in your home (please put an X below and explain):

__ Calm, No Conflict __ Distant, not much interaction __ Parent Conflicts __ A lot of Arguing/Conflict __ Very Close __ Conflict Only Regarding Child

Explain:_____

Has the child or the family been involved with the Child Protective Services? _____

(Dates):_____ (Reason for Involvement):_____

_____

If child is adopted:

Adoption source: _____

Reason and circumstances: _____

Age when child first in home: _____ Date of legal adoption: _____

What has the child been told? _____

Living Arrangements:	Places	Dates
Number of moves in child's life	_____	_____
	_____	_____
	_____	_____
Present Home: __ renting __ own	_____	_____
__ house __ apartment	_____	_____

Does the child share a room with anyone else? __ Yes __ No

If yes, with whom? _____

Was the child ever placed, boarded, or lived away from the family? __ Yes __ No

Explain: _____

What are the major family stresses at the present time, if any? _____

_____

What are the sources of family income? _____

Has the child been exposed to any of the following:

(Please put an X next to all that apply and explain below):

( ) Physical Abuse:_____

( ) Emotional or Verbal Abuse:_____

( ) Sexual Abuse: _____

( ) Domestic or Family Violence: _____

( ) Substance Use or Abuse: _____

( ) Neglect or Abandonment: _____

( ) Separation from Parent:_____

Child's reaction to divorce/separation:_____

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

____Allergies	____Deafness	____Muscular Dystrophy
____Anemia	____Diabetes	____Anxiety

____Asthma	____Glandular problems	____Autism
____Bleeding tendency	____Heart diseases	____Mental Retardation
____Depression	____High blood pressure	____Seizures
____Cancer	____Kidney disease	____Cerebral Palsy
____Mental illness	____Alcohol/Drug Problem	____Migraines
____ Suicide	_____ Learning Problems	____Other (specify):

Comments re: Family Health: _____

_____

Education History:

Does/did your child receive early intervention? Behavioral/Speech/OT/PT

Other _____ Did your child attend daycare/preschool?_____

How old was child when began school?_____ Where did they attend?_____

Name of Current School: _____ District:_____

Grades/classes repeated or failed: _____Reason: _____

Typical Grades:_____

Circle Classroom Type: Mainstream Class Special Education Class

Resource Assistance Other: _____

ARD/IEP Primary Eligibility: MD Mild MD Mod MD Sev MD Prof Autism OHI

ARD/IEP Secondary Eligibility: _____

Has your child had educational/developmental testing? (**If yes**, Where, When, What Were results) _____

_____

Please **check** any services child receives or had: ___ speech therapy ___ occupational therapy ___ physical therapy ____ adaptive PE ____tutoring

Number of schools the child has attended & reason for changes?

_____

Describe any history of learning problems the child has:_____

_____

Any History of Attendance Problems (truancy)? Describe:_____

Describe any behavior problems reported by the school:_____

_____

Has the child ever been suspended or expelled?_____ Number of suspensions in last two years?_____ Reason for suspensions/expulsions?_____

Favorite class or classes:_____ Least favorite:_____

Social/Emotional Functioning:

Describe the child's personality:_____

_____

What behaviors are concerning to you?_____

_____

How does he/she deal with frustration or anger ? (Mark those that apply and explain):

( ) No Issues ( ) Physical Aggressiveness ( ) Destruction of Property ( ) Self-Harm

( ) Crying/Sadness ( ) Withdrawal ( ) Verbal Aggressiveness

Explain:_____

What are your child's strengths?:_____

What are your child's weaknesses?_____

What is the child afraid of (fears)?_____

Are there any concerns about: ( ) Low Self-Esteem ( ) Sadness/Depression ( ) Worry or Nervousness ( ) Crying _____

Describe your child's relationships with other children or peers:

_____

Does your child have a Boyfriend/Girlfriend? _____

Is your child sexually active?_____

How does the child spend his/her free time?_____

How do you discipline the child?: ( ) Physical:_____ ( ) Time Out ( ) Take Away Privileges ( ) No Discipline

What event/changes(s) have impacted the child?_____

_____

At what age did you first notice any behavioral or emotional issues?

_____What did you do about it at that time?_____

Legal & Substance Abuse History:

Has the child been involved with the court currently or in the past? _____

(Date/s):_____

(Describe)_____

_____

Current Probation? ( ) yes ( ) no

Probation Officer:_____ Phone #:_____

Has the child ever used or abused drugs or alcohol? (Circle): Yes No Not Sure

What Substance(s)?_____

(includes nicotine and excessive caffeine use)

Age of First Use?_____ Frequency of Use?_____

Any Consequences of Substance Use?_____

Please list any other important background information that was not listed on this questionnaire:_____
_____

FOR OFFICE USE ONLY:

Treatment Goals:
1. Reduce the frequency/intensity of:

2. Increase the frequency/intensity of:

3. Eliminate:

Treatment Methods and Duration:
____Individual sessions weekly
____Family sessions weekly
____ Group Sessions
____ Formal Assessment
____ Other

Diagnosis:
Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

Recommendations for Adjunctive Treatment/Assessment:

Plan Review/Revision:

_____ _____
Dr. Lauren Pasqua Client/Guardian

Symptom Checklist

Please check all that apply: (Please write any symptoms not listed at the bottom)

____ Low Intelligence
____ Learning Problems
____ Motor Delays
____ Language Delays
____ Stuttering
____ Refusing to Speak
____ Bedwetting
____ Urinating in Pants
____ Soiling Pants
____ Smearing Feces
____ Increased Self Esteem
____ Repetitive Movements
____ Poor Social Skills
____ Lack of Eye Contact
____ Obsessed with Specific Objects/Topics (e.g. sex, shopping, etc.)
____ Inattention
____ Does Not Listen
____ Problems with Organization
____ Loses Things Easily
____ Distracted Easily
____ Forgetful
____ Excessive Energy
____ Blurts Out/ Talks without Thinking
____ Impulsiveness
____ Excessive Talking
____ Interrupts Others
____ Fear of Social Situations
____ Gets into Physical Fights
____ Has Harmed Others with a Weapon (knife, gun, bat, bottle)
____ Cruel to Animals
____ Stealing Objects
____ Running Away from Home
____ Skipping School
____ Recurrent Thoughts Related to Trauma
____ Loses Temper Easily
____ Arguing
____ Defies Adults
____ Annoys Others on Purpose
____ Angry and Resentful
____ Spiteful or Vindictive
____ Afraid of the Dark or Storms
____ Alcohol Use
____ Cocaine Use
____ Amphetamine Use
____ Marijuana Use
____ Excessive Use of Caffeine
____ Smoking Cigarettes
____ Inhalant Use
____ Any Other Use of Substances
____ Extreme Exercising or Dieting
____ Seeing Things That Others Do Not

____ Depressed Mood
____ Lack of Pleasure in Activities
____ Weight Loss or Gain
____ Insomnia or Oversleeping
____ Feeling Restless or Slowed Down
____ Loss of Energy
____ Feeling Worthless or Guilty
____ Poor Concentration
____ Thoughts of Death
____ Eating Non-Edible Things
____ Less Need for Sleep
____ More Talkative than Usual
____ Racing Thoughts
____ Increased Pleasurable Activities
____ Pounding Heart, Increased Heart Rate
____ Sweating
____ Shaking or Trembling
____ Feeling Like Choking
____ Chest Pain
____ Nausea and/or Stomachaches
____ Feeling Dizzy, Lightheaded, or Faint
____ Feeling Like Going Crazy
____ Fear of Dying
____ Chills or Hot Flashes
____ Fear of Leaving the House
____ Bullies/Threatens Others
____ Recurrent Thoughts or Images
____ Constant Worrying or Nervousness
____ Repetitive Handwashing, Cleaning, etc.
____ Other Repetitive Behaviors
____ Damaged Property
____ History of Trauma or Abuse
____ Fear Related to Trauma or Abuse
____ Avoiding Situations Related to Trauma
____ Blocking Out Memories of Trauma
____ Extreme Startle Response
____ Sleep Problems and/or Nightmares
____ Will Not Separate From Parents
____ Fear of New Situations
____ Sexual Problems
____ Gambling
____ Identity or Gender Issues
____ Making Sick or Vomiting
____ Binge Eating
____ Hearing Voices
____ Sleepwalking