



# PATIENT REGISTRATION

PLEASE PRINT

		Today's Date			
Name					
	Last	First	Middle		
Date of Birth		Age		Sex	M/F

Social Security Number		-		-	
Parent's Name					
Parent's SSN		-		-	

Home Address					
	Address	City	State	Zip	
Home Phone			Work Phone		
Place of Employment					
Work Address					
	Address	City	State	Zip	
Family Physician					

## INSURED/RESPONSIBLE PARTY INFORMATION

Please complete this section regardless of insurance coverage

Insurance Company	
Identification Number	
Name of Insured	

Secondary Insurance	
Identification Number	

**SAMARITAN BEHAVIORAL HEALTHCARE**

**Medical Records Release Authorization**

I authorize Samaritan Behavioral Healthcare to release to my insurer or sponsoring church any medical or mental health information necessary to obtain payment of medical or mental health benefits under my health insurance or from my sponsoring church.

\_\_\_\_\_ Date \_\_\_\_\_  
Insured or Authorized Signature

Furthermore, I authorize Samaritan Behavioral Healthcare to release to my primary care physician, referral source, or other treatment providers health information necessary to coordinate my care.

\_\_\_\_\_ Date \_\_\_\_\_  
Insured or Authorized Signature

**Benefits Assignment Authorization**

I authorize my insurer or sponsoring church to pay Samaritan Behavioral Healthcare any medical or mental health benefits due me under my health insurance or church agreement for services rendered by Samaritan Behavioral Healthcare to me or my dependent

\_\_\_\_\_ Date \_\_\_\_\_  
Insured or Authorized Signature

**Financial Obligation Acknowledgment**

I understand that I am responsible to pay Samaritan Behavioral Healthcare for services rendered to my dependent or me if payment of assigned benefits under my health insurance or sponsoring church agreement is denied or not paid within a reasonable length of time by my insurer or sponsoring church.

X \_\_\_\_\_ Date \_\_\_\_\_  
Insured or Authorized Signature

\_\_\_\_\_  
Name **Please Print** Social Security Number

**Samaritan Behavioral Healthcare**  
Missed Appointments

Because of the shortage of mental health counselors in Scott County, our appointment schedule is nearly always full. If you must miss an appointment please call to cancel so that we may offer your appointment to someone else. Patients who miss appointments or fail to cancel their appointments within 24 hours will be charged \$20.00. Please note that this will be your responsibility because third party payers do not cover missed appointments. Any patient who misses two appointments without calling to cancel may be asked to find another counselor. Thank you in advance for your cooperation

I \_\_\_\_\_ have read the above statement and agree to call to cancel prior to missing an appointment

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature

**Samaritan Behavioral Healthcare**  
Informed Consent for Psychotherapy

**Cognitive Therapy:** I understand that I am going to receive psychotherapy through Samaritan Behavioral Healthcare. I will be treated using a form of Cognitive Therapy or variation of Cognitive Behavioral Therapy. My treatment will be based on treatment protocols that have been shown to be the most effective in treating my particular disorder. I also understand that I have the choice of being treated with standard Cognitive Therapy or with Christian-Oriented Cognitive Therapy.

**Confidentiality:** I understand that my records will be held confidential to the best of the therapist ability and to the extent permitted by law. Only those involved in your treatment or supervision of your treatment will be privy to this information. However, absolute confidentiality cannot be guaranteed. I understand that I will not be identified in any publication or scientific presentation. Disclosure may be required under the following circumstances: Where there is reasonable suspicion of the child or elder abuse; where there is reasonable suspicion that the patient presents a danger of harm to himself or herself; and where there is reasonable suspicion that the patient presents a danger of violence to others. Disclosure may also be required pursuant to a legal proceeding.

**Informed Consent:** I understand the above information and consent to therapy. I understand that if I have any questions, the staff at Samaritan Behavioral Healthcare will be glad to discuss my questions and/or concerns.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**SAMARITAN BEHAVIORAL HEALTHCARE**  
Permission to Record for Supervision or Research

I understand that Samaritan Behavioral Healthcare is a training and research site for counseling. Because of that, patients are sometimes video or audio taped for supervision or research. I understand that I will be informed if this is going to occur. I understand that my records will be handled with confidentiality and only those directly involved in care, research or supervision will be privy to these tapes. I also understand that I will not be identified in any publication or scientific presentation. I also understand that these materials will not be used in any other way without my express written authorization.

- I grant permission
- I **DO NOT** grant permission

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_



# Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**If you have any questions about this Notice please contact: our Privacy Contact who is D. Kristen Small, Ph.D.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website, [www.samaritanbhc.org](http://www.samaritanbhc.org), calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

## **1. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information Based Upon Your Written Consent**

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health

information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

### **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

#### **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made in accordance with state law for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Communicable Diseases:** We may disclose your protected health information, according to state law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information under law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office at (812) 754-1660 and requesting a restriction.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the

right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice electronically.

### **3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, D. Kristen Small, Ph.D. at (812) 754-1660 or [info@samaritanbhc.org](mailto:info@samaritanbhc.org) for further information about the complaint process.

**THIS NOTICE IS EFFECTIVE AS OF FEBRUARY 1, 2005**

### **REVISION OF NOTICE OF PRIVACY PRACTICES**

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at Samaritan Behavioral Healthcare and will make paper copies of the revised Notice of Privacy Practices available upon request.

### **ACKNOWLEDGMENT:**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Samaritan Behavioral Healthcare's Notice of Privacy Practices.

Patient or Patient's Representative		Date
Representative's Relationship to Patient		

**CHILDREN’S QUESTIONNAIRE (REV 11/21/2006)**

**Main Problem:** What is the main problem that made you decide to seek treatment for your child?

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**Who Referred You:** \_\_\_\_\_

**I. PRESENTING PROBLEM**

A. **Symptom Check List Instructions:** For *EACH* symptom in the following list, place a check in one of the boxes (Not Present, Mild, Moderate, Severe, or Extreme). Try to average out the symptoms you have observed in your child over the *PAST WEEK* when you make the ratings. Be sure to check one of the boxes for *EVERY ONE* of the symptoms.

Symptom	Not Present	Mild	Moderate	Severe	Extreme
Loses temper					
Argues with adults					
Defiant					
Anger or hostility towards others					
Violent					
Criminal Activity					
Fire Setting					
Running Away					
Out of Control Behavior					
Difficulty Concentrating					
Hyperactive					
Impulsive					
Confusion					
Anxious					

Symptom	Not Present	Mild	Moderate	Severe	Extreme
Intrusive or unwanted thoughts					
Compulsions or ritual behavior					
Excessive fears					
Fear of sleeping alone or leaving care taker					
Depression					
Suicidal thoughts or gestures					
Loss of Energy					
Sleep problems					
If sleep is a problem, please circle <span style="margin-left: 150px;">too little</span> <span style="margin-left: 150px;">too much</span>					
Appetite Problems					
If appetite is a problem, please circle <span style="margin-left: 150px;">too little</span> <span style="margin-left: 150px;">too much</span>					
Loss of interest in usual activities					
Guilty thoughts or low self-esteem					
Having unreal or strange thoughts					
Hallucinations (hearing voices or "seeing things")					
Sexual Acting Out					
Bed-wetting or loss of bladder control					
Soling pants					

1. When did you first notice these symptoms and how long has your child had them?

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2. Has your child ever had these symptoms before? If so, when? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**B. CURRENT STRESSORS:** Place a check in *EACH ONE* of the boxes (Not Present, Mild, Moderate Severe, or Extreme) for each of the stressors in the following list. Use the check list to indicate how much stress your child has been under during the past year. **THIS CAN INCLUDE STRESS PLACED ON THE CHILD DUE TO FAMILY STRESS.** Be sure to check one of the boxes for *EVERY ONE* of the stressors. Use the “Not Present” column if you have not experienced a specific type of stress during the *PAST YEAR*

List of Stressors	Not Present	Mild	Moderate	Severe	Extreme
Parental Marital Problems					
Conflict with Parents					
Parent or Child Job Problems					
Move					
Parental Separation or divorce					
Death of loved one					
Child or Parent Physical illness					
Family Financial problems					
Conflict with children					
Sexual problems					
Child or Parent School problems					
Child or Parent Legal problems					
Child or Parent Addictions					

## II. History of Psychiatric Treatment

A. **Treatment History:** Please check Yes or No to answer each of the questions in the following list.

	Yes	No
Has your child ever received psychiatric treatment?		
Has your child had periods of significant emotional difficulty or problems in coping but <b>did not</b> seek treatment?		
Has your child had inpatient treatment?		
Has your child had outpatient treatment?		
Has your child ever receive treatment for emotional symptoms from a non-psychiatric MD?		
Has your child had suicidal thoughts?		
Has your child ever attempted suicide?		
Has your child engaged in any other self-harmful behavior?		
Has your child ever had drug or alcohol treatment?		

B. **History of Medication Use:** Please check a Yes or No to indicate whether your child has ever been prescribed medication for any of the following problems

	Yes	No
Depression		
Anxiety or Panic Attacks		
Unreal or strange thoughts		
For side effects of psychiatric medication		
Insomnia or other sleeping problems		
Attention Deficit Hyperactivity Disorder		
Substance abuse		
Other psychiatric problems		



Cocaine								
Other Uppers								
Pain Killers								
<b>Chemical</b>	<b>Age of First Use</b>	<b>Age of Regular Use</b>	<b>First Saw as a Problem</b>	<b>Arrests</b>	<b>Most Ever Used</b>	<b>Last Use</b>	<b>Chemical of Preference</b>	<b>Route of Administration</b>
Marijuana								
Hallucinogens								
Inhalants								
Nicotine								
Caffeine								
Over the Counter								
Other								
Longest period of sobriety your child has had since beginning to continuously use drugs/alcohol								
Has your child ever experienced withdrawal symptoms (Several hours to several days after stopping or reducing use (including):								
<input type="checkbox"/> Tremors			<input type="checkbox"/> Nausea/Vomiting/Diarrhea			<input type="checkbox"/> Increased Heart Rate/Blood Pressure/Sweating		
<input type="checkbox"/> Insomnia or Hypersomnia			<input type="checkbox"/> Anxiety/Depression/Irritability			<input type="checkbox"/> Runny Nose/Eyes		
<input type="checkbox"/> Achy Joints/Muscles			<input type="checkbox"/> Poor Concentration			<input type="checkbox"/> Headaches		
Have you ever had								
<input type="checkbox"/> Seizures			<input type="checkbox"/> Cirrhosis			<input type="checkbox"/> Hepatitis		
Have they ever overdosed?					<input type="checkbox"/> Yes			
					<input type="checkbox"/> No			
What is the highest Blood Alcohol Level Your Child has ever had?								
Do they every experience black outs?					<input type="checkbox"/> Yes			
					<input type="checkbox"/> No			
What is their typical daily usage during the last six months?								

**B. Reactions to Drug and Alcohol Use:** Please check a Yes or No to answer each of the questions in the following list

	Yes	No
Have they ever felt they should cut down on your drinking or drug use?		

Have people annoyed them by criticizing them about their drinking or drug use?		
Have they ever felt bad or guilty about their drinking or drug use?		
Have they ever had a drink or used drugs first thing in the morning (eye opener) to steady their nerves or get rid of a hangover?		

IV. **MEDICAL HISTORY:** Please use this section of the questionnaire to give information on illnesses, hospitalizations, surgeries, and allergies that you have experienced. Fill in the blanks where requested.

Family Physician \_\_\_\_\_

History of Medical Illness (List Any Previous and/or Current Medical Illnesses or Conditions)			
Date of Onset	Illness or Condition	Check if Current	Physician

Previous Hospitalizations		
Year	Description of Illnesses or Condition	Hospital

Surgical History			
Year	Surgery Performed	Hospital	Surgeon

Allergies	
Medications	Other Substances



## V. Family History

A. **Childhood:** Please answer the following questions to describe your child's personal background and experiences

How would you rate your child's life?	<input type="checkbox"/> Happy <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Fair <input type="checkbox"/> Sad <input type="checkbox"/> Terrible
What is your child's current living situation?	<input type="checkbox"/> Lives with both parents <input type="checkbox"/> Lives with one parent <input type="checkbox"/> Lives with grandparent or relative <input type="checkbox"/> Lives with guardian <input type="checkbox"/> Other
Has your child ever experienced trauma or abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there other children? If so, how many? Ages	<input type="checkbox"/> Yes <input type="checkbox"/> No
If there are other children, do they live in the same household?	<input type="checkbox"/> Yes <input type="checkbox"/> No

B. **Relationships:** Please use the following check list to describe your child's relationships with his or her family and others

	Not Present or not applicable	Poor	Fair	Average	Good	Excellent
Father						
Step-Father						
Mother						
Step-Mother						
Brothers						
Step-Brothers						
Sisters						
Step-Sisters						
Grandparents						

Step-Grandparents						
Other						

## VI. DEVELOPMENTAL HISTORY

### A. Pregnancy and Delivery

Was the pregnancy planned?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were the mother and father married at the time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the pregnancy normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What was the length of the pregnancy	
How long was active labor?	
What type of delivery	<input type="checkbox"/> Spontaneous <input type="checkbox"/> Caesarean
Was the child born	<input type="checkbox"/> Head first <input type="checkbox"/> Feet first
Birth weight	
Was the child a twin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was a blood transfusion done?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### B. In the first two weeks, did the child

Appear yellow	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have blue lips	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have convulsions/twitching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have feeding difficulty	<input type="checkbox"/> Yes

	<input type="checkbox"/> No
Show irritability	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respond slowly	<input type="checkbox"/> Yes <input type="checkbox"/> No

C. In later infancy, did the child have

Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleeping problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes (how long) <input type="checkbox"/> No
Colic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual weight gain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Overactive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Underactive	<input type="checkbox"/> Yes <input type="checkbox"/> No

D. When did your child (age, in months)

Smile	
Get first teeth	
Crawl	
Stand	
Walk	
Speak words	
Speak Sentence (give example)	

Feed self	
Dress self	
Was the child breast fed?	<input type="checkbox"/> Yes (how long) <input type="checkbox"/> No
How old when toilet training was begun?	
How old when child was dry during the day?	
How old when child was dry during the night?	
Any special toilet training problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

E. Puberty: If your child has reached puberty, please complete this section. If not, go on to the next session. At what age did the following change or develop?

Boys	Girls
Voice	Menstruation
Body Hair	Body Hair
Hair on Face	Breast Development
“Wet dreams”	Pregnancy

**VII. SOCIAL HISTORY:** Please answer the following questions about your child’s social history

How much education has your child had?	<input type="checkbox"/> <1 <sup>st</sup> grade <input type="checkbox"/> 1 <sup>st</sup> -5 <sup>th</sup> grade <input type="checkbox"/> 6 <sup>th</sup> -8 <sup>th</sup> grade <input type="checkbox"/> 9 <sup>th</sup> -11 <sup>th</sup> grade
How well is your child doing in school	<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Average <input type="checkbox"/> Good <input type="checkbox"/> Excellent
Does your child have a job?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have any hobbies and/or recreational interests?	<input type="checkbox"/> yes <input type="checkbox"/> no
Their degree of involvement in leisure and recreational activities can be best described as	<input type="checkbox"/> none <input type="checkbox"/> little <input type="checkbox"/> moderate

	<input type="checkbox"/> much <input type="checkbox"/> a great deal
Their level of enjoyment of their leisure and recreational activities is:	<input type="checkbox"/> none <input type="checkbox"/> little <input type="checkbox"/> moderate <input type="checkbox"/> much <input type="checkbox"/> a great deal
How much are they involved in an exercise program?	<input type="checkbox"/> never <input type="checkbox"/> occasional <input type="checkbox"/> regular
Does your child or family have a religious preference?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If your child or family has a religious preference, what is it?	<input type="checkbox"/> Protestant <input type="checkbox"/> Catholic <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim <input type="checkbox"/> None <input type="checkbox"/> Other
How often does your child attend or participate in religious/spiritual activities?	<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> More than once a week
Has your child ever had a religious/spiritual experience (got saved, had a mystical experience, became a Christian, etc). Please describe	<input type="checkbox"/> Yes <input type="checkbox"/> No