PRINTABLE Child - Therapy Forms

Please complete these forms prior to your child's first therapy appointment.

Patient Registration Information

Childs Name

First | Middle | Last

Child's Sex
○ Male ○ Female

Child's Date of Birth

Home Phone

Cell/Work Phone

May we leave a message on your Home Phone?
○ Yes ○ No

May we leave a message on your Cell Phone?
○ Yes ○ No

Address

Address Line 1

Address Line 2

City | State | Zip Code

Parent/Guardian's Name

First | Middle | Last

Parent/Guardian's Cell/Work Phone

Parent/Guardian's Email

In Case of Emergency, Please Contact:

First

Last

Emergency Contact's Relationship to Child

Emergency Contact Phone Number

Chose Clinic Because/Referred to Clinic by (Please choose one)
○ Doctor ○ Insurance Plan ○ Hospital ○ Family/Friend ○ Convenient Location ○ Found on Google or Social Media

⊙

Payment (Choose One)

○ I will pay for these services directly and do not wish to have you bill my insurance.

○ Please bill my insurance using the information provided on the next page.

Insurance Information

Child's Name:

Child's Social Security Number

Primary Insurance Name:

Subscriber (Policy Holder)'s Birthdate

Name of Subscriber

First

Last

Child's Relationship to Subscriber

○ Self ○ Spouse ○ Child

◉

ID or Policy Number

Group Number

Occupation of Subscriber

Subscriber's Employer

Employer's Address

Address Line 1

Address Line 2

City

State

Zip Code

Employer's Phone

Secondary Insurance Name

Name of Insured

First

Child's Relationship to Subscriber

○ Self ○ Spouse ○ Child

◉

Last

ID or Policy Number

Group Number

(Initials) I authorize Mission Psychology and the above insurance provider(s) to release any information required to process my claims.

Cancellation Policy

Failure to cancel an appointment within 24 hours of the scheduled time is considered a "No-Show" and is billed at the full rate. I understand that insurance usually does not pay for no-shows, and I will be responsible for the fee myself.

(Initials)

Authorization of Treatment and Payment

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Mission Psychology. I understand that I am financially responsible for any balance.

Signature

Date

Name of Responsible Party

First

Last

Notice of Receipt of Policy Regarding Protected Health Information

Please sign below to indicate that you have been given the opportunity to review Mission Psychology's policies regarding protected health information. If you request it, we will provide you with a paper copy of the policy.

Name

First

Last

Signature

Date

Child Custody Affirmation

Your Name

First | Last

Your Relationship to the Child

Do you have legal authority to consent to medical and psychological care for your child?

○ Yes ⊙ No

If the parents are divorced, our office requires a copy of the divorce decree for our records. We will not conduct an assessment until we have a copy of the MOST RECENT divorce decree that confirms that you are the custodial parent with authority to consent to medical and psychological treatment. If at all possible, we prefer for both parents to consent to assessment or treatment, regardless of custody arrangements.

(Initials) Please confirm the above statement by initialing.

I, the undersigned, have read and understand the purpose for assessment and treatment, the potential uses of information, and the limits of confidentiality. I affirm that I have legal authority to consent to medical and psychological care for my child.

I consent to psychotherapy.

Signature **Date**

Name

First | Last

You may upload a copy of the Most Recent Divorce Decree or Custody Arrangement here.

Child/Adolescent History

The following is a questionnaire about the child's development, medical history, and current functioning at home and at school. This information will be integrated with any testing results or case conceptualization to provide a better picture of the child's abilities as well as any problem areas. Please fill out this questionnaire as completely as you can.

Child's Name

First

Last

Child's Birthdate

Child's Current Age

Birth Country

Age of Child on Arrival in Country if Born Elsewhere

Name of Person Completing Form

First

Last

Relationship to Child

What questions do you hope will be answered?

What Concerns Bring you Here?

Child's Family

Biological Mother's Name

First

Last

Age

Highest Grade Completed

Degree/Diploma (if applicable)

Occupation

Biological Father's Name

First

Last

Age

Highest Grade Completed | **Degree/Diploma (if applicable)** | **Occupation**

Marital Status of Biological Parents

○ Married ○ Separated ○ Divorced ○ Widowed

⊙

Does the child live with either of the biological parents?

○ Yes ○ No

If the child is not living with either biological parent, what is the reason?

Who does the child live with?

○ Adoptive Parents ○ Foster Parents ○ Other Family Members ○ Group Home

⊙

Name of Legal Guardian

First | Last

List all people currently living in the child's household (include their name, relationship to the child, and age):

If any brothers or sisters are living outside of the home, list their names and ages:

Primary Language Spoken in Home
⊙ English ○ Spanish
○

Other Languages Spoken in the Home

Is the child's first language English?
⊙ Yes ○ No

Current Medications

Is the child currently taking medications?
⊙ Yes ○ No

Medication #1	Reason Taken	Dosage	Start Date

Medication #2	Reason Taken	Dosage	Start Date

Medication #3	Reason Taken	Dosage	Start Date

Medication #4	Reason Taken	Dosage	Start Date

List any other medications the child is taking

Behaviors of Concern

Check all the behaviors you believe the child exhibits to an excessive degree compared to other children his or her age.

SLEEP
☐ Nightmares ☐ Problems going to sleep ☐ Problems staying asleep

EATING
☐ Eats poorly ☐ Eats excessively ☐ Picky eater ☐ Poor appetite

SELF-HARM
☐ Dangerous to self or others ☐ Purposely harms or injures self ☐ Talks about killing self

SOCIAL AND EMOTIONAL FUNCTIONING

- ☐ Prefers to be alone
- ☐ Very shy or timid
- ☐ Difficulty making friends
- ☐ Teased by other children
- ☐ Bullies other children
- ☐ Not sought out for friendships by peers
- ☐ Difficulty seeing another person's point of view
- ☐ Doesn't empathize with others
- ☐ Doesn't appreciate humor
- ☐ Unusual fears, habits, or mannerisms
- ☐ Depressed
- ☐ Cries frequently
- ☐ Worried or anxious
- ☐ Overly preoccupied with details
- ☐ Not affected by negative consequences
- ☐ Drug abuse
- ☐ Alcohol abuse
- ☐ Sexually active

BEHAVIOR PROBLEMS

- ☑ Stubborn
- ☐ Strikes out at others
- ☐ Lying
- ☐ Argues with adults
- ☐ Daredevil behavior
- ☐ Needs lots of supervision
- ☐ Poor sense of danger
- ☐ Irritable, angry, or resentful
- ☐ Throws or destroys things
- ☐ Stealing
- ☐ Low frustration tolerance
- ☐ Runs away
- ☐ Impulsive (does things without thinking)
- ☐ Skips school

OTHER PROBLEMS

- ☑ Bladder control problems
- ☐ Motor/vocal tics
- ☐ Problems with taste or smell
- ☐ Excessive daydreaming or fantasy life
- ☐ Bowel control problems
- ☐ Overreacts to noises
- ☐ Tactile sensitivity

MOTOR SKILLS

- ☑ Poor fine motor coordination
- ☐ Poor gross motor coordination

Please describe any other behaviors of concern:

Education Program

Where does the child go to school?

Child's Grade

Does the child have a modified learning program?
○ Yes ○ No

Is there an individualized education program (IEP)?
○ Yes ○ No

{if (!AreYouSatisfiedWithTheChildsCurrentLearningProgram)}

If not, please explain:

{IfNotPleaseExplain}

{ end if }

Has the child been held back a grade?
○ Yes ○ No

{if (HasTheChildBeenHeldBackAGrade)}

If so, what grade(s)?

{IfSoWhatGrades}

{ end if }

Is the child in any special education classes?
○ Yes ○ No

Is the child receiving learning assistance or tutoring in or after school?
○ Yes ○ No

Has the child ever been suspended or expelled from school?
○ Yes ○ No

{if (HasTheChildEverBeenSuspendedOrExpelledFromSchool)}

If yes, please explain:

{IfYesPleaseExplain3}

{ end if }

Please describe any classroom or school problems (if applicable):

For the following items, please rate the child's cognitive skills compared to other children of the same age.

Speech
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Comprehension of Speech
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Problem Solving
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Attention Span
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Organization Skills
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Remembering Events
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Remembering Facts
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Learning from Experience
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Understanding Concepts
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Overall Intelligence
○ Above Average ○ Average ○ Below Average ○ Severe Problem

Check any specific problems

☐ Poor articulation
☐ Difficulty finding words to express self
☐ Disorganized speech
☐ Ungrammatical speech
☐ Frequently loses belongings
☐ Difficulty planning tasks
☐ Doesn't foresee consequences
☐ Slow thinking

☐ Talks like a younger child
☐ Slow learner
☐ Forgets to do things
☐ Easily distracted
☐ Difficulty with math/handling money
☐ Poor understanding of time
☐ Frequently forgets instructions
☐ Poor articulation/speech defect

Describe any other cognitive problems that the child has:

Describe any special skills or abilities that the child has:

Developmental History

During pregnancy, did the mother of the child:

Take Any medication?
○ Yes ○ No

If yes, what?

Smoke?
○ Yes ○ No

If yes, how many cigarettes per day?

Drink?
○ Yes ○ No

If yes, what did she drink and how much per day or week?

Use Drugs?
○ Yes ○ No

If yes, what and how often?

List any complications during pregnancy (vomiting, staining/blood loss, threatened miscarriage, infections, toxemia, etc)

Duration of pregnancy (weeks):

Duration of labor (hours):

APGAR:

Were there any signs of fetal distress?
○ Yes ○ No

If yes, what were the indications?

Check any that apply to the birth:
☐ Labor Induced ☐ Assisted Delivery (Forceps, vacuum) ☐ Breech ☐ C-Section

Were there any other birth complications?
○ Yes ○ No

{if (WereThereAnyOtherComplications)}

If yes, what?

{IfYesWhat2}

{ end if }

Were there any feeding problems?
○ Yes ○ No

Were there any sleeping problems?
○ Yes ○ No

Were there any developmental problems?
○ Yes ○ No

{if (WereThereAnyDevelopmentalProblems)}

If yes, what?

{IfYesWhat5}

{ end if }

Were any of the following present (to a significant degree) during infancy or the first few years of life?

☐ Unusually quiet or active
☐ Colic
☐ Headbanging
☐ Did not like to be held or cuddled
☐ Excessive restlessness
☐ Constantly into everything
☐ Not alert
☐ Excessive sleep
☐ Excessive number of accidents
☐ Difficult to soothe
☐ Diminished sleep

Please indicate the approximate age at which the child first showed the following behaviors. Choose "Never" if the child has never shown the behavior.

Smiled
○ Early ○ Average ○ Late ○ Never

Tied Shoelaces
○ Early ○ Average ○ Late ○ Never

Rolled Over
○ Early ○ Average ○ Late ○ Never

Dressed Self
○ Early ○ Average ○ Late ○ Never

Sat Alone
○ Early ○ Average ○ Late ○ Never

Fed Self
○ Early ○ Average ○ Late ○ Never

Crawled
○ Early ○ Average ○ Late ○ Never

Bladder Trained, Day
○ Early ○ Average ○ Late ○ Never

Walked
○ Early ○ Average ○ Late ○ Never

Bladder Trained, Night
○ Early ○ Average ○ Late ○ Never

Babbled
○ Early ○ Average ○ Late ○ Never

Bowel Trained
○ Early ○ Average ○ Late ○ Never

First Word
○ Early ○ Average ○ Late ○ Never

Rode Tricycle
○ Early ○ Average ○ Late ○ Never

Sentences
○ Early ○ Average ○ Late ○ Never

Rode Bicycle
○ Early ○ Average ○ Late ○ Never

Medical History

Vision Problems?
○ Yes ⊙ No

Date of last vision exam

Hearing Problems?
○ Yes ⊙ No

Date of last hearing exam

Please indicate any illness/condition the child has had, along with the approximate age or date of illness.

☐ **Measles**

☐ **Mumps**

☐ **Whooping Cough**

☐ **Scarlet Fever**

☐ **Encephalitis**

☐ **Seizures**

☐ **Hay Fever**

☐ **Attention Deficit**

☐ **Chicken Pox**

☐ **Diphtheria**

☐ **Meningitis**

☐ **High Fever**

☐ **Allergy**

☐ **Injuries to Head**

☐ **Broken Bones**

☐ **Hospitalizations**

☐ **Operations**

☐ **Ear Infections**

☐ **Paralysis**

☐ **Loss of consciousness**

☐ **Poisoning**

☐ **Severe Headaches**

☐ **Rheumatic Fever**

☐ **Tuberculosis**

☐ **Bone or Joint Disease**

☐ **Sexually Transmitted**

Disease

☐ **Anemia**

☐ **Jaundice/Hepatitis**

☐ **Diabetes**

☐ **Cancer**

☐ **High Blood Pressure**

☐ **Heart Disease**

☐ **Asthma**

☐ **Bleeding Problems**

☐ **Eczema**

☐ **Physical Abuse**

☐ **Sexual Abuse**

Other

FAMILY MEDICAL HISTORY - Indicate any problem that any family member has had:

☐ **Seizures/epilepsy**

☐ **Attention Deficit**

☐ **Learning Disabilities**

☐ **Intellectual Disability**

☐ **Behavior Problems**

☐ **Mental Illness**

☐ **Depression or Anxiety**

☐ **Neurological Disease**

☐ **Tics or Tourette's Syndrome**

☐ **Alcohol or Drug Abuse**

☐ **Suicide Attempt**

☐ **Physical Abuse**

☐ **Sexual Abuse**

☐ **Parkinson's Disease**

☐ **Huntington's Disease**

☐ **Antisocial Behavior**

List any previous assessments the child has had:

Psychiatric (Include Date of Testing and Name of Examiner)

Neuropsychological (Include Date of Testing and Name of Examiner)

Educational (Include Date of Testing and Name of Examiner)

Speech Pathology (Include Date of Testing and Name of Examiner)

If possible, please upload any previous assessment results/reports here:

List any form of Mental Health Treatment the child has had (e.g., psychotherapy, family therapy, residential treatment). Please include Type of Treatment, Dates, and Names of Provider.

Please list any recent stressors that might be contributing to the child's difficulties:

Other Information

What are the child's favorite activities?

Has the child ever been in trouble with the law:
○ Yes ○ No

{if (YesNo)}

If yes, please describe:

{IfYesPleaseDescribe}

{ end if }

On average, what percentage of the time does the child comply with requests or commands?

Please describe the typical form of discipline for this child:

What have you found to be the most satisfactory ways of helping this child?

What are the child's strengths or assets?

Is there any other information that may help us in assessing the child?

Credit Card Authorization

We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable, including, but not limited to, copayments, coinsurance, any amound applied to your deductible, no show appointment fees, and other billing charges. If you have any questions or concerns about this policy, please discuss with your clinician before signing.

Your credit card information is kept confidential and secure and payments to your card are processed only afgter the cliam has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account.

I authorize Mission Psychology to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Card Type
○ Visa ○ Mastercard ○ Discover

Credit Card Number

Expiration Date

3-Digit Security Code

Cardholder Name

First

Last

Signature

Billing Address

Address Line 1

Address Line 2

City

State

Zip Code

I, the undersigned, authorize and request Mission Psychology to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Mission Psychology. This authorization will remain in effect until I cancel this authorization. To cancel, I must give 60 day notification to Mission Psychology in writing and the account must be in good standing.

Patient Name

First Last

Responsible Party Name

First Last

Responsible Party Signature

Date