Child - Assessment Forms

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

Patient Registration Information

Child's Name

First | Middle | Last

Child's Gender
○ 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 Social Security Number

Primary Insurance Name:

E.g. BCBS, Aetna, etc.

Subscriber'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

Your Relationship to the Child

First

Last

Child's Name

First

Last

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 treatement, 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 the evaluation.

Signature

Date

Name

First

Last

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

Child/Adolescent Neuropsychology Questionnaire

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 questionniare 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 (!DoesTheChildLiveWithEitherOfTheBiologicalParents)}

Name of Legal Guardian

{NameOfLegalGuardian.First} {NameOfLegalGuardian.Last}

First Last

{ end if }

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

Medication Name	Reason Taken	Dosage	Start Date

Please list any side effects or concerns about the child's current medications

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

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

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

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

Are you satisfied with the child's current learning program?
⊙ Yes ○ No

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

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

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
☐ Frequently loses belongings
☐ Difficulty finding words to express self
☐ Difficulty planning tasks
☐ Disorganized speech
☐ Doesn't foresee consequences
☐ Ungrammatical speech
☐ Slow thinking
☐ Talks like a younger child
☐ Difficulty with math/handling money
☐ Slow learner
☐ Poor understanding of time
☐ Forgets to do things
☐ Frequently forgets instructions
☐ Easily distracted
☐ 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

Smoke?
○ Yes ⊙ No

Drink Alcohol?
○ Yes ⊙ No

Use drugs?
○ Yes ⊙ No

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 indications of fetal distress?
○ Yes ⊙ No

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

Were there any other complications?
○ Yes ⊙ No

Were there any feeding

problems?
○ Yes ⊙ No

Were there any sleeping problems?
○ Yes ⊙ No

Were there any developmental problems?
○ Yes ⊙ No

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

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

Rolled Over
○ Early ○ Average ○ Late ○ Never

Sat Alone
○ Early ○ Average ○ Late ○ Never

Crawled
○ Early ○ Average ○ Late ○ Never

Walked
○ Early ○ Average ○ Late ○ Never

Babbled
○ Early ○ Average ○ Late ○ Never

First Word
○ Early ○ Average ○ Late ○ Never

Sentences
○ Early ○ Average ○ Late ○ Never

Tied Shoelaces
○ Early ○ Average ○ Late ○ Never

Dressed Self
○ Early ○ Average ○ Late ○ Never

Fed Self
○ Early ○ Average ○ Late ○ Never

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

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

Bowel Trained
○ Early ○ Average ○ Late ○ Never

Rode Tricycle
○ 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
○ Yes ⊙ No

Mumps
○ Yes ⊙ No

Whooping Cough
○ Yes ⊙ No

Scarlet Fever
○ Yes ⊙ No

Encephalitis
○ Yes ⊙ No

Seizures
○ Yes ⊙ No

Hay Fever
○ Yes ⊙ No

Attention Deficit
○ Yes ⊙ No

Chicken Pox
○ Yes ⊙ No

Diptheria
○ Yes ⊙ No

Meningitis
○ Yes ⊙ No

High Fever
○ Yes ⊙ No

Allergy
○ Yes ⊙ No

Injuries to Head
○ Yes ⊙ No

Broken Bones
○ Yes ⊙ No

Hospitalizations
○ Yes ⊙ No

Operations
○ Yes ⊙ No

Ear Infections
○ Yes ⊙ No

Paralysis
○ Yes ⊙ No

Loss of consciousness
○ Yes ⊙ No

Poisoning
○ Yes ⊙ No

Severe Headaches
○ Yes ⊙ No

Rheumatic Fever
○ Yes ⊙ No

Tuberculosis
○ Yes ⊙ No

Bone or Joint Disease
○ Yes ⊙ No

Sexually Transmitted Disease
○ Yes ⊙ No

Anemia
○ Yes ⊙ No

Jaundice/Hepatitis
○ Yes ⊙ No

Diabetes
○ Yes ⊙ No

Cancer
○ Yes ⊙ No

High Blood Pressure
○ Yes ⊙ No

Heart Disease
○ Yes ⊙ No

Asthma

○ Yes ⊙ No

Bleeding Problems
○ Yes ⊙ No

Eczema
○ Yes ⊙ No

Physical Abuse
○ Yes ⊙ No

Sexual Abuse
○ Yes ⊙ No

Other

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

Seizures/epilepsy
○ Yes ⊙ No

Attention Deficit
○ Yes ⊙ No

Learning Disabilities
○ Yes ⊙ No

Intellectual Disability
○ Yes ⊙ No

Behavior Problems
○ Yes ⊙ No

Mental Illness
○ Yes ⊙ No

Depression or Anxiety
○ Yes ⊙ No

Neurological Disease
○ Yes ⊙ No

Tics or Tourette's Syndrome
○ Yes ⊙ No

Alcohol or Drug Abuse
○ Yes ⊙ No

Suicide Attempt
○ Yes ⊙ No

Physical Abuse
○ Yes ⊙ No

Sexual Abuse
○ Yes ⊙ No

Parkingson's Disease
○ Yes ⊙ No

Huntington's Disease
○ Yes ⊙ No

Antisocial Behavior
○ Yes ⊙ No

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

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?

Collateral Information

In order to collect collateral data and information, the evaluator may need to speak with or send questionnaires to your child's teacher and/or school counselor. Please provide a valid email for your child's teacher and/or school counselor below.

Name of Teacher

First

Last

Email of teacher

Name of School Counselor

First

Last

Email of School Counselor

By signing below, you are giving Mission Psychology permission to contact your child's teacher and/or school counselor by email.

Parent or Guardian Signature

Date

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 after the claim 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