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Child Developmental History Intake Form

Date of first visit (consult): ______________________ Referred by: ______________________________

Child's full legal name: _________________ Nickname: ____

Child's date of birth: ___________________ Child's age: ______________ Grade in School: __________

Other children in the primary family and their ages (see pages 2 & 3 for blended family members):

____

____

Child's primary address (include zip code): ____

Home phone number: ___________________________ Home fax _________________________________

Child's current school: ____

Mother's name: First _______________ Last _____________________ Maiden _____________________

Cell ___________________ Email ______________________________ Work phone __________________

Father's name: ____

Cell ___________________ Email ______________________________ Work phone __________________

Alternate parent address if different: ____

Is this your biological child? _________ Was your child adopted? or a foster child? ________________

If so, please provide information regarding the child's history prior to joining your family:

____

____

Reason for referral to Dr. Zelinger at this time: ____

____

____

____

How would you rate the frequency and severity of this problem? _________________________________

____

What discipline approaches are used at home? ____

____

____

Pregnancy and Delivery

Did the mother engage in any of the following during pregnancy? Routine obstetrical care _________

Recreational drugs _______ Smoking _______ Alcohol use _______ Required bed rest _________

Were fertility treatments utilized? ____

Prescribed medication during pregnancy (describe purpose): ___________________________________

____

Issues during pregnancy? ____

Birth weight _______________

Mother's age at time of baby's birth: _______ Father's age at time of birth: ________

Was infant full term? _________ Complications during pregnancy or delivery? ___________________

Did baby leave hospital with mother? ________________

Baby's birth order in family: #__________ of how many children? ________

Infancy

Which parents/adults provided most of the care during first year? ______________________________

____

Breast fed? How long? _________ Bottle fed? How long? _______ Pacifier? How long? ____________

Describe temperament as baby:

____

Developmental Milestones

Please provide approximate age for each:

Babbled/cooed _______ First words ________ Two words together _______ Sentences __________

Made self understood with words or gestures ____________

Regression in language seen after learning to speak? ________________

Other languages spoken in the home? By whom? ____________________________________

Crawled ___________ Walking with support ___________ Walking independently ___________

Urine trained (day) _____________ Urine trained (night) ______________

Bowel trained (day) ____________ Bowel trained (night) ______________

Were any **evaluations** performed based on concerns during first three years of life? ________

Did child receive **Early Intervention** ages 0-3 and/or services through **Committee on Preschool Education** (CPSE) ages 4-5?

Please list: ____

____

Family Structure

Are mother and father married? _____ Separated? ______ Divorced? ______ Never married? ______

Mother's name: ____________________________ Date of birth: _____________________________

Occupation:____

What does child call mother? ____

Father's name: _____________________________ Date of birth: ____________________________

Occupation:____

What does child call father? ____

Is this child part of a blended family (stepchild)? _________ Please describe family constellation:

____

____

Stepfather's name: _______________ DOB: ___________ Occupation: _________________________

Child's age at time of mother's re-marriage: _______ Child's name for stepfather: _________________

List stepsiblings (stepfather's children) and ages: ____

____

Stepmother's name: ______________ DOB: ___________ Occupation: _________________________

Child's age at time of father's re-marriage: ________ Child's name for stepmother: ________________

List stepsiblings (stepmother's children) and ages: ____

____

List **half**siblings (union of remarriage) and ages (with same mother): ___________________________

____

List **half**siblings (union of remarriage) and ages (with same father): ___________________________

____

Other adults living in the primary home (i.e. grandparent, housekeeper, nanny):

____

Does either parent have a "significant other"? Please describe: __________________________________

____

If divorce, what are custody/visitation arrangements? ____

____

Is there an Order of Protection? _____ Against whom? __________________________________

Has Child Protective Services (CPS or ACS) been involved? ____ Allegation? ____________________

CPS Findings: ____

Stressors in the Environment

What causes stress in your family? ____

____

Psychological/emotional issues on mother's side:

____

____

Psychological/emotional issues on father's side:

____

____

Psychological/behavioral issues in your other children:

____

____

School

When did child first begin a day experience away from home? (day care, nursery school, pre-K) List <u>first</u> school, child's age and adjustment: ____

<u>Next school</u> and adjustment: ____

Next school and adjustment: ____

Current school name and phone number: ____

Current teacher's name: _______________________ Second teacher's name: ____________________

Describe academic strengths: ____

Describe academic weaknesses: ____

Does your child have an Individualized Education Program (IEP)? _____________

What is the IDEA classification? ____

What services does your child receive? ____

____

Does your child have a Section 504 Plan? Please describe accommodations: ______________________

____

****** Please send a copy of the IEP or 504 to Dr. Zelinger ******

What are the school's concerns? ____

____

What are your child's interests? ____

Who provides primary care of your child after school? _______________________________________

What are your child’s summer plans? ____

Medical

Does your child have a medical diagnosis? ____

What medication or supplements does your child take on a regular basis? __________________________

____

Allergies? ______________________________ EPI pen? _________________________________

Has your child ever been hospitalized? Give age and reason: _________________________________

Name and phone number of pediatrician: ____

Name and phone number of neurologist: ____

Name and phone number of psychiatrist: ____

Other treating physician: ____

Social/Behavioral

Does your child have social difficulties? Please describe: ___________________________________

____

Is your child asked for playdates (hangouts)? _____________ Does (s)he have friends? _____________

Does your child complain that they have no friends? _________

Will your child sleep at a friend’s house? _________

Does your child have specific fears? Please describe: ______________________________________

____

Does your child have any habits or mannerisms that concern you? ____________________________

Has your child experienced a significant **trauma**? ____

Does your child have **sleep** problems? ____

Does your child often **get into trouble**? ____

Does your child **wet the bed**? ________ How often? _________ Have **bad dreams**? ______________

Does your child have **sensory issues**? (e.g. smells, sounds, foods, clothing textures, sensitivity to touch or need for deep pressure contact) ____

Does your child engage in any **stereotypical behaviors**? (e.g. hand flapping, rocking or spinning, poor eye contact, repetitive movements) ____

Does your child have trouble **regulating his/her activity level**? ______________________________

____

Has your child ever been seen by a psychologist or social worker for psychotherapy? When? _________

Please describe: ____

____

Choose five (5) adjectives to describe your child: ______________________________________

____

Comments: ____

____

This form was completed by: ____

Parent signature indicates agreement to have Dr. Zelinger work with your child and that you have read and signed the HIPAA form. Parental signature also indicates an understanding of fees and charges for missed or cancelled appointments.

Please give 24-hour notice by phone or email to avoid cancellation fees, except in cases of emergency. Requested written letters, treatment summaries or phone calls taking more than 15 minutes will incur a fee. Payment for sessions is requested at the time of each visit.

Parent consultation (75 minutes) $ ___________ Therapy session (45 minutes) $ _________________

Print mother's name _______________________ Signature ________________________________

Print father's name _______________________ Signature ________________________________

Please give 24-hour notice to avoid cancellation fees.

Thank you.

INFORMED CONSENT TO CHILD PSYCHOTHERAPY

This form documents that we, ____,
(the "parents") give our consent and agreement to Laurie Zelinger, Ph.D. (the "psychotherapist") to provide psychotherapeutic treatment to our child, ____,
(the "child") and to include us, the parents, as necessary, as adjuncts in the child's treatment.

While the parents can expect benefits from this treatment for the child, they fully understand that no particular outcome can be guaranteed. The parents understand that they are free to discontinue treatment of the child at any time but that it would be best to discuss with the psychotherapist any plans to end therapy before doing so.

The parents have fully discussed with the psychotherapist what is involved in psychotherapy and understand and agree to the policies about scheduling, fees and missed appointments. The discussion about therapy has included the psychotherapist's evaluation and diagnostic formulation of the child's problems, the method of treatment, goals and length of treatment, and information about record-keeping. The parents have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. The parents understand that therapy can sometimes cause upsetting feelings to emerge, and that the child's problems may worsen temporarily before improving.

The parents understand that the psychotherapist cannot provide emergency service. The psychotherapist has told the parents whom to call if an emergency arises and the psychotherapist is unavailable.

The parents have received the HIPAA Notice of Privacy Practices from the psychotherapist or from her website. The parents understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others besides the parents unless a parent authorizes such release. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain of those exceptions follow:

1. The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities.

2. If a child tells the psychotherapist that he or she intends to harm another person, the psychotherapist must try to protect the endangered person, including by telling the police, the person and other health care providers. Similarly, if a child threatens to harm him or herself, or a child's life or health is in any immediate danger, the psychotherapist will try to protect the child, including, as necessary, by telling the police and other health care providers, who may be able to assist in protecting the child.

3. If a child is involved in certain court proceedings, the psychotherapist may be required by law to reveal information about the child's treatment. These situations include child custody disputes, cases where a patient's psychological condition is an issue, lawsuits or formal complaints against the psychotherapist, civil commitment hearings, and court-ordered treatment.

4. If the parents' and child's health insurance or managed care plan will be reimbursing either party, they will require that confidentiality be waived and that the psychotherapist give them information about the child's treatment.

5. The psychotherapist may consult with other healthcare professionals about the child's treatment, but in doing so will not reveal the child's name or other information that would identify the child unless specific consent to do so is obtained from a parent. Further, when the psychotherapist is away or unavailable, another psychotherapist might answer calls and so will need to have access to information about the child's treatment.

6. If an account with the psychotherapist becomes overdue and responsible parties do not work out a payment plan, the psychotherapist will have to reveal a limited amount of information about a patient's treatment in taking legal measures to be paid. This would include the child's and parents' names, social security number, address, dates and type of treatment and the amount due. In all of the situations described above, the psychotherapist will try to discuss the situation with a parent before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

7. The parents, as legal guardians of the child, have rights to general information about what takes place in the child's therapy, to information about the child's progress in therapy, to information about any dangers the child might present to self or others, and, upon request, to obtain copies of the child's treatment record (with certain qualifications and exceptions). **The parents understand that it is usually best not to ask for specific information about what was said in therapy sessions because this might break the trust between the child and the psychotherapist.**

8. The parents agree that in the event custody of, or visitation with, the child is contested in a legal proceeding, each of the parents and their attorneys will not require the psychotherapist to testify at any of the proceedings, because to do so would hurt the child's treatment, because the psychotherapist's role is a therapeutic and not evaluative one, and because other forensic professionals would be better able and more appropriate to conduct any necessary evaluation. Because of these limitations, the psychotherapist also will not be able to give any opinion regarding custody, visitation or any other legal issue. If such a proceeding does occur, the parents agree that the psychotherapist's role will be limited to providing to a mental health professional appointed to perform such an evaluation, and/or to the attorneys, law guardian, if any, and the judge involved in the legal proceedings, written information regarding, and/or the record of, the child's treatment; the psychotherapist will provide these either as required by law or upon the authorization of either parent. The psychotherapist has explained to the parents that

children with two parents have the best chance to benefit from therapy if both parents are involved and cooperate with each other and the psychotherapist.

9. If both of a child's parents are consenting to therapy:

    - Each of us agrees that he or she will not end the child's therapy without the agreement of the other parent, and that if we disagree about the child's continuing in therapy, we will try to come to an agreement, by counseling if necessary, before ending the child's therapy.
    - We each agree to cooperate with the treatment plan of the psychotherapist for the child and understand that without mutual cooperation, the psychotherapist may not be able to act in the child's best interests and may have to end therapy.
    - We agree that each of us has and shall continue to have the right to information about the child's treatment and to the treatment records of the psychotherapist regarding the child, and agree that the psychotherapist may release information or records to either of us without any additional authorization of the other.

If the parents and child are participating in a managed care plan in order to be reimbursed, the parents have discussed with the psychotherapist the plan's limits on the number of therapy sessions. The psychotherapist has also discussed options for continuation of treatment when managed care or health insurance benefits end. **Parents are responsible for payment in full directly to Dr. Zelinger at the time of service**, and may request a receipt in order to pursue reimbursement through their private health insurance benefits program. **Dr. Zelinger does not participate in any insurance plans and payment is requested at the time of visit.**

The parents understand that they have a right to ask the psychotherapist about the psychotherapist's training and qualifications and about where to file complaints about the psychotherapist's professional conduct.

By signing below, the parents are indicating that they have read and understand this agreement, that they give consent to the psychotherapist's treatment of the child, and that they have the proper legal status to give consent to therapy for the child.

Parent print name and signature for consent: ____
Date: ________________________________

Parent print name and signature for consent: ____
Date: ________________________________

Child Signature for assent: ____