

**Child Developmental History Intake Form**

--- Please complete this form and bring it with you to the parent consultation meeting ---

Date of first visit (consult): \_\_\_\_\_ Referred by: \_\_\_\_\_

Child's full legal name: \_\_\_\_\_ Nickname or other name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_ Child's age: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Child's address (include zip code): \_\_\_\_\_

Home phone number: \_\_\_\_\_ Home fax \_\_\_\_\_

Child's current school and grade: \_\_\_\_\_

Mother's name: First \_\_\_\_\_ Last \_\_\_\_\_ Maiden \_\_\_\_\_

Cell \_\_\_\_\_ Email \_\_\_\_\_ Work phone \_\_\_\_\_

Father's name: \_\_\_\_\_

Cell \_\_\_\_\_ Email \_\_\_\_\_ Work phone \_\_\_\_\_

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

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? \_\_\_\_\_

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? \_\_\_\_\_

APGAR scores if known (at one minute): \_\_\_\_\_ (at five minutes): \_\_\_\_\_

Birthweight: \_\_\_\_\_ 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 or services through Committee on Preschool Education (CPSE)?

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  
first school, child's age and adjustment: \_\_\_\_\_

Next school and adjustment: \_\_\_\_\_

Next school and adjustment: \_\_\_\_\_

School address 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 bring a copy of the IEP to the parent consultation meeting \*\*\*\***

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 (s)he has 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? 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.

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.

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. 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, 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 understood 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(of parent)

Signature: \_\_\_\_\_  
(of parent)

Signature: \_\_\_\_\_  
(of child over 12 years of age)