Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

Client Registration Information

(PLEASE PRINT CLEARLY)

CLIENT NAME_____**DATE**_____

DATE OF BIRTH_____**AGE**_____

*Name of Legal Guardian (if applicable)*_____

CLIENT ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

CLIENT PHONE NUMBER_____

MARITAL STATUS: *(circle) SINGLE ENGAGED MARRIED SEPARATED DIVORCED WIDOWED IN A RELATIONSHIP LIVING WITH A PARTNER*

EMPLOYMENT STATUS: *(circle)* FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED FULL-TIME STUDENT PART-TIME STUDENT

In Case of an Emergency notify *(specify relationship to patient):*

NAME_____**RELATIONSHIP**_____

EMERGENCY CONTACT'S PHONE:_____

PLEASE TELL ME HOW YOU HEARD ABOUT ME:_____

_____

CLIENT SIGNATURE (OR LEGAL REPRESENTATIVE) **DATE**

_____

MARIYA KHOLODOVA, Ph.D. **DATE**

CLIENT INITIALS_____

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INFORMED CONSENT TO TREATMENT AND NOTICE OF BUSINESS POLICIES AND PRIVACY PRACTICES

This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

ABOUT YOUR PROVIDER:
I have a doctorate degree in clinical psychology from Alliant International University, San Diego, and I am a licensed psychologist in the state of California. I have experience in both individual and group psychotherapy with adults and adolescents; I also have experience in couples counseling. I have worked in various clinical settings throughout my career, and have provided treatment for mood disorders, anxiety disorders, trauma, substance abuse, divorce, domestic violence, grief, and relationship concerns, among other clinical issues. If you have any questions regarding my training and qualifications, I would be happy to discuss them with you. I look forward to working with you.

COMMUNICATION:
I am available between the hours of 9:00 a.m. and 7:00 p.m., Monday through Friday. I am generally able to return voicemail messages within 24 hours. I am not, however, always able to return emergency messages right away. If you are in need of immediate help and I can't reach you soon enough, please call 911 or the San Diego Crisis Line at1-888-724-7240. Please keep in mind that email and texting are not the secure ways to transmit confidential information. To discuss confidential matters, emergency situations, and safety concerns, please call me instead.

If I leave on vacation and if you would like to continue your sessions while I am away, I will designate another therapist to see you for the duration of my absence. Both you and I will discuss this prior to my departure. If you decide not to see another therapist in my absence, please call the Access and Crisis line (888-724-7240) or call 911 if you are in need of immediate assistance or if you are experiencing a psychiatric crisis (i.e. having thoughts of harming yourself or harming another person).

PSYCHOTHERAPY:
In general, psychotherapy is a type of treatment of psychological concerns that uses the strategies of talking, in addition to other techniques. The goal of therapy is to relieve or change emotional, behavioral, or cognitive factors that may stand in the way of living a healthier, happier, and a more meaningful life. Another goal of psychotherapy could be self-exploration – to learn more about yourself.

CLIENT INITIALS_____

Each psychotherapy session will last approximately 45 minutes. Please remember that your session starts and ends at the scheduled time. If you are late, your session will still end at the scheduled time and you will be responsible for the entire fee, regardless of how late you were. Generally, clients attend sessions once a week for 45 minutes.

Occasionally, I see clients more or less often than once a week. Both you and I will agree on the frequency of sessions, according to your needs.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own impressions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures or become dissatisfied for any reason with your clinical care, please let me know your concerns as soon as possible. This may provide you with a helpful means to work through the issues that concern you about your treatment. If your doubts persist or if you are still unhappy with your care, I will be happy to provide referrals to you to see a different therapist. I also suggest you discuss terminating treatment with me before doing so, as the majority of clients find this to be a beneficial part of their treatment.

MY APPROACH:
My approach to therapy is psychodynamic and cognitive behavioral in orientation. I use a variety of techniques in therapy, trying to find what will work best for you. These techniques are likely to include dialogue, interpretation, and cognitive reframing, among others. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting. I may suggest that you consult with a physical health care provider regarding corollary medical treatment that could help you. You have the right to refuse anything that I suggest.

RISKS INVOLVED:
Therapy has potential emotional risks. Approaching feelings or thoughts that you have tried to distance yourself from may be painful, and may sometimes, temporarily, disrupt relationships or other aspects of your life. Learning new strategies and releasing the old ones can be frightening and energy consuming. It is important that you consider carefully whether these risks are worth the benefits to you. Most people who take these risks find that therapy is helpful. It is important to remember that there are no guarantees of what you will experience or if the treatment will work for you.

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CONSULTATION:
To ensure that I am providing you with appropriate care, I may, on occasion, consult (talk) about your treatment with another mental health professional. I will not reveal your full identity, and the other professional is also legally bound to maintain the confidentiality of your information.

CONFIDENTIALITY:
With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may also request anyone you wish to attend a therapy session with you.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record. In addition, please note that text messages can, in theory, be retrieved by your cell phone company, and hence, are not confidential either.

The following are the <u>exceptions to your right to confidentiality</u>:

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services and Adult Protective Services.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am obligated to protect your

CLIENT INITIALS_____

safety, and would explore all other options with you before I involve other parties. If at that point you were unwilling to take steps to guarantee your safety, I would call the police or the crisis team.

4. In general, if you get involved in court proceedings you can prevent me from testifying about what you have told me. This is called privilege, and it always your choice to invoke it or waive it allowing me to testify. However, I cannot assert privilege on your behalf if I receive a court order instructing me to testify in legal proceedings that you might be involved in, or instructing me to release any/all records.

5. Section 215 of the Patriot Act of 2001 requires mental health providers to disclose parts or all of the client's record (if requested by the FBI) and prohibits the therapist from disclosing to the client that an FBI agent sought or obtained the client's personal information under the Act.

6. If you are using your insurance plan to pay for my fees, I am required to disclose certain information about your treatment to the insurance company. This information may include your diagnosis, my fee, dates of service, treatment plan, or/and a summary of treatment.

REKORDKEEPING:
The laws and standards of my profession require that I keep treatment records. What may be included in your record is the initial assessment, intake paperwork, your diagnosis, notes regarding each session, any communication that occurs outside of session, any information released to third parties, court documents, and other paperwork I receive or send out regarding your treatment. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them, or a treatment summary to a mental health professional of your choice. You will be charged a fee for any time spent in preparing information requests. I do not keep electronic records at this time.

DIAGNOSIS:
Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If you are using your insurance plan to pay for my services, I am normally required to give a diagnosis in order to be paid. If you do not meet the criteria for a mental health diagnosis, I will not be able to bill your insurance. In that case, you will be responsible for payment for my services.

TERMINATION:
You have the right to end your treatment any time for any reason. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures or become dissatisfied

for any reason with your clinical care, *please let me know your concerns as soon as possible*. This may provide you with a helpful means to work through the issues that concern you about your treatment. If your doubts persist or if you are still unhappy with your care, I will be happy to provide referrals to you to see a different therapist. I also suggest you discuss terminating treatment with me before doing so, as the majority of clients find this to be a beneficial part of their treatment.

You alone or both of us together will decide when therapy will end *except under the following circumstances:*

1. If we have contracted for a specific short-term work, we will finish therapy at the end of that contract.
2. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs.
3. If you or a person close to you does violence to, threatens verbally or physically, or harasses myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but I cannot guarantee that they will accept you for therapy.

Psychotherapy is not the only option for dealing with emotional concerns. Depending on the reasons that led you to seek therapy, alternative options that may be helpful for you may include meditation, yoga, diet and exercise, psychiatric medications, pastoral counseling, and others.

OTHER RIGHTS:
You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I am doing, and to look at alternatives that might work better. Please feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing you concerns with me, you can always contact California Board of Psychology, and they will review your complaint.

Board of Psychology
1625 North Market Blvd., Ste. N-125
Sacramento, CA 95834
866-503-3221

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PAYMENT INFORMATION:

Please Read This Information Carefully Regarding Your Financial Responsibility.

1. My fee is $200 per session with each session lasting approximately 45 minutes. Payment is made in the beginning of the session on the day of service, unless prior arrangements have been made. I accept cash or check.

2. Payment of any unpaid balance on an account must be received in full before close of the month. You will be charged a $30 fee for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings for which you agree to pay all associated costs.

3. If you have health insurance, it will usually provide some coverage for mental health treatment. I am an in-network provider with Anthem Blue Cross, Blue Shield, Magellan, and Aetna. Please note that *you* are financially responsible for my fees if your insurance plan does not cover my services for any reason (unless I made a billing error and in that case I will resubmit the claim).

4. I also accept other PPO plans as an out-of network provider. If I am an out-of-network provider with your insurance plan and if you plan to seek reimbursement for a part of my fee, I will provide a signed receipt with the necessary information for you to submit to your insurance company.

Please note that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes, I have to provide additional clinical information such as treatment plans or treatment summaries. This information will become a part of the insurance company files and will probably be stored in the computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide your insurance company with only the information required in order to meet their administrative needs. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above. *By signing this consent, you authorize me to provide information to your insurance company as needed for payment for my services.*

5. <u>You are financially responsible for sessions missed without a 24-hour advance cancellation</u>. Please keep in mind that you will be charged a full fee for the missed appointment.

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6. Insurance plans do not reimburse for late notice cancellations or missed appointments. Phone calls are charged at the usual session rate and charges are made if they last longer than *five* minutes. Your insurance company may not provide reimbursement for phone calls.

Please provide the following information for your insurance plan:

INSURANCE COMPANY:_____

NAME OF INSURED SPONSOR:_____

SPONSOR DATE OF BIRTH:_____

SPONSOR ADDRESS:_____

SPONSOR PHON NUMBER:_____

GROUP NUMBER:_____

POLICY NUMBER:_____

Client Consent to Psychotherapy

I have read this statement (Informed Consent to Treatment and the Notice of Business Policies and Privacy Practices), had sufficient time to be sure that I considered it carefully, and asked any questions that I needed to understand it fully. I agree to pay the agreed upon fee per session. I understand my rights and responsibilities as a client, and I understand my therapist's responsibilities to me. I agree to undertake therapy with Mariya Kholodova, Ph.D., and I know I can end therapy at any time. I know I can refuse any requests or suggestions made by Mariya Kholodova, Ph.D.

I have read, understand, and agree to comply fully with the above policies (pages one through eight). I accept full financial responsibility for all professional services rendered.

CLIENT SIGNATURE (OR LEGAL REPRESENTATIVE) **DATE**

MARIYA KHOLODOVA, Ph.D. **DATE**

CLIENT INITIALS_____

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NOTICE OF PRIVACY PRACTICES (HIPAA)

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. As required by "HIPAA" I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I may use and disclose your medical records only for the following purposes:

- Treatment - providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- Payment - such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running my practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. I may also create and distribute de-identified health information by removing all references to individually identifiable information. I may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing - I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other persons identified by you. I, however, am not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from me by alternative means or at alternative locations.

CLIENT INITIALS_____

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from me upon request.

I am required by law to maintain the privacy of your protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of my Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with my office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of my office. I will not retaliate against you for filing a complaint. Please contact me for more information at the address listed at the top of this page.

For more information about HIPPA or to file a complaint:
The U.S. Dept. of Health & Human Services Office of Civil Right
200 Independence Avenue, S.W.
Washington, D.C. 20201

CLIENT SIGNATURE (OR LEGAL REPRESENTATIVE) **DATE**

MARIYA KHOLODOVA, Ph.D. **DATE**

Mariya Kholodova, Ph.D. **3636 Fourth Avenue, Suite 210**
Clinical Psychologist **San Diego, CA 92103**
PSY25103 **858-805-5302**

Intake Questionnaire (to be completed by the client)

Name Date of Birth Date

What brought you to see me today? Why *now?*

Have you seen a therapist before? If yes, please provide the following: the name of the therapist, when you saw him/her, and the reason for seeking treatment. Was it helpful? Why/why not?

Have you seen a psychiatrist (a doctor who prescribes psychiatric medication) before? If yes, please provide the doctor's name, when you saw this doctor, and what medications you were prescribed.

Have you ever used the following substances and how often do/did you use:

-Coffee:
-Tobacco (smoking or chewing):
-Alcohol:
-Marijuana:
-Any form of cocaine, crystal, speed, or ecstasy:
-Pain-killing or sedative drugs, such as Valium, Quaaludes, heroin, morphine, opium, etc.:
-Hallucinogenic drugs, such as LSD, Psilocybin mushrooms ('shrooms), etc.:

Please put a checkmark if any of your biological relatives (parents, grandparents, siblings, aunts, or uncles) have experienced the following:

_____Have been treated in a psychiatric hospital
_____Threatened to die by suicide
_____Died by suicide
_____Had problems with alcohol
_____Abused drugs
_____Had an eating disorder
_____Have been in trouble with the law
_____Have been severely depressed
_____Have been diagnosed with bipolar disorder
_____Have been diagnosed with schizophrenia
_____Seemed excessively anxious or prone to worry

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In the last six months, how often have you experienced each of the following?

	Never	Occasionally	Fairly Often	Very Often
Trouble sleeping	0	1	2	3
Restless sleep	0	1	2	3
Nightmares	0	1	2	3
Waking up in the middle of the night	0	1	2	3
Waking up early in the morning and can't go back to sleep	0	1	2	3
Not feeling rested in the morning	0	1	2	3
Weight loss (without dieting)	0	1	2	3
Weight gain	0	1	2	3
Binge eating	0	1	2	3
Purging	0	1	2	3
Isolating from others	0	1	2	3
Feeling alone	0	1	2	3
Low sex drive	0	1	2	3
Sadness	0	1	2	3
Flashbacks (sudden, vivid, distracting memories)	0	1	2	3
Headaches	0	1	2	3
Stomachaches	0	1	2	3
Anxiety	0	1	2	3

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	Never	Occasionally	Fairly Often	Very Often
Uncontrollable crying	0	1	2	3
Panic attacks	0	1	2	3
Trouble controlling your temper	0	1	2	3
Trouble getting along with others	0	1	2	3
Dizziness	0	1	2	3
Desire to physically hurt yourself	0	1	2	3
Desire to hurt others	0	1	2	3
Not feeling satisfied with your sex life	0	1	2	3
Being confused about your sexual feelings	0	1	2	3
Sexual feelings when you shouldn't have them	0	1	2	3
Unnecessary or over-frequent washing	0	1	2	3
Feelings of inferiority	0	1	2	3
Feelings of guilt	0	1	2	3
Feeling that things are "unreal"	0	1	2	3
Memory problems	0	1	2	3
Feeling that you are not always in your body	0	1	2	3
Feeling tense	0	1	2	3
Trouble breathing	0	1	2	3

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ADDITIONAL CONFIDENTIALITY CONSIDERATIONS WHEN TREATING MINORS OR DEPENDENT ADULTS

This written policy is intended to inform you, the client's legal representative or responsible party, about confidentiality issues specific to treating minors or dependent adults, and supplements the documents already given to you that deal with related issues of privacy in therapy.

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is important in securing and maintaining that trust. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy, or for older adults who have already lived such a life. By signing this agreement, and although it is not legally binding, you are waiving your right of access to the patient's clinical record.

It is my policy to provide you with general information about treatment status. I will meet with you or communicate regularly with you if that is important for us. I will tell you if your child or an older adult does not attend sessions.

There are important exceptions to the confidentiality limitations. It is possible that the client will reveal sensitive information about sexual contact, alcohol and drug use, or other potentially high risk behaviors. Sometimes these behaviors are experimental, occasionally they are regularly occurring practices, and sometimes they escalate to behaviors that involve imminent threat to the health or safety of the patient. I am only allowed by law to violate confidentiality when there is an imminent threat of harm.

Your signature below indicates that you have read the information in this document and agree to abide by these terms during our professional relationship. If you have any questions or concerns regarding this information, I would be happy to discuss them with you.

SIGNATURE OF THE PARENT OR LEGAL REPRESENTATIVE **DATE**

CLIENT SIGNATURE **DATE**

CLIENT INITIALS_____

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MARIYA KHOLODOVA, Ph.D. **DATE**

Background Questionnaire for Parents

Instructions: Please take a few minutes to answer these questions. If you are uncertain about any question, leave it blank and we will discuss it later. Thank you.

Child's Name:

Date:

Your Name:

Relationship to child:

Please answer the following questions regarding the child:

Address:

Telephone: _____ Age: _____ Sex:

Date of Birth: _____ Place of birth:_____

School: _____ Teacher: _____ Grade: _____

Pediatrician: _____ Date of last physical:

Please list everyone who lives with the child:

What brings you/your child to see me today and why *now*?

Has your child seen a *therapist* before? If yes, please provide the following: the name of the therapist, when your child saw him/her, and the reason for seeking treatment. Was it helpful? Why/why not?

Has your child ever seen a *psychiatrist* before? If yes, please provide the doctor's name, when your child saw this doctor, and what medications were prescribed.

Is your child seeing a psychiatrist currently? Please provide the name of the treating psychiatrist and list the medications that your child is currently prescribed.

I. FAMILY COMPOSITION

1. Please answer the following questions regarding the child's natural father:
   Name:
   Address:
   Telephone: Day Evening
   Education: Occupation:
   Race/Nationality: Religion:
   Briefly describe the child's relationship with the father:

2. Please answer the following questions regarding the child's natural mother:
   Name:
   Address:
   Telephone: Day Evening
   Education: Occupation:
   Race/Nationality: Religion:
   Briefly describe the child's relationship with the mother:

3. List any other adults who act as parental figures or caretakers for this child:
   Name Relationship to child

4. Please provide the following information regarding siblings, including children from other marriages:

Name	Age	Any problems or concerns

5. Age of parents when married: Mother Father
6. Number of times mother has been married:
7. Number of times father has been married:

II. Family History

1. Have any of the child's relatives (parents, grandparents, siblings, aunts, or uncles) ever . . .

_____Been treated in a psychiatric hospital?
_____Threatened to commit suicide?
_____Committed suicide?
_____Had problems with alcohol?
_____Abused drugs?
_____Had an eating disorder?
_____Been obese?
_____Been in trouble with the law/arrested?
_____Been severely depressed?
_____Been diagnosed with bipolar disorder or depression?
_____Been diagnosed with schizophrenia?
_____Seemed excessively anxious or prone to worry?
_____Had problems with reading or spelling?
_____Had problems with paying attention or restlessness?

2. To your knowledge, has anyone ever . . .

_____Made the child feel unwanted?
_____Told the child that they were proud of them?
_____Told the child they wished they were the opposite sex?
_____Embarrassed the child?
_____Threatened to leave or send the child away?
_____Told the child they love them?
_____Yelled or cursed at the child?
_____Called the child names?
_____Threatened to hit the child?
_____Physically hurt the child?
_____Used excessive force in disciplining the child?
_____Sexually molested the child?
_____Made the child feel that nothing they did was good enough?
_____Made the child feel that sex is bad or wrong?
_____Made the child feel overprotected?

_____Made the child responsible for things that the adults should be responsible for?
_____Placed the child in a parental role?
_____Hit another person in the child's presence?

3. Place a check by any area you feel is a problem in the child's household:

____Financial problems
____Not enough time with child
____One parent absent much of the time
____Drug or alcohol problems
____Too much fighting
____Inconsistency in discipline
____Problems with in-laws
____Excessively harsh discipline
____Other:

III. Pregnancy

1. Age of mother at the time of child's birth: _____
2. Was this a planned pregnancy? Yes No
3. How did each parent react when they found out about the pregnancy?

   Mother: _____

   Father:
4. Were there any complications in the pregnancy or delivery? If yes, please explain.

IV. DEVELOPMENTAL HISTORY

1. As an infant, did the child . . .

_____Have problems with feeding or sucking?
_____Have problems breathing (infant apnea)?
_____Have any infections?
_____Vomit excessively?
_____Have excessive diarrhea?
_____Enjoy cuddling and being held?
_____Resist being calmed by being held or stroked?
_____Have colic?
_____Exhibit excessive restlessness?
_____Have trouble establishing a regular sleeping schedule?
_____Seem to wake up a lot at night?
_____Bang his or her head?
_____Get into everything as soon as they could crawl?

2. As best you can recall, record the age at which the child first . . .

_____ smiled
_____ sat without support
_____ crawled
_____ stood without support
_____ walked

_____ spoke first words
_____ said sentences
_____ bowel trained, day
_____ bowel trained, night
_____ bladder trained, day
_____ bladder trained, night
_____ rode tricycle
_____ rode bicycle
_____ buttoned clothing
_____ tied shoelaces
_____ named colors
_____ named coins
_____ said alphabet in order
_____ began to read

3. Rate your child on the following skills:
_____Walking
_____Running
_____Throwing
_____Catching
_____Shoelace tying
_____Buttoning
_____Writing
_____Reading
_____Math Skills
_____Overall coordination
_____Musical ability

4. As a toddler and preschooler, did the child . . .
_____Rock him/herself to sleep
_____Seem to have more accidents than other children
_____Have temper tantrums
_____Burst into tears easily
_____Hit, bite or kick other children
_____Act like he/she was driven by a motor
_____Seem disinterested in other people outside the family
_____Have difficulty tolerating change
_____Fail to imitate adult behaviors
_____Seem heedless to danger
_____Seem especially afraid of strangers
_____Act the same to strangers as to people they know
_____Have trouble remembering things
_____Seem more active than most children
_____Have trouble following instructions or directions

5. Would you say the child had a happy childhood? _____ Yes _____ No
6. Who would you say your child feels closest to? (Circle one)

Father Mother Brother Sister Grandparent Friend Other No one

7. How was the child disciplined as a toddler? _____
8. How was the child disciplined as a school-age child? _____

9. How was the child disciplined as a teenager? _____

_____

V.SCHOOL HISTORY

1. What kinds of schools has the child attended? (check all that apply)

_____Pre-school	_____Public school
_____Private school	_____Continuation school
_____Parochial or religious school	_____Independent learning school
_____Special education classes	_____Remediation classes
_____Summer school	_____Home study

2. What subjects is your child good in? _____
3. What subjects are difficult for your child? _____
4. What are the usual grades your child makes? _____
5. Did your child's grades ever suddenly change (get better or worse than usual)?

_____ Yes _____ No When? _____

6. Did the child ever . . .

_____Become afraid of going to school	_____Need help in reading
_____Have trouble doing math	_____Have trouble with writing
_____Fail a class	_____Have to repeat a grade
_____Get suspended from school	_____Skip classes
_____Have behavioral problems in class	_____Have trouble getting along with teacher

VI.PEER RELATIONSHIPS

1. Does your child seek out friends? _____Yes _____No
2. Do other children seek to befriend your child? _____Yes _____No
3. Does the child play primarily with children his/her _____ own age _____ younger, or _____ older

4. Does your child . . .

_____Tease or bully others	_____Get teased or bullied often
_____Seem to fight a lot	_____Seem sensitive to rejection
_____Get feelings hurt easily	_____Seem shy
_____Need to get his/her own way	_____Get along better with girls
_____Get along better with boys	_____Seem popular at school
_____Seem sensitive to others' feelings	_____Like to help others
_____Prefer being alone	____Seem excessively self-centered
_____Get angry easily	_____Seem guarded around others

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VII.INTERESTS AND HOBBIES

1. What are the child's main interests and hobbies?

2. In what areas does the child show talent?

3. What does the child enjoy doing most?

4. What does the child dislike doing the most?

5. What does the child feel most proud of?

VIII.PROBLEMS, CURRENT AND PAST

Please check any problems the child has had in the past or present. Only check problems you consider unusual or atypical for the child's age.

_____Thumb-sucking
_____Bedwetting
_____Soiling in pants
_____Afraid of being apart from parents
_____Trouble sleeping
_____Overly dependent
_____Acts like opposite sex
_____Excessive silliness or clowning
_____Cries frequently
_____Eats non-edible substances
_____Overeats
_____Poor motivation
_____Looks for easy way out
_____Baby Talk
_____Preoccupied with food
_____Jealous of brother or sister
_____Can't sit still
_____Frequent bad dreams / nightmares
_____Preoccupied with bowel movements
_____Temper tantrums
_____Needs too much attention
_____Seems immature
_____Night terrors
_____Sleepwalking
_____Blames others for problems

IX.PROBLEMS (continued):

_____Frequent sex play with other kids
_____Diets or skips meals
_____Avoids responsibility
_____Steals
_____Suspicious of others
_____Lack of appetite
_____Fights with other kids
_____Lies
_____Little curiosity

CLIENT INITIALS_____

_____Defiant of authority figures
_____Few friends
_____Oppositional
_____Swears
_____Excessively competitive
_____Cheats when playing games
_____Trouble with police
_____Torture animals
_____Run away from home
_____Attempt suicide
_____Truant from school
_____Violent outbursts of rage
_____Cruel to younger children
_____Hits other children
_____Argumentative
_____Often unhappy
_____Likes to tease others
_____Little guilt over wrong-doing
_____Disorganized
_____Hair pulling
_____Nervous tics
_____Seems tense much of the time
_____Speaks rapidly under pressure
_____Doesn't take care of own things
_____Excessive desire to please others
_____Preoccupied with certain ideas
_____Acts older than actual age
_____Afraid to try new things
_____Mute (refuses to speak)
_____Is never angry
_____Gullible and naïve
_____Procrastination
_____Easily distracted
_____Talks excessively
_____Argues with adults
_____Reluctance/refusal to go to school
_____Lack of friends
_____Worries about the future
_____Excessive need for reassurance
_____Wishes to be opposite sex
_____Little contact with people outside family

_____Poor common sense
_____Acts like a loner
_____Blatantly uncooperative
_____Not accepted by peer group
_____Does not follow through
_____Bites nails
_____Too critical of self
_____Set fires for fun
_____Use drugs or alcohol
_____Carve marks or words on body
_____Does not respect rights of others
_____Has to have things his/her own way
_____Feels life is not fair
_____Destroys property
_____Critical of others
_____Stubborn
_____Worries too much
_____Pessimistic
_____Feelings easily hurt
_____Picks on skin
_____Stutters
_____Perfectionist
_____Little concern for appearance
_____Irritable
_____Unable to concentrate
_____Seems insincere or superficial
_____Excessive guilt
_____Low self-esteem
_____Shows little emotion
_____Passive and easily led
_____Lives in his/her own world
_____Fidgets or squirms in seat
_____Has difficulty playing quietly
_____Difficulty expressing feelings
_____Deliberately annoys others
_____Reluctant to sleep alone
_____Startles easily
_____Self-conscious
_____Unable to relax
_____Motor or vocal tics

Does the child show fears of . . .

_____The dark
_____Strangers
_____Death
_____Visiting other children's homes
_____Certain animals
_____Being assertive
_____Crowded places
_____Small, enclosed places
_____Being in a car
_____Open, airy spaces
_____New situations
_____Being alone
_____Separation from parents
_____Going away to camp
_____Talking with adults
_____Dating situations
_____Heights
_____Blood or injury
_____Air travel
_____Medical or dental visits

_____Other:

X. MEDICAL HISTORY

1. Do you worry about your child's health?_____ Yes _____ No
2. Does the child worry about his/her health? _____Yes _____ No
3. List any allergies the child has:
4. Does the child wear glasses or contact lenses? _____ Yes _____ No
5. Does the child eat three well-balanced meals each day? _____ Yes _____ No
6. Does the child exercise regularly? Yes No
7. Describe any surgeries the child has had:

8. Does the child smoke cigarettes? Yes No

9. Does the child drink caffeine? Yes No

10. Do any family members have a history of serious medical illness?
Yes No If so, please describe:

11. List any medications the child is currently taking:

12. Please place a check by any physical problems the child has had. Indicate any current problems with an (C), and any past problems with a (P).

_____Headaches
_____Head injury
_____High fever
_____Meningitis
_____Poisoning
_____Difficulty swallowing
_____Choking
_____Loss of hearing
_____Memory loss
_____Paralysis
_____Numbness or tingling
_____Muscle weakness
_____Trouble walking
_____Frequent vomiting
_____Joint pain
_____Diarrhea
_____Shortness of breath
_____Frequent urination
_____Grinding teeth
_____Problems with menstruation
_____Does not like to be touched
_____High blood pressure
_____Heart problems
_____Stomachaches
_____Convulsions
_____Infections
_____Encephalitis
_____Coma
_____Loss of voice
_____Excessive sweating
_____Problems with vision
_____Seizures
_____Trembling or shaking
_____Muscle tension
_____Difficulty urinating
_____Nausea
_____Tires easily
_____Eating binges
_____Dizziness or fainting
_____Wheezing
_____Changes in appetite
_____Overeating
_____Skin problems
_____Diabetes
_____Liver or kidney problems
_____Asthma