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Patient Information

Date: _____ Name: _____ Birth Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ email: _____

Referred by: _____ Primary Physician: _____

Current Medication(s): _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Responsible Party: ( ) Self ( ) Spouse ( ) Parent Name: _____

Address: _____

Social Security Number of Responsible Party: _____ His/Her Employer: _____

Address: _____

His/Her Job Title: _____ Work Phone: _____

I UNDERSTAND THAT ALTHOUGH DR. LaMORGESE DOES ACCEPT SOME INSURANCE, THIRD PARTY CARRIERS MAY NOT BE CONTRACTING DR. LaMORGESE AND I HAVE VERIFIED WHETHER THESE SERVICES ARE COVERED AND IF NOT, I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT.

Please list each professional, program, or hospital that has provided behavioral health services to you or your family.
If you don't have their current addresses, please bring this information to the next appointment.
Professional/Program or Hospital Address/Location Dates Close Family Members (Parents, Siblings, Spouse, Children, etc.)
Name Relationship Age Any Mental Health, Drug/Alcohol Problems

_____

_____

_____

_____

_____

Patient or Parent Signature: _____ Date: _____

Patient or Parent Printed Name: _____

Patient Information

Name: _____ Date: _____

Reason for seeking help and/or Current problems experienced.
Please circle any relevant problems.

Sadness Anxiety Drug Abuse Parenting Spouse Stress Limited Communications Behavior problems

Sexual behavior Anger control Work conflicts Lonely Nightmares Lack of energy Confused thinking

Sexual dysfunction Marriage problems Family conflicts Stealing Sibling conflicts Physical abuse

Criminal/delinquent behavior Assertiveness Co-dependency Panic attacks Fears Compulsive behavior

Underachievement Hyperactivity Short Attention Eating disorder Stuttering Apathy Job Stress

Learning disability Financial problems Physical disability Death/loss Spirituality Weight/appearance Legal problems

(If the minor is age 7-9, guardian answers, 10-12 please answer these questions together, 13+ answer should answer independently)

In a few words, what do you think therapy is all about? _____

_____

_____

How long do you think your therapy should last? _____

_____

My/Our Goals for Treatment: _____

_____

_____

What personal qualities do you think the ideal therapist should possess? _____

_____

_____

Anything else you would like your doctor/therapist to know? _____

_____

_____

_____

PATIENT/RESPONSIBLE PARTY LETTER OF AGREEMENT
NON-INSURANCE BILLING AND PAYMENT POLICY
PLEASE INITIAL EACH ITEM BELOW

_____ I authorize Dr. LaMorgese to bill my/our insurance carrier for services and provide any information regarding services or treatment requested by said carrier.

_____ I acknowledge that all copays/coinsurance/not covered charges for services will be paid by me: _____.

_____ Payment liability for Non-insured patients and for charges of DENIED services rests with the patient, or responsible party, who is the beneficiary of those services.

_____ I agree to be personally responsible for payment of those services, as well as, any legal fees, court costs, collection fees, and late fees connected with collection of payment.

_____ I agree to pay a $25.00 fee for any personal checks returned for insufficient funds.

_____ I agree that the person who brought the child in to see the doctor is responsible for all the fees associated with the visit.

APPOINTMENT POLICY

_____ The cooperation of each patient is necessary to assure that everyone's needs are met. Frequently, patients are placed on a "waiting list" for appointment cancellations. It is therefore necessary that every consideration be given to avoid missed appointments that could be used by someone else.

_____ Each patient is responsible for keeping appointments with his or her provider. If it becomes necessary to break an appointment, it is EXPECTED that a patient contact this office 24 hours in ADVANCE of scheduled appointment.

_____ If a patient misses his or her scheduled appointment or fails to provide 24 hours advance notice, there will be a charge of $50.00. This charge will not and cannot be billed to your insurance company. You are personally responsible for this charge. In the event my account is turned over for collection. I understand that I will be responsible for all collection costs.

Responsible Party Name and Relationship: _____

Responsible Party Signature: _____ Date: _____

Witness to Signature: _____ Date: _____

CHILDHOOD HISTORY FORM

Child's Name_____ Birth Date_____ Age_____ Sex_____

Home Address_____

Home Phone (_____)_____ Child's School/City_____

Grade _____ Special Placement (if any) _____

Child is presently living with _____Natural Mother _____Natural Father ____Stepmother _____Stepfather _____Foster Mother

____Foster Father ____Adoptive Mother ____Adoptive Father _____Other (Specify) _____

Non-residential adults involved with this child on a regular basis: _____

_____

Referral Source: Name _____ Phone _____

Address _____

Briefly state the main problem of this child: _____

_____

_____

PARENTS

Mother _____ Occupation _____ Bus. Phone_____

Current Age _____ Age and marital status at time of pregnancy with patient _____

School: Highest grade completed _____

Any learning problems/Attention problems/behavior problems _____

Medical Problems _____

Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____

_____

_____

Father _____ Occupation _____ Bus. Phone_____

Current Age _____ School: Highest grade completed _____

Any learning problems/Attention problems/behavior problems _____

Medical Problems _____

Have any of Father's blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____

_____

_____

SIBLINGS

Names, ages, medical/psychological/learning issues:

_____

_____

_____

Pregnancy- Complications

Excessive vomiting (circle) YES / NO Hospitalization required YES / NO Excessive staining/Blood loss YES / NO

Threatened miscarriage) YES / NO Infection(s) (specify) YES / NO Toxemia) YES / NO

Operation(s) (specify) _____

Other illness(es) (specify) _____

Smoking during pregnancy?) YES / NO #cigarettes/day_____ Alcohol during pregnancy YES / NO Amt _____

Medication taken during pregnancy _____

X-ray studies during pregnancy _____ Duration of pregnancy (weeks)_____

DELIVERY

Type of labor: Spontaneous YES / NO Induced Duration YES / NO #hrs._____ Type of delivery: Normal YES / NO

Breech YES / NO Caesarean YES / NO Cord around neck YES / NO Hemorrhage YES / NO Infant injured in delivery YES / NO

Other _____ Birth Weight _____ Inches _____ APGAR Scores _____

POST DELIVERY PERIOD

Jaundice YES / NO Cyanosis (turned blue) YES / NO Incubator Care YES / NO Infection(specify)_____

Number of days infant was in the hospital after delivery_____

INFANCY PERIOD

Were any of the following present, to a significant degree, during the first year of life? If so, describe:

Did not enjoy cuddling _____

Was not calmed by being held or stroked _____

Difficult to comfort _____

Colic _____ Excessive restlessness_____

Excessive irritability _____

Diminished sleep _____

Frequent head banging _____

Difficult nursing _____

Constantly into everything _____

TEMPERAMENT

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity level: _____

Distractibility:_____

Adaptability:_____

Approach/Withdrawal:_____

Intensity:_____

Mood: _____

MEDICAL HISTORY

If you child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases: _____

Operations: _____

Hospitalizations: _____

Head injuries: _____

Convulsions YES / NO With fever YES / NO Without fever YES / NO Coma YES / NO Persistent high fever YES / NO

Eye Problems YES / NO Tics (i.e., eye blinking, sniffing, any repetitive, no-purposeful movements) YES / NO Type: _____

Ear Problems YES / NO Type: _____ Allergies or Asthma YES / NO Poisoning YES / NO Type: _____

Sleep – Does your child settle down to sleep? YES / NO Sleep through the night without disruption? YES / NO

Experience nightmares, night terrors, sleep walking, sleep talking? YES / NO Is your child a very restless sleeper? YES / NO

Does you child snore? YES / NO Appetite _____

PRESENT MEDICAL STATUS

Height _____ Weight _____ Present illness(es) child is being treated for _____

_____

Medicine child takes regularly _____

_____

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. Please note their age, if you cannot recall exact age, please note if you think it was early, normal, or late:

Smiled _____ Sat without support _____ Crawled _____

Stood without support _____ Walked without assistance_____ Spoke first words_____

Said phrases _____ Said sentences _____ Bladder trained, day _____

Bladder trained, night _____ Bowel trained, day _____ Bowel trained, night _____

Rode tricycle _____ Rode bicycle (without training wheels) _____ Buttoned clothing _____

Tied shoelaces _____ Named colors _____ Named coins _____

Said alphabet in order _____ Began to read _____

COORDINATION

Rate your child on the following skills as Good, Average, or Poor :

Walking _____ Running _____ Throwing _____

Buttoning _____ Writing _____ Athletic Abilities _____

Excessive number of accidents compared to other children: YES / NO Types: _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand direction and situation as well as other children his or her age? YES / NO

If no, why not? _____

How would you rate your child's overall intelligence compared to other children? Below___ Average_____ Above Average_____

SCHOOL HISTORY

Were you concerned about your child's ability to succeed in kindergarten? If so, please explain: _____

_____

Rate you child's school experience related to academic learning as Good, Average, or Poor:

Pre-school _____ Kindergarten _____ Current grade _____

To the best of your knowledge, at what grade level is your child functioning:

Reading _____ Spelling_____ Arithmetic_____

Has you child ever had to repeat a grade? YES / NO If so, when and what grade? _____

Present class placement: Regular class _____ Special Class (if so, specify) YES / NO _____

Kinds of special counseling or remedial work your child is currently receiving: _____

_____

Describe briefly any academic school problems _____

_____

Rate your child's school experiences related to behavior as Good, Average, or Poor:

Pre-school _____ Kindergarten _____ Current grade _____

Does your child's teacher describe any of the following as significant classroom problems?

Doesn't sit still in his or her seat as Good, Average, or Poor:

Pre-school _____ Kindergarten _____ Current grade _____

Frequently gets up and walks around classroom YES / NO Shouts out YES / NO Doesn't wait to be called on YES / NO

Won't wait his/her turn YES / NO Doesn't cooperate well in group activities YES / NO

Typically does better in one-to-one relationship YES / NO Doesn't respect the rights of others YES / NO

Doesn't pay attention during storytelling or show and tell YES / NO Any other classroom behavioral problems_ YES / NO

Describe: _____

PEER RELATIONSHIPS

Does your child seek friendships with peers? YES / NO Is your child sought by peers for friendship? YES / NO

Does your child play with children primarily his or her own age? YES / NO Describe any problems your child is having with peers?

_____

_____

_____

HOME BEHAVIOR

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her own age.

Fidgets with hands feet or squirms in seat _____
Has difficulty remaining seated when required to do so _____
Easily distracted by extraneous stimulation _____
Has difficulty awaiting his turn in games or group situations _____
Blurts out answers to questions before they have been completed _____
Has problems following through with instructions (usually not due to opposition or failure to comprehend) _____

Has difficulty paying attention during tasks or play activities _____
Shifts from one uncompleted activity to another _____
Has difficulty playing quietly _____
Often talks excessively _____
Interrupts or intrudes on others (impulsive) _____
Does not appear to listen to what is being said _____
Does things necessary for tasks or activities in home _____
Boundless energy and poor judgment _____
Impulsivity (poor self-control) _____
History of temper tantrums _____
Temper outbursts _____
Frustrates easily _____
Sloppy table manners _____
Sudden outbursts of physical abuse of other children _____
Acts like he or she is driven by a motor _____
Wears out shoes more frequently than siblings _____
Excessive number of accidents _____
Doesn't seem to learn from experience _____
Poor memory _____
A "different child" _____

How well does your child work for rewards? _____

Does your child create more problems, either on purpose or not, within the home setting than his or her siblings? YES / NO

Does your child have difficulty benefiting from his experiences? YES / NO

Types of discipline used with your child: _____

Is there a particular form of discipline that has proven effective? _____

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management?

_____

INTERESTS AND ACCOMPLISHMENTS

What are you child's main hobbies and interests? _____

_____

What are your child's greatest accomplishments? _____

_____

What does your child enjoy doing most? _____

What does your child dislike doing most? _____

What do you like most about your child? _____

_____

LIST ANY OTHER PROFESSIONALS CONSULTED (including family doctor)(we need signed releases to speak to them)

_____

_____

_____

ADDITIONAL REMARKS:

_____