INFORMATION FORM

Today's Date: _____

Client Information

Name: _____ _____ ___
First Last M.I.

Address:_____
Street and Number City State Zip

Phone:_____ Age:_____ Social Security No.:____-____-____

Date of Birth:____/____/____ Gender:_____ Marital Status:_____

Did someone refer you? Yes/No If yes, who?_____
May we send a thank you to whom ever referred you? Yes/No

A second phone number in case of an emergency:_____

Name of person:_____ Relationship to you:_____

Billing Information

Responsible Party #1

Name:_____ _____ _____
First Last M.I.

Address:_____
Street and Number City State Zip

Home Phone: _____ Work Phone: _____

Responsible Party #2

Name: _____ _____ _____
First Last M.I.

Address: _____
Street and Number City State Zip

Home Phone: _____ Work Phone:_____

Insurance Information

Primary Insurance:

Insurance Company:_____ Plan Name:_____

Address:_____
Street and Number

_____
City State Zip

Policy #:_____ Group:_____ Insured's ID #:_____

Phone Number:_____ Fax Number:_____

Insured Information

Name of Person Insured:_____ _____ ____
First Last MI

SSN:____-____-____ Home Phone:_____ Work Phone:_____

Insured's Address:_____
Street and Number City State Zip

Birth Date:____/____/____ Gender: ____Male ____Female

CHILDHOOD HISTORY FORM

Child's Name _____ Date_____

Birthdate _____ Age_____ Sex _____

Adopted ___ yes ___ no Is your child aware of adoption? ___ yes ___ no

Others in Household:	Relationship to child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly state your main concerns about your child:

Have any of the child's blood relatives experienced similar problems?

Did the child's mother or the child experience any complications during pregnancy/delivery?

MEDICAL HISTORY Please note the age and any other pertinent information. Use back if necessary.

Childhood diseases: _____
Operations: _____
Other hospitalizations: _____
Head injuries:_____
Convulsions/seizures: _____
Persistent high fevers: _____
Eye problems: _____
Tics (eye blinking, sniffing, or any repetitive movement): _____
Ear problems: _____
Allergies or asthma: _____
Sleep problems (restless, night waking, sleepwalking): _____
Bedwetting or soiling pants in daytime: _____
Describe the child's appetite: _____
Please list other doctors or professionals consulted: _____
Current medications and dose: _____
Counseling: _____

FAMILY/SOCIAL HISTORY

Include any brothers or sisters you (the parent) have/had as well as your (the parent) natural parents (In other words, YOUR childhood history). Be sure to include PAST or PRESENT behavior.

Birth Mother Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Birth Father Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Step-Mother Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Step-Father Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Adopted Mother Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Adopted Father Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness
__Homosexuality

Which family member has the best relationship with the patient?_____

INFANCY - TODDLERHOOD

Were any of the following present during the first few years?

_____ did not enjoy cuddling
_____ difficult to comfort
_____ excessive restlessness
_____ frequent head banging
_____ was not calmed by being held
_____ colic
_____ excessive irritability
_____ constantly into everything

TEMPERAMENT: please rate the following as you child appeared in infancy and toddlerhood:

Activity level: _____ underactive _____ average activity level _____ overactive
Adaptability: _____ adapted easily to change _____ resisted change
Intensity: _____ average _____ feelings were often intense
Mood: _____ often happy _____ average range of moods
_____ often dissatisfied or irritable

DEVELOPMENTAL MILESTONES

As best you can recall, list age of development, or check item at right:

	Age or	Early	Normal	Late
Walked without assistance	_____	_____	_____	_____
Spoke first words	_____	_____	_____	_____
Any speech/articulation problems?				
Toilet trained daytime	_____	_____	_____	_____
Toilet trained nighttime	_____	_____	_____	_____

COORDINATION Rate your child on the following skills:

	Good	Average	Poor
Walking	_____	_____	_____
Running	_____	_____	_____
Throwing	_____	_____	_____
Catching	_____	_____	_____
Shoelace tying	_____	_____	_____
Writing	_____	_____	_____
Athletic abilities	_____	_____	_____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his/her age?

_____

How would you rate your child's overall level of intelligence?

_____ Below average _____ Above average _____ Average

PEER RELATIONSHIPS

How does your child get along with others his/her age? Describe any problems.

SCHOOL HISTORY

School currently attending: _____Grade level _____

Is you child in any resource or special classes? _____

Has your child ever repeated a grade? If so, which? _____

Briefly describe your child's school progress. Note usual grades, any problems or successes, strong subjects and weak subjects:

Preschool - K _____

1st - 5th _____

6th - 8th _____

9th - 12th _____

Describe any conduct problems you child has had in school:

How would you rate your child's homework/study skills? ___ Good ___ Average ___ Poor

Describe difficulties: _____

Has your child had tutoring or remedial work? _____

Does your child like to read? Yes No
How often (circle one) Never Seldom Occasionally Often

Please rate reading ability as _____ good _____ fair _____ poor

Any other comments on your child's performance and behavior:

HOME BEHAVIOR AND MOOD

Check which of the following applies to your child:

_____ frequently irritable or moody
_____ can't seem to enjoy doing anything
_____ sad spells
_____ crying spells
_____ easily bored
_____ poor or low motivation
_____ low self-esteem (makes negative statements about self)
_____ can't seem to concentrate
_____ has had thoughts of or made comments about suicide
_____ other: _____
_____ eats (too much) or (too little)
_____ frequent arguing at home
_____ fearfulness
_____ nervous, anxious
_____ frequent headaches
_____ frequent stomachaches
_____ has had a panic attack (rapid heartbeat, sweaty palms, feeling something bad about to happen)
_____ difficulty sleeping:
___ goes to sleep very late
___ hard to get up in morning
___ very restless sleep
___ bad dreams
_____ acts like driven by a motor
_____ doesn't seem to learn from experience
_____ very disorganized (loses things, has very messy room)
_____ has ever been physically or sexually abused
_____ drug or tobacco use: _____
_____ argues with or rude to teachers

If you child experienced any stressful or traumatic situations in the past few months or in the last few years please describe:

Any additional comments you would like to make about your child (mood, behavior, personality, etc.):

Thank you for the time and effort you gave in completing this form. Please also complete any check lists which accompany this history form.

ATTENTION CHECKLIST

Name _____

Please circle the number corresponding to the degree the following characteristics have been experienced.

	None	Just A little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.	0	1	2	3
Often has difficulty sustaining attention in tasks or play activities	0	1	2	3
Often does not seem to listen when spoken to directly	0	1	2	3
Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace	0	1	2	3
Often has difficulty organizing tasks and activities	0	1	2	3
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
Often loses things necessary for tasks or activities (in play, school, or work)	0	1	2	3
Is often easily distracted by sounds, noises, movements unrelated to the task at hand (listening in class, studying)	0	1	2	3
Is often forgetful in daily activities	0	1	2	3
Often fidgets with hands or feet or squirms in seat	0	1	2	3
Often leaves seat in classroom or in other situations in which it is inappropriate	0	1	2	3
Often has difficulty playing or engaging in leisure activities quietly	0	1	2	3
Is often "on the go" or often acts as if "driven by a motor"	0	1	2	3
Often talks excessively	0	1	2	3
Often blurts out answers before questions are completed	0	1	2	3
Often has difficulty awaiting turn	0	1	2	3
Often interrupts or intrudes on others	0	1	2	3

How long have the above marked symptoms been evident?

___ by school age (6 or 7) ___ by high school Other:

Does your child show these symptoms in more than one setting (i.e. home, school, public)?

_____ yes _____no

MOOD RATING SCALE

Name
_____

Carefully consider which apply to your child or teenager. Circle the corresponding number.

Depressed mood (sad, gloomy, forlorn)
1. None
2. Mild
3. Moderate (brief periods of unhappiness or no emotion
4. Severe (often looks sad or withdrawn)

Weeping
1. None
2. Normal for age
3. Seems to cry more frequently than peers
4. Cries frequently

Self Esteem
1. Child describes self in mostly positive terms
2. Little or no evidence of lowered self esteem
3. Describes self in some positive, some negative terms
4. Positive and negative terms, but mostly negative
5. Refers to self in derogatory terms, or avoids the question

Morbid thinking (death, violence)
1. None apparent
2. Some morbid thoughts - related to actual events
3. Somewhat more than usual morbid thoughts
5. Elaborate or extensive morbid thinking

Suicide and Suicide Ideation
1. None apparent
2. Has thought of suicide - usually when angry
3. Recurrent thoughts of suicide
4. Thinks about suicide and names methods
5. Has recently attempted suicide

Irritability (whining, chip on shoulder, hostility)
1. None
2. Normal amount
3. Occasional-slightly more than normal
4. Episodic - comes and goes
5. Frequent
6. Constant

Schoolwork
1. Performing at or above expected level
2. Not working to capacity or recent disinterest
3. Doing poorly in most subjects or major decline

Capacity to have fun
1. Interests & hobbies appropriate for age
2. Some interests but mostly passive, lacks enthusiasm
3. Easily bored, "Nothing to do"
4. No initiative, watches others or only TV, has to be coaxed to be involved in any activities.

Social Withdrawal
1. Enjoys good friendships with peers
2. Has several friends, not very close
3. Is passive in getting friends
4. Rejects opportunities for interaction
5. Does not relate to other children

Expressive communication
1. Expresses self fairly well
2. Not very talkative, but will talk
3. Withdrawn, very reluctant to talk

Sleep
1. Occasional or no difficulty sleeping
2. Mild but frequent difficulty sleeping
3. Moderate difficulty sleeping almost every night
    a.. problem getting to sleep
    b. problem waking at night
    c. Problem waking in morning

Disturbance of eating
1. No problem
2. Mild____ Too little____ Too much____
3. Moderate____ Too little____ Too much____

Frequent Physical Complaints (head, stomach)
1. No complaints
2. Mild, occasional complaints
3. Frequent complaints,
4. Preoccupies with aches and pains

General Somatic
1. Normal
2. Occasional complaints of fatigue
3. Frequent complaints of being tired

Activity Level
1. Activity at usual level
2. Slight reduction of activity level
3. Activity greatly reduced from usual

Completed by:
_____

Comments:

TAYLOR SCREENING CHECKLIST

Name _____

Please rate your child's natural tendencies for each trait listed.

More Like This **No Trend** **More Like This**

A.		B.		C.
	A quiet person		A noisy and talkative person	
	Voice volume is soft or average		Voice generally is too loud	
	Few mouth or body noises		Makes lots of sounds with mouth or body	
	Walks at appropriate times		Flits around, runs ahead, jumpy	
	Keeps hands to self		Pokes, touches, feels, grabs	
	Appears calm, can be still		Always moving, fidgets, squirmy	
	Can just sit		Has to be doing something; quickly bored	
	Slow to react; deliberate; not impulsive		Too quick to react, engages mouth or muscles	
	Understands why parents or teachers are displeased after misbehavior		Feels picked on, is surprised and confused about why others are displeased	
	Planful; thinks ahead to consequences before acting		Does things without considering consequences	
	Avoids other children's mischief		Gets involved in mischief; attracted to or starts	
	Concerned about punishment and consequences		Pretends to have an "I don't care" attitude	
	Obeys directions and follows orders		Disobeys; needs supervision or reminding	
	Constant mood with mild or slow mood changes		Mood unpredictable; quick to anger or tears	
	Easygoing; handles frustration without much anger		Irritable; impatient; easily frustrated	
	Emotions are reasonable and controlled, are not extreme, and don't disrupt relationships		Emotions are extreme and poorly controlled; no damper on emotion; explosive tantrum-like	
	Cooperates with, obeys and enforces rules		Argues and gripes about the rules; wants to be the exception	
	Gives up when denied a requested privilege, item, or activity		Badgers, pesters, won't give up or take no for an answer	
	Concentrates and blocks out distraction when working on something of medium interest		Easily distracted by noises and people nearby; short attention span	
	Follows through, has an organized approach		Flits from activity to activity, does not finish things	
	Does not try to bother or hurt others with words		Needles, teases, has to have the last word	

Most children exhibit, at one time or another, one or more of the symptoms listed below. Place a P next to those that your child has exhibited in the PAST and N next to those that your child exhibits NOW. Only mark those symptoms that have been or are present to a significant degree over a period of time. Only check as problems behaviors that you suspect are unusual or atypical when compared to what you consider to be normal for your child's age.

_____ Thumb-sucking

_____ Baby Talk

_____ Overly dependent for age

_____ Frequent temper tantrums

_____ Excessiveness silliness and clowning

_____ Excessive demands for attention

_____ Cries easily and frequently

_____ Generally immature

_____ Eats non-edible substances

_____ Overeating with overweight

_____ Eating binges with overweight

_____ Under eating with underweight

_____ Long periods of dieting and food abstinence with underweight

_____ Preoccupied with food--what to eat and what not to eat

_____ Preoccupation with bowel movements

_____ Constipation

_____ Encopresis (soiling)

_____ Insomnia (difficulty sleeping)

_____ Enuresis (bed wetting)

_____ Frequent nightmares

_____ Night terrors (terrifying night time out bursts)

_____ Sleepwalking

_____ Excessive sexual interest and preoccupation

_____ Frequent sex play with other children

_____ Excessive masturbation

_____ Frequently likes to wear clothing of the opposite sex

_____ Exhibits gestures and intonations of the opposite sex

_____ Frequent headaches

_____ Frequent stomach aches

_____ Frequent nausea and vomiting

_____ Often complains of bodily aches and pains

_____ Worries over bodily illness

_____ Poor motivation

_____ Apathy

_____ Takes path of least resistance

_____ Ever trying to avoid responsibility

_____ Poor follow through

_____ Low curiosity

_____ Open defiance of authority

_____ Blatantly uncooperative

_____ Persistent lying

_____ Frequent use of profanity to parents, teachers, and other authorities

_____ Truancy from school

_____ Runs away from home

_____ Violent outbursts of rage

_____ Stealing

_____ Cruelty to animals, children, and others

_____ Destruction of property

_____ Criminal and/or dangerous acts

_____ Trouble with the police

_____ Violent assault

_____ Fire setting

_____ Little, if any, guilt over behavior that causes others pain and discomfort

_____ Little, if any, response to punishment for antisocial behavior

_____ Few, if any, friends

_____ Does not seek friendships

_____ Rarely sought by peers

_____ Not accepted by peer group

_____ Selfish

_____ Argumentative

_____ Does not respect the rights of others

_____ Wants things own way with exaggerated reaction if thwarted

_____ Trouble putting self in other person's position

_____ Egocentric (self-centered)

_____ Frequently hits other children

_____ Excessively critical of others

_____ Excessively taunts other children

_____ Ever complaining

_____ Is often picked on and easily bullied by other children

_____ Suspicious, distrustful

_____ Aloof

_____ "Wise-guy" or smart aleck attitude

_____ Brags or boasts

_____ Bribes other children

_____ Excessively competitive

_____ Often cheats when playing games

_____ "Sore Loser"

_____ "Does not know when to stop"

_____ Poor common sense in social situations

_____ Often feels cheated or gypped

_____ Feels others are persecuting him when there is no evidence for such

_____ Typically wants his or her own way

_____ Very stubborn

_____ Obstructi on-istic

_____ Negativis tic (does just the opposite of what is requested)

_____ Quietly. or often silently, defiant of authority

_____ Feigns or verbalizes complianc e or cooperati on but does not comply with requests

_____ Drug abuse

_____ Alcohol abuse

_____ Very tense

_____ Nail biting

_____ Chews on clothes, blankets, etc.

_____ Head banging

_____ Hair pulling

_____ Picks on skin

_____ Speaks rapidly and under pressure

_____ Irritabilit y, easily "flies off the handle"

FEARS/PHOBIAS

_____ dark

_____ new situations

_____ strangers

_____ being alone

_____ death

_____ separatio n from parent

_____ school

_____ visiting other children's homes

_____ going away to camp

_____ animals

_____ other fears (name)

_____ Anxiety attacks with palpitatio ns (heart pounding), shortness of breath, sweating, etc.

_____ Disorgani zed

_____ Excessive worrying over minor things

_____ Tics such as eye blinking, grimacing, or other spasmodic repetitiou s movement s

_____ Involunta ry grunts, vocalizati ons (understa ndable or not)

_____ Stutterin g

_____ Depressio n

_____ Frequent crying spells

_____ Suicidal preoccupa tion, gestures, or attempts

_____ Excessive desire to please authority

_____ "Too Good"

_____ Often appears insincere and/or artificial

_____ Too mature, frequentl y acts older than actual age

_____ Excessive guilt over minor indiscreti ons

_____ Asks to be punished

_____ Low self-esteem

_____ Excessive self-criticism

_____ Very poor toleration of criticism

_____ Feelings easily hurt

_____ Dissatis-faction with appearanc

e or body part(s)

_____ Excessive modesty or exposure

_____ Perfectionist, rarely satisfied with performance

_____ Frequently blames others as a cover up for own short comings

_____ Little concern for personal appearance or hygiene

_____ Little concern for or pride in personal property

_____ "Gets hooked" on certain ideas and remains preoccupied

_____ Compulsive repetition of seemingly meaningless physical acts

_____ Shy

_____ Inhibited self expression in dancing, singing, laughing, etc.

_____ Recoils from affectionate physical contact

_____ Withdrawn

_____ Fears asserting self

_____ Inhibits open expression of anger

_____ Allows self to be easily taken advantage of

_____ Frequently pouts and/or sulks

_____ Mute (refuses to speak) but can

_____ Gullible/naive

_____ Passive and easily led

_____ Excessive fantasizing, "lives in his (her own world"

_____ Flat emotional tone

_____ Speech is non-communicative or poorly communicative

_____ Hears voices

_____ Sees visions

Self-Pay Fee Scales

Fees are as follows:

1 Hour: $70.00
1/2 Hour: $40.00

Cancellation Policy

Scheduling appointments can be made over the phone or in person. The parent is primarily responsible for scheduling appointments and keeping blocked out times up-to-date. Your time has been reserved exclusively for you and I do not double book appointments; therefore, **I reserve the right to bill for missed appointments or cancellations within 24 hours.**

I do not charge extra for the initial assessment, family therapy, conjoint sessions, or inpatient visits. This tends to simplify my billing practices and reduces confusion over the various billing codes.

Payments are expected at the time of your visit **unless previously arranged**. Please do not let financial concerns restrict your participation in the child's treatment.

Emergency Situations

After Hours Emergency calls into the office will go to my cell phone number (334) 328-9134. If I am not immediately available, I will call you at the number you leave on my cell number.

Client Responsibilities

Clients are expected to follow all office procedures for scheduling and keeping appointments, payment of services, and notification or termination of primary mental health professional previous to the initial assessment. Clients are also expected to be motivated for treatment and show improvement in overall functioning over time. If for some reason the patient does not show improvement over a determined amount of time and/or in your opinion treatment is ineffective you will be referred to another qualified professional.

Medical Records Policy

A child's medical record will only be released with the signature of both natural parents or legal guardians.