PENNY A. HAYS, PH.D.

LICENSED PSYCHOLOGIST

WWW.DRPENNYHAYS.COM

pennyhays@drpennyhays.com

CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

The following questionnaire is to be completed by you as a parent or guardian. This form has been designed to provide necessary information to my staff before our initial conference in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.

Please use the backs of the pages for additional details.

GENERAL INFORMATION:

Person Completing Form: _____

Child's Name _____Date of Birth_____ Age_____

Home Address _____
Street

_____
City State Zip

Home Phone: _____Work Phone(s): Mother: _____
Father: _____

Cell Phone Numbers: Mother:_____
Father: _____
Email: Mother: _____
Email: Father: _____

School_____System_____Grade_____

School's telephone number:_____

Teacher 1 Name: _____Email: _____
Teacher 2 Name: _____Email: _____

Who referred you to our office? _____

Relationship to child? _____

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems.

_____

_____

_____

_____

_____

_____

_____

_____

INDICATE PARENTS/GUARDIANS LIVING IN THE HOME:

Marital Status- Please check: ☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Cohabitants

If divorced who has physical custody? _____ Is it full or joint? _____ Who has legal custody?_____ Is it full or joint? _____ **Please provide a copy of the custody agreement**.

Mother's Name_____ Age_____

Occupation_____ Education Completed_____

Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Father's Name_____ Age_____

Occupation_____ Education Completed _____

Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

If married, how long have you been married?_____
If divorced, how long have the biological parents been divorced? _____

Has either parent been married before or since? Mother:_____Father:_____

If yes, provide dates of previous marriage(s), names, and ages of children from these marriages:

Mother:_____ Children & Ages:_____

Father:_____ Children & Ages:_____

Is there a birth parent living outside the home: (circle one) MOTHER FATHER

Name:_____ Where do they live?_____

If birth parent(s) do/does not live in the child's home, how much contact does the child have with the parent not having custody, with stepsiblings, etc.?

_____

_____

How would you rate the quality of your present marriage?

Father: ☐ Great ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Mother: ☐ Great ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Does either parent's job require him/her to be away from home long hours or extended periods?_____

If yes, please explain:_____

_____

Who supervises the child's care when not in school? _____

_____

_____

Siblings: List IN ORDER OF AGE siblings of child/adolescent for whom you are seeking services.

	Sibling Name	Age	School	Grade Placement	Grade Average	Conduct*
1.	_____	____	_____	_____	_____	_____
2.	_____	____	_____	_____	_____	_____
3.	_____	____	_____	_____	_____	_____
4.	_____	____	_____	_____	_____	_____
5.	_____	____	_____	_____	_____	_____

*(Please indicate good, fair, or poor)

In general, how would you say the child for whom you are seeking services gets along with these siblings?

☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Describe: _____

_____

_____

Others: List any other people who currently, or in the child's lifetime, have lived in your home.

	Name	Age	Relationship to Child	Years Living in Home
1.	_____	_____	_____	From_____ To_____
2.	_____	_____	_____	From_____ To_____
3.	_____	_____	_____	From_____ To_____
4.	_____	_____	_____	From_____ To_____
5.	_____	_____	_____	From_____ To_____

Are there other relatives who have a significant impact on how this child is raised?

_____

_____

PSYCHOLOGICAL HISTORY

Is there a history in your immediate or in the mother's or father's extended biological family, of the following, and if so who?

Yes	No		Who
☐	☐	Mental Retardation	_____
☐	☐	Learning Problems/Disabilities	_____
☐	☐	Behavioral Problems in School	_____
☐	☐	Attention Deficit/Hyperactivity/Impulsivity	_____
☐	☐	Anxiety Problems/Phobia	_____
☐	☐	Bipolar Disorder	_____
☐	☐	Substance Abuse (alcohol/drugs)	_____
☐	☐	Other Emotional Issue (please list)	_____

How would you rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY)

Mother: _____ Father: _____

MEDICAL AND DEVELOPMENTAL HISTORY

Is there a history in your immediate or in the mother or father's extended family of any medical difficulties, illnesses or surgeries? Please list:

_____

_____

_____

_____

FAMILY STRESS LEVEL

Using the scale below, please rate your level of stress in each of the following areas:

1: VERY LOW 2: LOW3: AVERAGE 4: HIGH 5: VERY HIGH

	Mother	Father		Mother	Father
Your job (if employed)	_____	_____	Your friends	_____	_____
Your home life:	_____	_____	Day-to-day hassles:	_____	_____
Parenting:	_____	_____	Your marriage	_____	_____
Extended Family:	_____	_____			

Rate the overall level of stress in the mother's life at this time (1 = low; 5 = high) _____

Rate the overall level of stress in the father's life at this time (1 = low; 5 = high) _____

What do you consider to be the greatest source of stress in the mother's life?

_____

_____

What do you consider to be the greatest source of stress in the father's life?

_____

_____

Rate the overall level of stress in your FAMILY at this time (1 = low; 5 = high) _____

What do you consider to be the greatest source of stress for your family at this time?

_____

_____

MEDICAL AND DEVELOPMENTAL HISTORY

1. Were there any complications during the period of pregnancy of this child, and if so, what? Please list medications, periods of bed-rest, etc.

_____

_____

_____

2. Was this child born: ☐ Premature ☐ At term ☐ Late?

3. Were there any difficulties during delivery of this child? If yes, please specify.

_____

_____

Weight at Birth: _____Lbs. _____Oz.

4. As an infant, did this child seem:

☐ less active than average ☐ average ☐ overly active

As a toddler, did this child seem:

☐ less active than average ☐ average ☐ overly active

As a preschooler, did this child seem:

☐ less active than average ☐ average ☐ overly active

As the child entered school, did this child seem:

☐ less active than average ☐ average ☐ overly active

5. At approximately what ages did this child:

	Early	Average	Late	Approximate Age
Sleep through the night	_____	_____	_____	_____
Roll over consistently	_____	_____	_____	_____
Sit unsupported	_____	_____	_____	_____
Walk alone	_____	_____	_____	_____
Say first word	_____	_____	_____	_____
Speak in sentences	_____	_____	_____	_____
Toilet trained	_____	_____	_____	_____

6. Please indicate if your child is experiencing any of the following:

Problems with eating _____
School concentration difficulties _____
Grades dropping or consistently low _____
Sadness or Depression _____
Isolated socially from peers _____
Problems making friends _____
Problems keeping friends _____
Problems getting to sleep _____
Problems sleeping through the night _____
Trouble waking up _____
Fatigue/tiredness during the day _____
Nightmares _____
Bed wetting _____

Soiling _____
Problems controlling temper _____
Problems with authority _____
Anxiety _____
Unmotivated _____
Stress from conflict between parents _____
Legal situation (anyone in family) _____
History of abuse (emotional, physical, sexual) _____
Alcohol/drug use/abuse _____
Stress due to family financial problems _____

7. List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

_____

_____

_____

8. List any medications your child is currently taking or has taken for extended periods (give dates and dosage level if possible):

_____

_____

_____

9. Child's current height: _____Ft. _____Inches

weight: _____Lbs.

10. With which hand does the child write? _____

11. Does the child have any vision problems? _____
Please list date of last vision test and who performed (pediatrician, optometrist, school) _____

12. Does the child have any hearing problems? _____
Please list date of last hearing test and who performed (pediatrician, audiologist, school) _____

13. How would you rate the child's overall health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

14. When and where did your child last have a physical examination?

_____

_____

15. Name of child's physician(s) _____

Address: _____

_____

Phone Number: _____

16. Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings?

_____

_____

_____

_____

EDUCATIONAL HISTORY

List in chronological order all schools your child has attended:

	Name of School	Dates Attended	Grade Placement	Grade Average	Behavioral Conduct
1.	_____	From_____ To_____	_____	_____	_____
2.	_____	From_____ To_____	_____	_____	_____
3.	_____	From_____ To_____	_____	_____	_____
4.	_____	From_____ To_____	_____	_____	_____
5.	_____	From_____ To_____	_____	_____	_____

*(Please indicate good, fair, or poor)

Name of current teacher (s)_____

Does your child's teacher have concerns about him/her (list)

_____

_____

What is this child's favorite subject?_____

What is this child's least favorite subject?_____

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

Has this child ever skipped a grade?_____ If so, which?_____

Has this child ever had tutoring?_____ If so, in what subject(s)_____

When and with whom? _____

Has this child ever been in a Special Education Program? _____If so, during what years? _____

How much of the school day? _____

What type of program? (Gifted, LD, BD, MR, etc.) _____

Child's attitude toward school _____

Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

☐ Football ☐ Karate ☐ Dance (type)_____

☐ Baseball ☐ Piano ☐ Music (type)_____

☐ Basketball ☐ Cheerleading ☐ Other:_____

☐ Soccer ☐ Scouts

List any special abilities, skills, strengths your child has.

_____
_____
_____

LEGAL HISTORY

Have you every filed or been involved in any litigation? Please explain

_____
_____
_____
_____

DISCIPLINE INFORMATION

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed: (check the appropriate number)

	Very Unlikely				Very Likely
Let situation go	☐1	☐2	☐3	☐4	☐5
Take away a privilege (ex., no TV)	☐1	☐2	☐3	☐4	☐5
Assign an additional chore	☐1	☐2	☐3	☐4	☐5
Take away something material (ex., no dessert)	☐1	☐2	☐3	☐4	☐5
Send to room	☐1	☐2	☐3	☐4	☐5
Physical punishment	☐1	☐2	☐3	☐4	☐5
Reason with child	☐1	☐2	☐3	☐4	☐5
Ground child	☐1	☐2	☐3	☐4	☐5

Yell at child	☐1	☐2	☐3	☐4	☐5
Send to time out	☐1	☐2	☐3	☐4	☐5

List anything else you may do:

_____	☐1	☐2	☐3	☐4	☐5
_____	☐1	☐2	☐3	☐4	☐5
_____	☐1	☐2	☐3	☐4	☐5

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective.

Then, please circle the strategy that is LEAST effective.

Please rate what percentage of discipline is handled by each of the following:

Father:_____% Mother:_____% Other:_____% (Please specify):_____

GENERAL INFORMATION

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Like Child to do More Often	Like Child to do Less Often
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

This information is intended to answer many of your questions about my basic policies and procedures. If you have any questions, please don't hesitate to ask me about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your psychologist is considered privileged and confidential. We will not release any information without your written release. (The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes). The only exception to these conditions may occur in situations such as child abuse, danger to life, or workers' compensation where by law other action is permitted. Please discuss this with your doctor.

OFFICE HOURS

We are typically available from 9:00 a.m. to 5:00 p.m. Monday through Friday. When we are not available, please call your psychologist/psychometrist's number and either leave a message or contact him/her through their cell phone or pager. The first priority and our primary concern is your well being. In an emergency, please go to the nearest hospital emergency room (ER) for help with your problem, and contact us by saying "This is an emergency!"

SCHEDULING APPOINTMENTS

An appointment can be scheduled directly with your psychologist/psychometrist.

APPOINTMENT LENGTH:

Individual, couples, and family therapy are billed on the basis of a 45-50 minute hour. Group therapy is based on a 90-minute session. If an appointment runs longer, you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

The first session involves assessment and may lasts for one to one and one-half hours. Your doctor/therapist will discuss with you any further assessment or testing that they feel is appropriate and necessary. The fees for these services will also be discussed at this time.

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from someone else in need. **Therefore, except in the case of an acute emergency, we require a 24 hour notice of any cancellation; otherwise, you will be charged for the visit.** In addition, because we are unable to bill insurance for missed appointments, you will be held

financially responsible for these charges. If our office is closed, leave a message on our voice mail to inform us of your cancellation so the time may be used appropriately.

FEES:

FEES FOR PROFESSIONAL SERVICES ARE DUE AND PAYABLE AT THE TIME THEY ARE RENDERED. ALL CLIENTS ARE EXPECTED TO TAKE CARE OF THEIR FEES AS SERVICES ARE RENDERED. ANY OTHER ARRANGEMENT IS CONSIDERED A SPECIAL ARRANGEMENT AND MUST BE DISCUSSED IN ADVANCE WITH YOUR THERAPIST. DELINQUENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY.

Collection of insurance benefits or any other arrangement regarding third party payment is the responsibility of the client (parent or guardian, if the client is a dependent child). An insurance receipt is available for your convenience in submitting your insurance claim. Additional copies can be made for you on request.

ASSESSMENT AND/OR TESTING:

Testing is billed on the basis of the type of test and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with information about the type of test and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis you will be informed before any additional procedures are initiated. The written report, if requested, is generated after payment in full for testing services is received.

REPORTS:

Reports not included in assessment and/or testing fees will be billed as a separate procedure. Requests for such reports and the fees will be discussed with you in advance.

I acknowledge responsibility for all fees incurred.

I have read and understand these policies.

_____ _____

PRINTED NAME OF CLIENT/person responsible for payment Date

_____

SIGNATURE OF CLIENT/person responsible for payment

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to psychological services by _____. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of undergoing psychological services may include obtaining a professional opinion, reduction of my psychological symptoms, and an increased understanding of myself. I understand that potential risks may include predictive validity of psychological assessment (when applicable), possible disagreement with the opinions offered to me, and possible emotional distress when addressing my situation. I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with the progress of my treatment.

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below: (1) where abuse or harmful neglect or children, the elderly, or disabled or incompetent individual is known or reasonably suspected; (2) where the validity of a will of a former patient is contested; (3) where such information is necessary for the psychologist to defend against a malpractice action brought by the client; (4) where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the psychologist; or (6) where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue; and (7) where the client is examined pursuant to a court order. I hold _____harmless for releasing information under the above conditions.

_____Signature _____Date

_____**Name of Client**

PERMISSION FOR TESTING/TREATMENT

I grant permission for Dr. _____ to test/treat _____
(child or minor's name)

and I accept full responsibility for any charges for this testing/treatment.

DATE: _____ _____
Signature of Parent or Guardian

PERMISSION FOR RELEASE OF INFORMATION

This release of information is for the purpose of allowing your psychologist to contact another person/professional.

I do hereby request and authorize: _____
(Name)
to release and discuss the results of my evaluation and/or treatment and to obtain information relevant to my treatment from:

_____
_____

Covering dates of service:
From (date) _____ to (date)_____

Signature of Client: _____
Signature of Professional: _____

Date: _____

PERMISSION TO RELEASE AND OBTAIN INFORMATION

I do hereby request and authorize _____ (Psychologist's Name) to release and discuss results of my child's _____ Psychological Evaluation/Testing _____ Treatment with the following and give those listed below my permission to discuss and release information regarding my child to the above named therapist.

1. _____ _____
Physician #1

2. _____ _____
School County

3. _____ _____
Teacher Teacher

Covering Dates of Services:
From (date)_____ to (date)_____

_____	_____
Date	Signature of Parent or Guardian