

Savannah Neuropsychology

CHILD DEVELOPMENTAL HISTORY QUESTIONNAIRE

This questionnaire has been prepared to allow a review of your child's development in a variety of areas. Please take the time to complete each of the following pages as thoroughly as possible, and feel free to add your comments and elaborations on additional sheets. Thank you in advance for your time and effort with this form.

DEMOGRAPHICS

Child's full name: _____ Child's preferred name: _____

Date of Birth: _____ Race/Ethnicity: _____

Handedness (Circle one): Right Left Ambidextrous

Present primary address: _____

Phone number: _____ Parent Email: _____

Person completing this form: _____ Relation to child: _____

Name of school: _____ Child's present grade level: _____

Has this child ever been in psychotherapy before? (Circle one) Yes No

If yes, please describe: _____

This child's response upon learning that s/he would be meeting with a psychologist was:

_____ "No way! I'm not going!" _____ "I'll give it a try." _____ Child requested services

_____ "Okay, if I have to..." _____ Child doesn't know yet

REASON FOR REFERRAL

Please briefly state the reason this child has been referred for psychological services: _____

Does your child take ADHD medication? (Circle one): Yes No

Do you plan to use the results from this evaluation for work/school accommodations, disability benefits, or

current or future court cases? (Circle one): Yes No If yes, please elaborate: _____

Please indicate below which of the following are concerns about this child. **Do not mark items that are not of concern.** Indicate the severity of concern as follows:

Concern	Most Severe/Important	Less Severe	Problem, but Not Severe
TOILETING: Bedwetting, Soiling, Smearing, Regressed to Diapers, Constipation			
EATING: Refuses to Eat, Compulsion to Eat, Picky Eater, Vomiting/Purging, Obesity			
SLEEPING: Difficulties Falling Asleep, Night Waking, Apnea, Sleep-Walking, Terrors			
ATTENTION: Inattention, Distractible, Can't Concentrate			
AGGRESSION: Fighting/Bullying, Setting Fires, Hurting Animals, Destroying Property			
SELF-DESTRUCTIVE: Cuts, Hits, Kicks, Burns, Self, Bangs Head, Risk Taking			
SOCIAL SKILLS: No Friends, Prefers Younger/Older Peers, Loses Friends Quickly			
DEPRESSION: Withdrawal, Isolation, Low Energy, Hopeless, Sad, Helpless			
ACTIVITY LEVEL: Over-Active, Hyper-Active, Out of Control, Inactive, Passive			
CONFUSION: Disoriented, Forgetful, Memory Impairments, Odd Statements			
MOVEMENT PROBLEMS: Twitches, Tics, Paralysis, Seizures, Weakness, Compulsions			
SCHOOL/WORK PERFORMANCE: Falling Grades, Fired or Expelled, Refuses to Attend			
SEXUAL: Preoccupation, Intrusive Ideas, Exposing Self, Touching Others, Role Confusion			
ABUSE/TRAUMA: Victim of Sexual/Physical/Emotional/Verbal Abuse, Accident, Injury			
SEPARATION/LOSS: Death, Divorce, Relocation			

Concern	Most Severe/Important	Less Severe	Problem, but Not Severe
OPPOSITIONAL/DEFIANT: Disrespectful, Defies Authority, Disobedient			
DELINQUENT: Theft, Assault, Police Involvement, CHINS			
DRUGS AND ALCOHOL: Experimentation, Abuse, Addiction, Peer Pressure			
MEDICAL PROBLEM: Chronic Illness, Terminal Illness, Medication Compliance			

SEPARATION AND DIVORCE: If this child's caregivers have separated or divorced at any time since the child's birth, please indicate below (a) the date of separations, reunion, divorce, and remarriages, as applicable; (b) the legal conditions of visitation and custody; and (c) your feelings about whether this child was successfully kept out of the middle of the divorce.

FOSTER CARE AND ADOPTION: If this child is or has been in foster care or is adopted, please indicate below (a) dates and reasons for foster care; (b) plan for return to or contact with other caregivers; and/or (c) details and history about natural parents/reasons for adoption.

CONCEPTION AND DELIVERY

Was this child's conception planned? (Circle one): Yes No

How long was necessary to become pregnant? _____

What was the reaction to learning of the pregnancy?

Father: _____

Mother: _____

Was the baby carried to term (9 months)? (Circle one): Yes No

Birth Weight: _____ Birth Length: _____

During pregnancy, the child's natural mother did which of the following?

_____ Smoked Tobacco Quantity: _____

_____ Drank Alcohol Type/Quantity: _____

_____ Consumed Caffeine Type/Quantity: _____

_____ Was Injured or Fell

_____ Had Serious Injury/Surgery Please specify: _____

_____ Used Prescription Drugs Please specify: _____

_____ Experienced Other Major Stress Please specify: _____

Please indicate which of the following was true of delivery:

_____ Vaginal Delivery _____ Cesarean Section _____ V-Back

_____ Mother had General Anesthetic

Did the baby experience fetal distress? (Circle one): Yes No

If yes, please elaborate: _____

What were the child's APGAR scores? _____ and _____

Did the mother or child experience medical complications following delivery? (Circle one): Yes No

If yes, please elaborate: _____

How many days after delivery did the mother return home? _____

How many days after delivery did the child return home? _____

INFANCY AND TODDLER YEARS (Approximately ages 0 through 2 years old)

Please check in the boxes below which caregiver was primarily responsible for each of the activities listed.

ACTIVITY:	MOTHER:	FATHER:	OTHER (Please Specify)
Feeding			
Bathing			
Diapering			
Responding to Crying			
Playing			

Was this child breastfed? (Circle one): Yes No If so, s/he was weaned at ____ months old.

Did you feel that the child's early behaviors were "odd" or "unusual?" (Circle one): Yes No

If so, please elaborate: _____

Please note the approximate ages at which this child consistently was able to do each of the following:

____ Sits Alone ____ Stands Unassisted ____ Rolls over Unassisted ____ Says First Words
 ____ Says First Words ____ Walks Unassisted ____ Says First Sentence ____ Fears Strangers
 ____ Full Bowel Control ____ Sleeps Through Night ____ Scribbled with a Crayon
 ____ Full Urine Control ____ Shared Toys with Others

What three adjectives best describe this child during infancy and toddler years?

What was the most difficult part of this child's first two years?

Did the child experience any illness, injury, or prolonged separations during the first two years?

(Circle one): Yes No If yes, please elaborate: _____

PRESCHOOL YEARS (Approximately 2 to 5 years old)

Please use the table below to indicate how this child responded to others during these years:

Activity	Happy	Indifferent	Upset
Held by mother			
Plays near mother			
Mother leaves child			
Held by father			
Plays near father			
Activity	Happy	Indifferent	Upset
Father leaves child			
Stranger approaches			
Stranger holds child			

Please note the approximate ages at which this child consistently was able to do each of the following:

Activity:	Age:	Activity:	Age:
Tie Shoes		Dresses Unassisted	
Bathes Unassisted		Brushes Own Teeth	
Began Daycare		Birth of Next Sibling	
Began Preschool		Shares and Cooperates	
Began Kindergarten		Writes Own Name	
Reads Short Words		Cleans Up When Asked	

Did this child have a favorite object (toy, animal) that seemed to comfort her or him? (Circle one): Yes No

If yes, when did the child give this object up? _____ years old.

ELEMENTARY SCHOOL YEARS (Approximately ages 6 through 11 years old)

Has this child...?

...had any prolonged absences from school? Yes No If yes, please explain: _____

...failed or repeated any grade? Yes No If yes, please explain: _____

...had psychological testing of any kind? Yes No If yes, please explain: _____

...had speech and language or audiological testing? Yes No If yes, please explain: _____

...ever been suspended or expelled from any activity? Yes No If yes, please explain: _____

What three adjectives best describe this child's attitude toward school and learning?

In elementary school, this child's...

Favorite subject: _____ Worst subject: _____

Best subject: _____

In elementary school, this child wanted to be a _____ when s/he grows up.

FAMILY AND HOME

Please describe this child's immediate and extended family below. In the right-hand column, marked ??? indicate any of the following codes that describe the individuals listed:

AC Alcohol or Chemical Dependency
 DS Depression or Suicide Attempts
 PSY Psychiatric/Psychological Problems
 CP Chronic Physical Illness
 LP Learning Problems/School Failure
 AI Arrested, Imprisoned or Convicted
 ID Intellectual Disability
 V Violent, Aggression, Dangerous
 P Physical Illness (please specify)

Relation	Full Name	Age	Live with Child	???

If anyone else lives in the same home with the child (butler, roommate), please list here:

Please list the place where this child has resided since birth.

Location	Between Ages:	Lived with whom?

MEDICAL STATUS

Has this child ever...	Yes	No
...require major surgery of any kind?		
...had seizures, blackouts, or "lost" time?		
...lost consciousness?		
...had heart or lung diseases?		
...had an infectious disease?		
...had a head injury?		
...required hospitalization?		

Please explain any yes responses:

Does this child complain of chronic physical discomfort? (Circle one): Yes No

If yes, please describe: _____

Medication	Dosage	Frequency/Day	Prescribed by:

Is there anything else that you would like the psychologist to know? _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____ [PATIENT or PARENT/GUARDIAN NAME], hereby authorize the disclosure of my child's health information FROM Savannah Neuropsychology, 400 Mall Blvd. STE W. Savannah, GA 31406, for the purpose of evaluation and treatment TO the medical provider(s) and other methods listed below:

Referring Physician/Facility:

Personal Email:

Physician/Facility:

Physician/Facility

I understand that the health information that may be disclosed includes, but is not limited to, the following:

- Medical records, including diagnoses, treatment plans, and medications prescribed.
- Laboratory and diagnostic test results.
- Surgical and operative reports.
- Mental health records, including therapy session notes and psychiatric evaluations.
- Substance abuse treatment records, if applicable.
- Any other pertinent health information deemed necessary for the purpose of disclosure.

I authorize Savannah Neuropsychology to obtain, use, and disclose this health information in accordance with the applicable privacy laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and any state or local laws governing the privacy and confidentiality of health information.

This authorization is valid for a period of one year from the date of signing this document unless otherwise specified. I understand that I have the right to revoke this authorization at any time by providing a written notice to Savannah Neuropsychology, except to the extent that action has already been taken based on this authorization.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION CONT.

I acknowledge that the disclosure of my health information is voluntary, and I am aware of the potential risks associated with the unauthorized use or disclosure of this information. I release Savannah Neuropsychology, its employees, agents, and representatives from any liability that may arise from the use or disclosure of my health information in accordance with this authorization.

Patient's Name:

Patient's Date of Birth:

Patient/Guardian Signature:

Relationship to Patient:

Today's Date:

Savannah Neuropsychology

INFORMED CONSENT FOR NEUROPSYCHOLOGICAL/PSYCHOLOGICAL SERVICES

You have been referred to our office for an evaluation and/or treatment. Your appointment has been scheduled with a licensed psychologist and/or a master's level psychology associate. The initial visit will consist of one or more of the clinical services listed below. We will review the evaluation/treatment plan and recommendations with the patient, at which time the patient may ask questions or voice concerns. The patient may choose to discontinue their relationship with this practice at any time during the course of evaluation and/or treatment with the understanding that fees associated with evaluation and treatment already rendered will be due and payable.

The following information is provided to the patient for review. Please sign the last page, acknowledging that you have read and understand the information provided. A copy of this information will be made available to you.

Clinical Services provided by our practice:

- A. Psychological Evaluation: consists of one or more clinical interviews with the patient and/or family members, a review of available medical and psychological records, and ***the completion of various psychological tests*** - all of which are designed to answer questions about the patient's psychological well-being, assist in making decisions concerning the patient, and assist in the treatment of the patient. These evaluations are often required as a part of surgical clearance for specific types of procedures.
- B. Neuropsychological Evaluation: a highly specialized form of evaluation to help answer questions about the health of a patient's brain, especially how well the brain is able to perform the tasks it needs to perform. This type of referral would normally be based on concern about observed changes in the patient and/or the experience of an injury or neurological disorder.
- C. Counseling/Therapeutic Services: these services are a way to help individuals with a wide variety of mental illnesses and emotional difficulties by eliminating or controlling troubling symptoms so a person can function better and increase their well-being. We primarily utilize Cognitive Behavioral Therapy (CBT), which helps people identify and change thinking and behavior patterns that are harmful or ineffective, replacing them with more accurate and functional thoughts and behaviors. It can help a person focus on current problems and how to solve them. It often involves practicing new skills in the "real world." CBT can be helpful in treating a variety of disorders, including depression, anxiety, trauma-related disorders, and eating disorders.

Confidentiality:

Patient cases are treated confidentially. This means that information about a patient is only shared with that patient and members of their treatment team, and then only in a manner necessary to enhance their care. Sensitive issues are handled very carefully - if there is a question about confidentiality, if you and your family have questions about any of the clinical services discussed, or about the financial aspects of your treatment, please call our practice manager or your psychologist.

There are some situations in which the psychologist is legally required to take action to protect others from harm, even if that requires revealing some information about a client's treatment. For example, if the psychologist believes that a child, an elderly person, or a disabled person is being abused, he must file a report with the appropriate state agency. If the psychologist believes that a patient is threatening serious bodily harm to another, he is required to take protective actions.

Informed Consent for Neuropsychological/Psychological Services Page 2

These may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If the patient threatens to harm him/herself, the psychologist may be required to seek hospitalization for the client or to contact family members or others who can help provide protection. These situations rarely arise in our practice, but should such a situation occur, the psychologist would make every effort to fully discuss the situation with the patient before taking any action.

With regard to electronic mail (e-mail) communications, we cannot guarantee complete privacy due to the nature of the Internet. We advise our patients to use this method of technology cautiously.

Professional Records:

Both Georgia state law and the standards of the field of psychology require that appropriate treatment records be kept on every patient seen by the psychologist. The patient is entitled to receive a copy of the records, unless the psychologist believes that seeing them would be emotionally damaging, in which case, the psychologist would provide them to an appropriate mental health professional of the patient's choice. Because these are professional records, they can be misinterpreted and/or can be upsetting. It is our recommendation that the records be reviewed by the patient and psychologist together so that they can discuss the content of the record.

Protected Health Information or "PHI":

Your personal medical information is called Protected Health Information or "PHI." This office and staff can use your PHI or share it with each other only in certain ways. We must follow certain rules about sharing the patient's PHI outside of our practice. You will be given the Georgia Notice Form regarding this information, how it may be used and disclosed, and how you can get access to it. Please review this Notice carefully.

Financial Responsibility

Our practice works hard to charge for services at a rate competitive for our region of the state while still meeting operating expenses. Fees reflect time spent with the patient and family, review of records, scoring, and interpretation of tests, preparation of reports, and treatment planning with health care teams. Debit/Credit cards will automatically be saved to our system by default but can be removed at any time upon request.

Please note that there is a \$25 fee for missed appointments not canceled with a 24-hour notice. This fee is not covered by insurance carriers and is the patient's responsibility.

Initial Above

Services are often paid for by insurance, government programs, or other benefit programs. Each patient will need to discuss potential coverage in advance with our office staff. Patients often assume coverage beyond what is actually available to them. Any estimate we provide is offered as a courtesy and does not guarantee benefits or payment. The contract between the patient and the insurer is strictly between those parties. For any questions regarding how a claim was processed, please contact your insurance provider directly. **You will be responsible for any unpaid balances once your insurance has processed the claim.**

Your signature below authorizes the release of any necessary information to process your insurance claims, including demographic information as well as clinical notes/information. It also indicates that you have read and understand the above. A copy of the Georgia Notice Form is available at your request.

Patient/Guardian Signature _____

Date _____

Witness _____

Date _____