



REASON FOR REFERRAL / CURRENT SYMPTOMS

Please describe the problems your child is now having and the type of services you are seeking.

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

- School attention/concentration problems
- Grades dropping or consistently low
- Hyperactive, difficulty being still
- Impulsive, doesn't think before acting
- Sadness or Depression
- Generalized Anxiety (across many situations)
- Specific fears/phobias (list): \_\_\_\_\_
- Social Anxiety
- Obsessive-Compulsive / Rigid behavior patterns
- Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
- Isolated socially from peers
- Problems making or keeping friends
- Problems with eating
- Problems falling asleep
- Problems sleeping through the night (middle of the night or early morning waking)
- Trouble waking up
- Fatigue/tiredness during the day
- Nightmares
- Noncompliant, purposely does not obey (not due to language or cognitive deficits)
- Oppositional, defiant behavior
- Problems controlling temper
- Tantrums / "Meltdowns"
- Problems with authority (breaking rules or laws)

- Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)  
 Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)  
 Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)  
 Wetting accidents (indicate day or night wetting): \_\_\_\_\_  
 Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)  
 History of abuse (emotional, physical, sexual)  
 Alcohol or drug use/abuse  
 Vocal or motor tics (e.g, grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)  
 Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)  
 Stress from conflict between parents  
 Stress due to family financial problems  
 Legal situation (anyone in family)  
 Other behavior problems: \_\_\_\_\_

### PARENTS / GUARDIANS AND FAMILY INFORMATION:

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education Completed: \_\_\_\_\_

Health:  Excellent  Good  Fair  Poor

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education Completed: \_\_\_\_\_

Health:  Excellent  Good  Fair  Poor

Marital Status (circle one): Married    Remarried    Divorced    Separated    Widowed    Single    Cohabitants

If married, how long have you been married? \_\_\_\_\_

If divorced, how long have you been divorced? \_\_\_\_\_

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.**

Has either parent been married before or since? Mother: \_\_\_\_\_ Father: \_\_\_\_\_

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

Mother: \_\_\_\_\_ Children and ages: \_\_\_\_\_

Father: \_\_\_\_\_ Children and ages: \_\_\_\_\_

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

Where does this parent live? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

How would you rate the quality of your present marriage?

Mother: \_\_\_\_Great \_\_\_\_Very Good \_\_\_\_Good \_\_\_\_Fair \_\_\_\_Poor \_\_\_\_Very Poor

Father: \_\_\_\_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, 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.

<u>Sibling Name</u>	<u>Age</u>	<u>School</u>	<u>Grade Placement</u>	<u>Grade Average</u>	<u>Conduct*</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

\*(Please indicate good, fair, or poor conduct)

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

\_\_\_\_Great \_\_\_\_Very Good \_\_\_\_Good \_\_\_\_Fair \_\_\_\_Poor \_\_\_\_Very Poor

Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Others: List any other people who currently, or in the child's lifetime, have lived in your home (other family members, caregivers, nannies, etc.).

Name	Age	Relationship to Child	Years Living in Home
_____	_____	_____	From _____ to _____
_____	_____	_____	From _____ to _____
_____	_____	_____	From _____ to _____
_____	_____	_____	From _____ to _____

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

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### FAMILY STRESS LEVEL

Please rate the overall level of FAMILY stress:

\_\_\_\_\_ Very Low    \_\_\_\_\_ Low    \_\_\_\_\_ Average    \_\_\_\_\_ High    \_\_\_\_\_ Very High

What is the greatest source of stress for the family at this time?

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Please rate the overall level of stress in the mother's life:

\_\_\_\_\_ Very Low    \_\_\_\_\_ Low    \_\_\_\_\_ Average    \_\_\_\_\_ High    \_\_\_\_\_ Very High

What are the greatest sources of stress in the mother's life?

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Please rate the overall level of stress in the father's life:

\_\_\_\_\_ Very Low    \_\_\_\_\_ Low    \_\_\_\_\_ Average    \_\_\_\_\_ High    \_\_\_\_\_ Very High

What are the greatest sources of stress in the father's life?

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

Mother: \_\_\_\_\_      Father: \_\_\_\_\_

FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who.

<u>Yes</u>	<u>Condition</u>	<u>Family Member</u>
_____	General Developmental Delays or Cognitive Delay	_____
_____	Speech or Communication Disorder	_____
_____	Intellectual Disability (mental retardation)	_____
_____	Attention-Deficit / Hyperactivity / Impulsivity	_____
_____	Learning Problems / Disabilities	_____
_____	Autism Spectrum / Asperger's Disorder	_____
_____	Sleep disorders	_____
_____	Generalized Anxiety (across many situations)	_____
_____	Social Anxiety	_____
_____	Obsessive-Compulsive Disorder	_____
_____	Phobias	_____
_____	Depression	_____
_____	Manic-Depression / Bipolar Disorder	_____
_____	Suicide attempts / Suicide	_____
_____	Schizophrenia or other psychosis	_____
_____	Alcohol / Substance Abuse	_____
_____	Seizures or other neurological disorder	_____
_____	Genetic Disorder (e.g., Down Syndrome, Fragile X)	_____
_____	Other: _____	_____

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DEVELOPMENTAL HISTORY

Any difficulties during the pregnancy or delivery of this child? Please list any medications, periods of bed rest, etc.

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Child was born:     \_\_\_premature     \_\_\_at full term     \_\_\_late

Birth Weight \_\_\_ lbs, \_\_\_ oz

Difficulties following delivery? \_\_\_\_\_

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Nursery (check all that apply): \_\_\_Well-baby     \_\_\_Transitional     \_\_\_Intensive Care     \_\_\_Other

Describe your child's temperament as an infant (e.g., easy-going, irritable, passive, difficult to soothe, etc.)

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Any medical problems diagnosed in infancy? \_\_\_\_\_

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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

At what age did your child accomplish these developmental tasks? If your child has not met one or more milestones, leave those items blank or write "not yet."

	Early	On-Time	Late	Approximate age (if known)
<u>Speech and Language</u>				
Coo/babble	_____	_____	_____	_____
Respond to name	_____	_____	_____	_____
Say first word	_____	_____	_____	_____
Use gestures (wave, point)	_____	_____	_____	_____
Put words together	_____	_____	_____	_____
Speak in sentences	_____	_____	_____	_____
Follow simple directions	_____	_____	_____	_____
Follow multistep directions	_____	_____	_____	_____
<u>Motor Skills</u>				
Roll over	_____	_____	_____	_____
Sit alone	_____	_____	_____	_____
Stand alone	_____	_____	_____	_____
Walk alone	_____	_____	_____	_____
Hold pencil correctly to mark	_____	_____	_____	_____
Write legibly	_____	_____	_____	_____
<u>Self-Help/Independence</u>				
Feed self	_____	_____	_____	_____
Toilet train (bladder)	_____	_____	_____	_____
Toilet train (bowel)	_____	_____	_____	_____
Dress self	_____	_____	_____	_____
Bathe self	_____	_____	_____	_____
<u>Social/Emotional</u>				
Smile at others	_____	_____	_____	_____
Laugh aloud	_____	_____	_____	_____
Show affection	_____	_____	_____	_____
Engage in pretend play	_____	_____	_____	_____
First friendship	_____	_____	_____	_____
Control feelings when upset	_____	_____	_____	_____
Understand others' feelings	_____	_____	_____	_____
Show responsibility	_____	_____	_____	_____

MEDICAL HISTORY

Name of Child's Primary Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

\_\_\_\_\_

Physician's Phone: \_\_\_\_\_

List any other physicians or health professionals your child sees for services on a regular basis.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your child last seen by a physician?

\_\_\_\_\_

Rate your child's overall health

\_\_\_\_ Excellent      \_\_\_\_ Good      \_\_\_\_ Fair      \_\_\_\_ Poor

Child's current height: \_\_\_\_ ft, \_\_\_\_ in.      Weight: \_\_\_\_ lbs.

Does your child have any vision problems? \_\_\_\_\_

Date of last vision test and who performed (physician, optometrist, school) \_\_\_\_\_

Does your child have any hearing problems? \_\_\_\_\_

Date of last hearing test and who performed (physician, audiologist, school) \_\_\_\_\_

Is your child:      \_\_\_\_ right handed      \_\_\_\_ left handed      \_\_\_\_ does not favor one hand

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medications your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time. Use back of page if needed.

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Describe your child's regular diet (i.e, favorite and least favorite foods). Do you have any concerns about your child's eating habits (e.g., aversion to certain tastes, textures, overly restricted eating, overeating, unhealthy eating)?

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What is your child's typical bedtime and wake time each day? Any concerns about your child's sleeping habits?

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

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**EDUCATIONAL AND SOCIAL 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 conduct)

Name of current teacher (s): \_\_\_\_\_

What concerns does your child's teacher have about him/her?

\_\_\_\_\_  
\_\_\_\_\_

What is your child's favorite subject? \_\_\_\_\_

What is your child's least favorite subject? \_\_\_\_\_

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

Has your child ever skipped a grade? \_\_\_\_\_ If so, which? \_\_\_\_\_

Has your child ever had tutoring? \_\_\_\_\_ Which subjects? \_\_\_\_\_

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? (LD, Gifted, EBD, ASD, etc.): \_\_\_\_\_

Child's attitude toward school: \_\_\_\_\_

How does your child interact with peers and adults in social situations? Do you have concerns about your child's social skills or development?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

\_\_\_\_\_ Sports (list): \_\_\_\_\_

\_\_\_\_\_ Music (list): \_\_\_\_\_

\_\_\_\_\_ Clubs/Groups (list): \_\_\_\_\_

\_\_\_\_\_ Dance (list): \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

Describe your child's strengths, positive qualities, and any special abilities or skills.

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### BEHAVIOR MANAGEMENT / DISCIPLINE

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: (circle the appropriate number)

	Very Unlikely				Very Likely
Let situation go	1	2	3	4	5
Time out	1	2	3	4	5
Send to room	1	2	3	4	5
Take away a privilege (ex., no TV)	1	2	3	4	5
Take away something material (ex., no dessert)	1	2	3	4	5
Assign an additional chore	1	2	3	4	5
Ground child	1	2	3	4	5
Reason with child / Problem-Solve / Negotiate	1	2	3	4	5
Yell at child	1	2	3	4	5
Physical punishment	1	2	3	4	5
List anything else you may do:					
_____	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): \_\_\_\_\_

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.

Would like Child to do More Often

Would like Child to do Less Often

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**LEGAL HISTORY**

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

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Is there anything else we should know about your child that was not covered by this form?

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## **NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT**

Welcome to the Behavioral Institute of Atlanta (BIA). This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner about these or any other matters when you meet. We are here to assist you.

### **CONFIDENTIALITY:**

Communication between you and your doctor/therapist 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/therapist.

### **OFFICE HOURS**

The office staff are typically available from 9:00 a.m. to 5:00 p.m. Monday through Friday. When the office staff is not available, please call your therapist's extension 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!"

If your doctor/therapist is out of town or unavailable for some other reason, one of our other doctors/therapists will be on-call.

### **SCHEDULING APPOINTMENTS**

An appointment can be scheduled by either your doctor/therapist or our office staff.

### **APPOINTMENT LENGTH:**

Individual, couples, and family therapy are billed on the basis of a 45-50 minute hour. 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 usually 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, your account will be charged for the visit.** In addition, because insurance will not pay or reimburse for missed appointments, you will be held financially responsible for these charges. If our office is closed, leave a message on your therapist's voice mail to inform us of your cancellation so the time may be used appropriately.

FEES:

Payment 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.

We accept checks, Visa, and Mastercard.

In most cases, 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 for reimbursement. Additional copies of bills can be made for you on request.

ASSESSMENT AND/OR TESTING:

Testing is billed on the basis of the types of tests 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 types 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 have read and understand these policies. I acknowledge responsibility for all fees incurred.

Date: \_\_\_\_\_

\_\_\_\_\_  
Client's Name

\_\_\_\_\_  
Signature of Responsible Party



**INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:**

I hereby voluntarily apply for and consent to psychological services from \_\_\_\_\_.  
(BIA clinician)

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 receiving psychological services may include obtaining a professional opinion, reduction of psychological symptoms, and an increased understanding of psychological issues. I understand that potential risks may include possible disagreement with the professional opinions offered, possible emotional distress when addressing my child’s difficulties, and limitations in the ability to make predictions based on results of psychological assessments (when applicable). 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 my services.

I understand and agree that 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 a 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 practitioner 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 practitioner
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order.

I hold \_\_\_\_\_ harmless for releasing information under the above conditions.  
(BIA clinician)

Child’s Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Parent/Guardian (print name) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PERMISSION TO RELEASE AND OBTAIN INFORMATION**

I do hereby authorize \_\_\_\_\_ to release and discuss the results of my child's  
(BIA clinician)

\_\_\_ Psychological Evaluation/Testing

\_\_\_ Treatment/Therapy

with the following individuals. I give those listed below my permission to discuss and release  
information regarding my child to \_\_\_\_\_.  
(BIA clinician)

This release of information is valid from \_\_\_\_\_ (date) to \_\_\_\_\_ (date).

Individual	Agency	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Child's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Parent/Guardian (print name) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_