239.599.5656 • Fax 239.599.5655
www.LSWpsychology.com • LSWpsychology@gmail.com
8359 Beacon Boulevard, Suite 503 • Fort Myers, Florida 33907

Child/Adolescent Client Information Form

Client's Full Name:____

Primary Address: (street/city/state/zip) ____

____

If applicable, Client's Phone#______________________ Client's Email ______________________________

Date of Birth:______________________ Age of Client:___________________ Grade________________

Social Security #:_____________________________Right or Left Handed___________________________

Relationship to Primary Insured:____

Name of Pediatrician ____Phone#____________________

How did you hear about us?____

Reason for Referral:____

____

Parent/Guardian Information

Mother's Name_________________________________ **Father's Name**____________________________

Address: ______________________________________ Address:_________________________________

City/State/Zip:_________________________________ City/State/Zip:____________________________

Home Phone:___________________________________ Home Phone:______________________________

Cell Phone:____________________________________ Cell Phone:________________________________

Email address:_________________________________ Email address:____________________________

Occupation: ___________________________________ Occupation:______________________________

Who does client live with (parent(s), grandparent(s), etc.)?_______________________________________

Name & Age of Siblings:____

Insurance Information

Insurance Company:___________________________ Insurance Phone Number: ____________________

Subscriber's Name:____________________________ Subscriber's Birthdate:_______________________

Subscriber's Social Security #___________________ Subscriber's Employer: _______________________

Subscriber's Address: ____

Member ID#_________________________________ Group#____________________________________

Specialist Copay:_____________________________ Specialist Coinsurance:________________________

PLEASE NOTE: In an effort to facilitate communication, LSW Psychological Services sends **TEXT MESSAGE** confirmations the business day prior to the scheduled appointment. Our office will also **E-mail** receipts for payments or account statements to the provided E-mail address. Please indicate which phone number and E-mail address you would like to have notifications sent to on the line below. If you **do not** want to receive these communications, please write "I decline" on the line below:

Phone: ________________________________ E-mail____

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Adolescent Background History:

Name:____

Date of Birth: ___________________________ Initial Appointment Date: _________________________

Handedness: ___________________________ Language(s) Spoken: _____________________________

Grade: ________________________________ School: ____

Who completed this form? ____

Social History:

Where were you born? _____________________________________

Please list all of the different cities/states in which you have lived since birth:	Ages or Years

Parents Names: ______________________________ ______________________________

Is your mother living? Yes No Is your father living? Yes No

If no, please explain when and how they passed away.

Are your parents still married to each other or together? Yes No

If not, please explain when they divorced/separated: ___________________________________

Are your parents re-married? Yes No

Mother's Job: ____________________________Father's Job: _____________________________

If your parents were divorced how often do/did you see your parent who does/did not live with you?

How many sisters do you have? _____ How many brothers do you have? ____

Please list your sisters/brothers names, ages, current jobs and any learning problems.

Name	Age	Current Job	Any learning problems?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Has how you were treated and raised as a child had more of a positive or negative effect on your personality? Positive Negative

If you circled negative, please explain:

Are there any traumatic events that have influenced your life?

Were you ever abused or mistreated? Yes No

If yes, please circle all that apply: ______ None

Sexual Abuse	Physical Abuse	Emotional Abuse	Neglect

Was the Department of Children and Families (DCF) ever involved with your family as a child?
Yes No

Has anyone in **your family** been diagnosed with any of the following? ______ None

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Disability (MR)	Substance Abuse/Alcoholism	Autism
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Other			

Current Family History:

Have you ever been married? Yes No How many times? _____

Spouse Name	Date Married	Date Separated/Divorced

Who do you currently live with? ____

Do you currently have a boyfriend/girlfriend? Yes No
How long? ____

Describe any common problems in your romantic relationships:

Do you have difficulty making friends? Yes No

Do you have difficulty keeping friends? Yes No

Number of close friends: ________
How often do you spend time with them?____

Describe any common problems in your relationships with friends:

Currently, what do you do for fun?

Do you have any children? Yes No

Name of child	Age	Current Job	Any learning problems?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Custody Status: Full Time:__________50/50 Split:____________ Weekends:____________

No Contact:_______________ Other:____________________

Has DCF been involved with your current family? Yes No

If yes, explain:

Developmental History:

Circle any of the following that were problems with **your** birth or delivery. ______ Within normal limits

Premature	Low Birth Weight	Gestational Diabetes	Jaundice
C-Section	Mom drank alcohol	Mom smoked	Mom used illegal drugs

Circle below whether you met your developmental milestones on time:

Talking? Yes No Walking? Yes No Toilet Training? Yes No

Did you have any speech difficulties? Never As a child Currently

Did you ever receive speech therapy? Yes No If so, when? _______________

Have you ever received occupational therapy? Yes No If so, when? _______________

Have you ever received physical therapy? Yes No If so, when? _______________

Medical History:

Place an “X” in the appropriate range if you have suffered from any of the following: _____None

Medical Disorder	Birth to age 12	As an adolescent/adult
Chronic Ear Infections		
Cancer		
HIV/AIDS		
Heart Attack		
Concussion		
Seizure/Epilepsy		
Broken Bones		
Chronic Stomach Problems		
Asthma		
Meningitis		
Multiple Sclerosis		
Thyroid Condition		
High Blood Pressure		
Diabetes		
Other		

Have you ever had surgery? Yes No If Yes, explain:

Any visual difficulties? Yes No Do you wear glasses or contacts? Yes No

Any hearing difficulties? Yes No Do you wear a hearing aid? Yes No

Circle any mental health disorder in which **you** have been diagnosed: _____ None

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Disability (MR)	Substance Abuse/Alcoholism	Autism
Anxiety	Conduct Disorder	Personality Disorder	ADHD/ADD
Other			

Please list any prescription medications that you currently use: _____ None

Medication	For What?	Doctor Who Prescribed?

Mental Health History:

Circle any of the following which have been an issue for you over the past year:

Getting to work/school on time	Fidgeting	Eating too little/too much	Getting along with people
Nervousness/Anxiety	Sad most of the day	Suicidal thoughts	Paying attention
Poor communication	Restlessness	Emotional control	Anger management
Self-esteem	Not thinking before I act	Self-injury	Organization
Easily distracted	Talk too much	Risky/Illegal behavior	Obsessions
Irritability	Loss of interest in normally enjoyable activities	Phobia with ______________________________	
Excessive spending	Sleep too much/too little	Vomit after eating	Hallucinations
Bizarre thinking	Hoarding	Unproductive rituals	Forgetfulness
Few close friends	Procrastination	Test Anxiety	Panic attacks

Have you been to counseling before? Yes No If so, when?___________________

Who was the therapist? What were you treated for?

Have you ever received inpatient hospitalization for a mental health issue? Yes No

If yes, explain each placement.

Have you ever attempted suicide? Yes No How many times? _________

Please explain each attempt:

Drug and Alcohol Use:

Please circle all substances you have used in the past: _____None
Alcohol, PCP (angel dust), marijuana, amphetamines (speed), cocaine, crack cocaine, hallucinogens (acid, mushrooms), ecstasy, methamphetamine (meth), opium, heroin, sleeping pills, pain killers

Please include last use for any items circled ____

____

____

What substances do you currently use? How often?

Have you ever been treated for drug or alcohol abuse? Yes No

If so, when and where?

Have you ever lost a job or relationship because of substance abuse? Yes No

If so, when and what happened?

Have you ever been in legal trouble for drug or alcohol abuse? Yes No

If so, when and what happened?

Legal History:

Have you ever been in trouble with the law? Yes No

If so, when and what happened?

Offense	Date	Length of jail time, probation, or fine

Educational History:

Did you attend Preschool? Yes No If so, where?_________________________

Please list all of the schools you have attended.

School	City, State	Ages or Years or Grades Attended

Did you graduate high school? Yes No When did you graduate? _______________

If you have not graduated, when do you expect to? ___________________________

Did you graduate with a standard diploma? Yes No

If you did not graduate high school, did you get a GED? Yes No

Do you intend to go to college? Yes No

Have you attended any college? Yes No Major ________________________

Did you graduate from college? Yes No Degree _______________________

If you attended college but did not finish, please explain.

Did you have an Individualized Education Program (IEP)/504 Plan? Yes No

Were you in special education/Exceptional Student Education (ESE) in school? Yes No

If so, which grade were you in when you began special education? _______________

Circle any disability that you were placed in ESE/special education for:

Reading learning disability	Math learning disability	Writing learning disability	Speech impaired
Hearing impaired	Visually impaired	Emotional disturbance	Mental retardation
Autism/Asperger's	Traumatic Brain Injury	Medical impairment	Other

What types of accommodations or help with school do/did you receive (mark all that apply)?

Extended time on tests	Tests taken in a quiet space	Tests taken in small group	Additional time to complete assignments
Intensive Reading	Intensive Mathematics	Social-Communication Classroom	Behavior Unit Classroom
Intensive English/Language Arts	Speech or Language Therapy	Occupational Therapy	Physical Therapy
Shortened Assignments	Subjects taught below grade level curriculum	Exempt from state-wide standardized tests	Functioning Living Skills Classroom

Did you ever have to repeat a grade? Yes No If so, what grade(s)?____________

Did you ever get in trouble at school? Yes No If so, when did it start?____________

Did you ever get detentions? Yes No Did you ever get suspended? Yes No

What types of behaviors did you get in trouble for at school?

Did you ever get expelled from school? Yes No What grade were you in?____________

If so, why were you expelled?

Please list any after school activities that you participated in (e.g., clubs, sports)

Daily Living:

Can you drive a car?	Yes	No
Do you have a driver's license?	Yes	No
Do you own/lease your own car?	Yes	No
Can you do your own laundry?	Yes	No
Can you calculate change?	Yes	No
Can you do your own grocery shopping?	Yes	No
Can you cook for yourself or your family?	Yes	No
Can you bathe and dress yourself without help?	Yes	No

Financial History:

Have you ever filed for bankruptcy? Yes No

If yes, please explain.

Describe your current debt: ____

You are financially dependent on (circle all that apply): Self Spouse Parents/Family

SSI/SSID Other: ___________________

Do you own your home or pay rent?

Are you able to pay your bills on time? Yes No

If No, explain why?

Do you have a checking account? Yes No

Describe any difficulties that you have maintaining your finances:

Job History:

In order, please list your job titles, where you worked, how long and why you left? _____None

Job Title	Business Name	How long?	Why did you leave?

Can you complete a job application without help? Yes No

Circle any of the following that have made it difficult for you to find or keep a job?

Reading	Math	Writing	Medical	Alcohol/Drugs	Mental Health	Legal

At work, do you have difficulty getting along with supervisors? Yes No

At work, do you have difficulty getting along with co-workers? Yes No

At work, do you have difficulty getting along with customers? Yes No

Have you ever been fired from a job? Yes No

If yes, please explain.

What strengths do you offer a job?

What are your weaknesses on the job?

What types of jobs would you like to do in the future?

What types of jobs would you not like to do in the future?

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Patient Consent for Use and Disclosure
of Protected Health Information (HIPPA Acknowledgement)

I hereby give my consent for LSW Psychological Services to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by LSW Psychological Services describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

LSW Psychological Services reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. LeighAnn Wong (239) 599-5656.

With this consent, LSW Psychological Services may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, LSW Psychological Services may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, LSW Psychological Services may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that LSW Psychological Services restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow LSW Psychological Services to use and disclose my PHI to carry out TPO.

in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LSW Psychological Services may decline to provide treatment to me.

____ ___________________________________

Name of client Date

____

Signature of adult client or parent/guardian of client

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Financial Responsibility and Guarantee of Payment for Services

Thank you for choosing LSW Psychological Services to work with you and/or your family. By signing this form, you agree to be charged for direct and indirect services that we provide. Direct services include but are not limited to: face to face counseling, assessment/evaluation, consultation, and observation. Indirect services include but are not limited to: attend IEP meeting, advocacy, report writing, and phone calls over 10 minutes. The standard hourly (50-minute) rate is $180. Assessment/Evaluation services involve billing for actual hours spent testing and time spent scoring, interpreting, and writing up results. Comprehensive reports generally require 2 to 5 hours and insurance companies rarely pay for this service.

Appointments are specifically held for the client and it is important that you give us 24 hours notice if you intend to cancel. If we do not receive notification within that time frame then we cannot fill that time slot with another client; therefore, we will charge you up to our standard hourly rate ($180/hr) for the late cancellation. For returned checks, you are expected to pay the bank fee and the full charge for those services in cash.

By signing this form, you are also consenting to allow LSW Psychological Services to contact your insurance company regarding payment of services. It is your responsibility to understand your insurance plan. Any precertification which is required by your insurance company must be done prior to your appointment. This must be submitted to LSW Psychological Services before services are rendered. It is difficult to understand all of the caveats of each insurance company and you will be responsible for payments which are not covered by your insurance company. Any issues with reimbursement are the responsibility of the client and the insurance company, not LSW Psychological Services.

If you would like to have a credit card on file, please provide the credit card information below. We do not accept American Express: **VISA MASTERCARD DISCOVER** _____ I decline

Full name on card ______________________________________ Expiration Date_________________

Credit Card #____ Security Code __________________

By signing below, you authorize LSW Psychological Services to charge your card for any unpaid balance after insurance discounts. If your carrier does not pay within 30 days and you are notified by phone/email, you will be given an additional 10 days to settle the balance. If not, your card will be charged for the unpaid balance.

____ _______________________________________

Name of client Date

____

Signature of adult client or parent/guardian of client

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Informed Consent

I, ______________________________, voluntarily give consent to LSW Psychological Services for the purposes of psychological services. (*If applicable:* This consent also includes psychological services for my child/children ____.) These services may include but are not limited to: psychological assessment or evaluation, counseling, consultation, parent training, and study skills enhancement. I understand that psychological services are confidential with the exception of the following scenarios: (A) knowledge or reasonable suspicion of harm to self or others, (B) knowledge or reasonable suspicion of child or elder abuse, and (C) court order for information regarding your case.
Psychological services are intended to be beneficial in the improvement of mental health or academic concerns; however, none of these benefits are guaranteed. You may disagree with the opinions offered to you and emotional distress may result from sensitive matters which are addressed during the course of psychological services. Alternative referrals to another health care provider will be given if desired.
LSW Psychological Services provides only outpatient mental health services and does not guarantee emergency intervention, particularly if it is necessary after business hours. If you require emergency services after business hours, please call 911 or Lee Mental Health Care (239) 275-3222.

By signing below, I confirm that I have read this form in its entirety or it was read to me, and I understood the information included in it. I have no additional questions and I have clarified any information with which I disagree. I concur that my consent is voluntary and can be revoked at any time.

____
Name of client

____ ____
Signature of adult client or parent/guardian of client Date