LSW
PSYCHOLOGICAL SERVICES
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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Child Background History

Name of Child	
Mother's Name	
Father's Name	
Guardian's Names (if different)	
Who completed this form?	
Birthdate	
Date of Initial Appointment	
School	
Grade	
Gender	
Ethnicity	
Languages spoken at home	

Which behaviors is your child struggling with most?

What are your child's strengths?

Please describe any life changes that could be affecting your child:

Social History:

Please list places your child has lived: Child's birthplace: _____

Location	Dates or Ages

Please list your child's siblings:

Name	Age/Grade	Learning problems?		Mental Health difficulties	
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No

Who currently lives in the family home?

Are the child's parents married? Yes No

If No, are they divorced or separated? Yes Never Married

If divorced or separated please describe current parenting plan?

Parent Time with Father: Frequency:_____Length of Visits:_____

Parent Time with Mother Frequency:_____Length of Visits:_____

Please describe the relationship status of both parents?

Relationship with Father: N/A Poor Fair Good

Relationship with Mother: N/A Poor Fair Good

Biological Father's Job:_____ Biological Mother's Job:_____

Does the child have step-parents? Yes No Names:_____

Step-Father's Job:_____ Step-Mother's Job:_____

Does your child attend a religious organization regularly? Yes No Where_____

Do any close family/friends in the area to provide support to your family and child? Yes No

Has your child ever been in trouble with the law? Yes No

If so, please list offenses and outcome

Who is in charge of discipline in the home?

Do all caregivers agree on discipline procedures in the home? Yes No

Describe discipline strategies that are used:

History of Trauma (circle all that apply):

Serious Illness in Family	Sexual Abuse	Victim of Violence
Serious Illness in Child	Exposure to Domestic Violence	Unsafe Neighborhood
Poverty	Child Abuse/Neglect	Homeless
Other traumatic events:		

Have the child's parents or guardians ever been on probation? Yes No

Served time in jail or prison? Yes No

Has the Department of Children & Families (DCF) ever been involved with your family? Yes No

Explain:

Has the child ever been placed outside of his/her home? Yes No

Explain:

Has the child ever been involved with Juvenile Services? Yes No

Explain:

Please circle any of the following mental health symptoms that your child often struggles with:

Irritable	Excessively sad	Excessively nervous	Difficulty separating from parents
Poor attention to detail	Paying attention for long periods	Poor organization	Easily distracted
Does not listen when spoken to directly	Fails to finish work	Often loses things	Forgetful
Loss of interest in normally enjoyable activities	Refuses to attend school	Frequent mood changes	Purposefully injuries self
Mistrustful	Defiant	Low self-esteem	Sleeps with parents
Test anxiety	Impulsive	Social anxiety	Strong beliefs that are unsupported by reality
Sees or hears things that are not present	Talks about suicide	Unemotional	Obsessions
Lack of remorse	Suicide attempt	Phobia with _____	
Fidgets	Restless	Physical aggression	Verbal aggression
Argues with adults	Cruel to animals	Steals	Hyper
Sexually inappropriate	Trespassing	Interrupts others	Leaves house without parent permission
Runs away from home	Talks excessively	Difficulty remaining quiet	Hostile
Excess spending	Takes risks	Ritual/routine behavior	Overly dramatic

Circle any of the following harmful eating behaviors that your child struggles with:

Refuses to eat in front of others	Induces vomiting after meals	Overly restrictive diet	Exercises right after meals
Uses diuretics	Purposefully fasts	Binge eats	Overly picky eater

Circle any of the following social skills which are difficult for your child:

Eye contact when not in trouble	Does not initiate interactions with peers	Lack of desire to share enjoyment in activities	Does not understand give and take of social relationships
Lacks empathy	Lack of age-appropriate pretend/make believe	Accepting criticism	Bossy
Inappropriate comments	Does not take turns	Does not share	Bragging
Sustaining conversations	Overly shy	Inflexible with routines/rules	Difficulty adjusting to change

Circle any communication difficulties which affect your child:

Not using eye contact to interact with others	Problems reading facial expressions	Using nonverbal signals to convey meaning	Difficulty expressing self effectively
Stutters	Facial expressions don't match emotion	Speaks in an odd voice	Speaks too loud
Speaks too soft	Invades personal space	Difficulty with pronunciation	Verbal tics
Does not speak in everyday situations	Unusual rate of speech	Uses words that have no meaning	Curses excessively

Circle any sensory difficulties that your child struggles with:

Waves hands in front of face	Refuses to eat foods with certain textures	Rocks while seated	Twisting or ringing hands
Looks at things too closely	Often looks at things out of the corner of their eye	Overly sensitive to loud noises	Under-responsive to loud noises
Motor tics	Refuses to wear certain fabrics	Only eats certain foods	Preoccupied with lights or parts of objects

<u>Developmental History:</u>

Was your child's pregnancy normal? Yes No

If no, explain complication?

Was your child's delivery normal? Yes No

If no, explain complication?

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

Number of days in hospital following birth?_____

Infant Temperament (circle all that apply): Easy to Soothe Happy

Under-responsive Fussy Difficult to Soothe Withdrawn

When did your child reach the following developmental milestones?

First Words: _____ First Steps:_____ Toilet training:_____

Describe any unusual development:

Is your child's vision normal? Yes No If not, what type of corrective lenses do they use?

Is your child's hearing normal? Yes No If not, what type of corrective device do they use?

Place an "X" next to any medical diagnosis that your child has received:

Medical Disorder	Birth to age 12	As an adolescent
Failure to Thrive		
Chronic Ear Infections		
Lead Poisoning		
Cancer		
HIV/AIDS		
Concussion		
Seizure/Epilepsy		
Digestion Issues		
Broken Bones		
Chronic Stomach Problems		
Asthma		
Meningitis		
Head Injury		
Other Illness_____		

Circle any of the following that have been present with your child's **family members**:

Heart Disease/Attack	Stroke	Cancer	Intellectual Disability/MR
Learning Problems	ADHD/Attention Problems	Anxiety	Depression
Social Difficulties	Autism/Asperger's	Bipolar Disorder	Obsessive-Compulsive
Personality Disorders	Schizophrenia	Conduct Disorder	Oppositional Defiant Disorder
Suicide	Extended Unemployment	Alcoholism	Drug Addiction/Abuse
Jail/Prison	Probation/Parole	Other	

Circle or list any diagnoses **your child** has been given: _____ None

Learning Disability/Problems	Developmental Disabilities	Intellectual Disability/MR	ADHD
Autism/Asperger's	Anxiety	Obsessive Compulsive Disorder	Schizophrenia
Depression	Bipolar Disorder	Oppositional Defiant Disorder	Conduct Disorder
Other			

Please list any current medications:_____

_____

Please list any previous medications:_____

_____

History of Treatment Services:

Practitioner	*Name/Organization*	*Dates*	*Treatment/Duration*
Psychiatrist			
Pediatric Neurologist			
Occupational Therapist			
Speech Therapist			
Physical Therapist			
Mental Health Services	1. 2. 3.		
Other Specialists:			

Has your child ever been hospitalized? Yes No

If so, what happened and when?

Circle any of the following that your child often struggles with:

Headaches	Fainting	Sleeps too little	Sleeps too much
Seizures	Nausea	Eats too much	Eats too little
Stomachaches	Vomiting	Diarrhea	Constipation
Heart racing	Chest pains	Excess sweating	Shallow breathing
Tension	Sore throat	Bed wetting	Bed soiling
Hair pulling	Nail biting	Wets self	Soils self

Circle any motor difficulties that your child has/had:

Clumsiness	Awkward gait	Difficulty skipping	Difficulty learning to ride a bike
Not athletic	Poor Fine Motor	Difficulty coordinating movements	Difficulty throwing or catching

Educational History:

Did your child attend Preschool? Yes No If so, where?_____

What is your child's current grade? _____

Please list your child's schools:

School	City and State	Age or Grade

Circle how well your student typically does in each of the following subjects:

Math	D or F	C	B	A
Language Arts	D or F	C	B	A
Social Studies	D or F	C	B	A
Science	D or F	C	B	A
Art	D or F	C	B	A
Gym/PE	D or F	C	B	A
Other:				

Circle any of the following which have been problematic for your child over the past year:

Off-task behavior in class	Victim of bullying	Poor School Attendance	Detention
Not doing HW	Bullying others	Several Changes of School	Suspension
Failing grades	Physical fights	Alcohol	Expulsion
School/Test Anxiety	Skipping school	Cigarettes	
Conflict w/teachers	School refusal	Drugs	

Has your child ever been retained in or repeated a grade? Yes No If so, what grade(s)?____

Does your child have an individual education plan (IEP)? Yes No

If so, circle all classifications that apply:

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
Fine Motor Difficulties	Gross Motor Difficulties		

Does your child have a 504 plan? Yes No

If so, what is the child's disability?

What special services or accommodations do they receive at School (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

Has your child started the Response to Intervention process? Yes No

If so, which tier is he/she in? Tier I Tier II Tier III

What current intervention is being used?

In which after school activities does your child participate?

Does your child make and maintain friendships easily? Yes No

If no, please explain:

Quality of Relationships with Peers: Poor Fair Good

Number of close friends: _____

How often does your child spend time with them outside of school?_____

Future Educational/Career Goals:_____

<u>If Applicable, complete:</u>

Is your son/daughter dating? Yes No

Is your child sexually active? Yes No Don't Know

To the best of your knowledge, has/does your child use any of the following? _____ None

Alcohol, PCP (angel dust), marijuana, amphetamines (speed), cocaine, crack cocaine, hallucinogens (acid, mushrooms), ecstasy, methamphetamine (meth), opium, heroin, sleeping pills, pain killers

Last used:_____

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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