PEDIATRIC INTAKE FORM

Today's Date ______________________

Child's Name ____ Age ________ Date of Birth ______________

Child's Address ____
Street City State Zip

Accompanying Parent's Name ___________________________________ Relationship to Child ___________

Parent's Marital Status ________________________ If divorced, who has custody of the child? ________

Accompanying Parent's Information:

Address ____
Street City State Zip

Home Number (_____)_________________________ Work Number (_____)___________________________
Cell Number (_____)___________________________ Fax Number (_____)____________________________
Occupation ___________________________________ Employer __________________________________
SSN ____ E-mail ____________________________________

Person to contact in case of emergency:
Name ____

Address ____
Street City State Zip
Home Number (_____)_________________________ Cell Number (_____)___________________________

Reason you are requesting an evaluation ____

What do you hope to learn as a result of the evaluation? ____

Has any member of your family previously been treated in our office? _____ If yes, when? _________

Does anyone else in the family have a problem similar to your child's? ____________________________

Whom may we thank for referring you to our office? ____

Describe briefly some of your child's strengths ____

____

Describe briefly some of your child's weaknesses ______________________________________

____

Child is: biological ________ adopted (at age______________) foster _________

List siblings (names, ages) ____

____

____

Is child in child care? **Y** or **N** How many hours/day? _______________________

Has your child experienced (circle all that apply):

Death of a loved one separation from a loved one emotional trauma sexual abuse

Family conflict marital conflict physical abuse emotional abuse

Please explain ____

____

Educational History

Current school and address ____

Grade ________ Placement: Gifted Regular Resource Special Education

Other ____

Teachers report problems in:

Reading Spelling Arithmetic Writing

Attention Behavior Social Adjustment Hyperactivity

Impulsivity Easily Distracted Other __________ Other __________

Please describe the above noted problem(s) ____

____

Pregnancy and Birth History

Known health problems of mother during pregnancy (circle all that apply)

Toxemia	Hypertension	Gestational Diabetes	Trauma
Fever	Allergies	Smoking	Alcohol Use
Drug Use	Antibiotics	Depression	Anxiety
Blood Incompatibility	Injury	Accidents	Emotional Abuse
Physical Abuse	Sexual Abuse	Fertility Used? ___	Other: __________
Mental Illness	Sexually Trans. Disease	Drug Use? _______	Other: __________

Delivery: Vaginal or Cesarean? If Cesarean, reason: ____

Baby: Full Term or Premature? If Premature, gestational weeks _________

Birth Weight _________ lbs. __________ oz.

Cirle any birth complications:

Feet first	Cord around neck	Meconium staining	Lacking oxygen
Jaundice	Not breathing	Other: ______________________________________	

Apgar scores (if known) _________________________

Please explain complications and interventions: ____

____

____

Please explain any medical problems after discharge and interventions _________________________

____

Any problems during the first few months? ____

Did you experience postpartum (after birth) depression? **Y** or **N**

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Developmental History

Motor:

Age sat alone _______ crawled ________ stood alone ________ walked alone ________

Was your child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball)? **Y** or **N** ____

Handedness: Right Left Ambidextrous (both)

Family history of left-handedness (list relatives)? ____

Please list any physical or occupational therapy services your child has received: _________________

____

Speech/Language:

Child's first language ______________________

Age spoke first word ______________________ Put 2-3 words together _____________________________

Circle all that apply:

Speech delays | Stuttering | Hard to understand | Late drooling

Poor suckling | Poor chewing | Articulation problems | Slow to learn alphabet

Slow to learn colors | Slow to learn counting | Other: _____________ | Other: _____________

Please list any speech therapy services your child has received ___________________________________

____

Toileting:

Age when toilet trained ____________

Problems with: Bedwetting Urinating Soiling Explain: ____________________________________

Any current problems? ____

____

Social Behavior:

My child (circle all that apply)

Gets along with peers	Gets along with older children	Has a sense of humor	Gets along with adults
Keeps friends	Understands others' feelings	Understands social cues	Bullies others
Initiates play	Has problems with peer pressure	Is "bossy"	Is bullied by others
Is teased at school	Gets along with siblings	Initiates bad behavior	Has empathy for others

Please explain any pertinent issues regarding your child's social behavior: ______________________________

____

Medical History

Has vision been checked? ________ Any problems? ____

Has hearing been checked? _______ Any problems? ____

CT _____ MRI ______ EEG ______ If yes, results? ____

____

Other tests and results: ____

List serious illnesses/injuries/hospitalizations/surgeries:

Date	Incident (explain)
___________	____
___________	____
___________	____

Circle all that apply:

Failure to thrive	Febrile seizures	Epilepsy	Staring spells	Lead poisoning/toxic	Meningitis
Encephalitis	Asthma	Allergies	Diabetes	Loss of consciousness	Abdominal pains
Vomiting	Headaches	Ear infections	Sleep difficulties	Sleep walking or talking	Eating difficulties

Eating disorder Facial or other tics Repetitive movements Impulsivity Temper tantrums

Nail biting Clumsiness Head banging Self-injurious behavior Physical injuries

Head injuries Other: ____________ Other: ____________ Other: ____________ Other ____________

Please explain the age of occurrence, relevant information, and interventions of any conditions circled above: ____

____

Current medications and reasons: ____

____

MATERNAL Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning difficulties Mental illness Neurological illness Seizures

Psychiatric disorder Schizophrenia Depression Bipolar disorder

Anxiety Suicide Alcoholism Drug abuse

Legal problems Arrests Obsessive-compulsive disorder Personality disorder

Other: ____________ Other: ____________ Other: ____________ Other ____________

Please explain: ____

____

Does anyone else in the family have an issue similar to your child's? ____________________________

____

PATERNAL Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning difficulties Mental illness Neurological illness Seizures

Psychiatric disorder Schizophrenia Depression Bipolar disorder

Anxiety Suicide Alcoholism Drug abuse

Legal problems Arrests Obsessive-compulsive disorder Personality disorder

Other: ______________ Other: ____________ Other: ____________ Other ________________________

Please explain: ____

____

Does anyone else in the family have an issue similar to your child's? ___________________________

____

Prior Psychological and Treatment History

Please include psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/Occupation **Dates Seen** **For What?** **Describe Progress**

____

____

____

____

____

Please add any additional information you would like us to know in the space below:

The information given is correct to the best of my knowledge.

Signature: ____ Date: ____________________

CHILD CHECKLIST OF CHARACTERISTICS

Child's Name: ____ Date: _____________________

Age: ______ Name of Person completing this form: __________________________________

Mark all that apply:

____ Affectionate
____ Argues, "talks back," smart-alecky, defiant
____ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
____ Cheats
____ Cruel to animals
____ Concern for others
____ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
____ Complains
____ Cries easily, feelings are easily hurt
____ Dawdles, procrastinates, wastes time
____ Difficulties with parent's love interest/new marriage/new family
____ Dependent, immature
____ Developmental delays
____ Disrupts family activities
____ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
____ Distractible, inattentive, poor concentration, daydreams, slow to respond
____ Dropping out of school
____ Drug or alcohol use
____ Eating: poor manners, refuses, appetite increase or decrease, odd combinations, overeats
____ Exercise problems
____ Extracurricular activities interfere with academics
____ Failure in school
____ Fearful
____ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
____ Fire setting
____ Friendly outgoing, social
____ Hypochondriac, frequently complains of feeling sick
____ Immature, "clowns around," has only younger playmates
____ Imaginary playmates, fantasy
____ Independent
____ Interrupts, talks out, yells
____ Lacks organization, unprepared
____ Lacks respect for authority, insults, dares, provokes, manipulates

Child Checklist of Characteristics

____ Learning disability
____ Legal difficulties – truancy, loitering, drinking, vandalism, stealing, fighting, drug sales
____ Likes to be alone, withdraws, isolates
____ Lying
____ Low frustration tolerance, irritability
____ Mental retardation
____ Moody
____ Mute, refuses to speak
____ Nail biting
____ Nervous
____ Nightmares
____ Need for high degree of supervision at home over play/chores/schedule
____ Obedient
____ Obesity
____ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, fidgety, noisiness
____ Oppositional, resists, refuses, does not comply, negativism
____ Prejudiced, bigoted, insulting, name calling, intolerant
____ Pouts
____ Recent move, new school, loss of friends
____ Relationships with brothers/sisters or friends/peers are poor – competition, fights, teasing/provoking, assaults
____ Responsible
____ Rocking or other repetitive movements
____ Runs away
____ Sad, unhappy
____ Self-harming behaviors – biting or hitting self, head banging, scratching self
____ Speech difficulties
____ Sexual – sexual preoccupation, public masturbation, inappropriate sexual behaviors
____ Shy, timid
____ Stubborn
____ Suicide talk or attempt
____ Swearing, bathroom language, foul language
____ Temper tantrums
____ Thumb sucking, finger sucking, hair chewing
____ Tics – involuntary rapid movements, noises, or word productions
____ Teased, picked on, victimized, bullied
____ Truant, school avoiding
____ Uncoordinated, accident-prone
____ Underactive, slow-moving or slow responding, lethargic
____ Wetting or soiling the bed or clothes
____ Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics: ____

Please look over the concerns you have checked off and choose the one that you most want help with for

your child. Which is it? ____

INFORMED CONSENT FOR SERVICES/PATIENT RIGHTS

Welcome! Please review each statement thoroughly and initial to acknowledge that you have read and understand the information.

____ I have chosen to receive psychotherapy and/or testing services for my child. This choice is voluntary and I may terminate services at any time. Psychotherapy is a collaborative effort between parent(s) or guardian, child, and the therapist or doctor; I have the right to be informed of the various steps and activities involved in receiving services. I have the right to make an informed decision whether to accept or refuse treatment. I will attempt to work with the therapist to develop and follow a plan of treatment. We use scientifically supported treatments at The Serin Center such as CBT (Cognitive Behavioral Therapy) and EMDR (Eye Movement Desensitization and Reprocessing) Therapy.

____The confidentiality of all records or information collected about parent(s), guardian, or child, and all information discussed in consultation and/or therapy sessions will be held in accordance with state and federal laws and will not be released or disclosed without my written consent unless otherwise provided for in state and federal regulations. I understand that state and local laws require that the therapist report all cases of physical or sexual abuse of minors or the elderly, as well as cases in which there exists a clear danger to self or others.

___ There are limitations and risks in providing therapy or exchanging information via electronic media. E-mail may not be completely secure or confidential. If you choose to communicate via email, it might be retained in the logs of Internet service providers. Any e-mail received by your therapist will be printed and kept in the treatment record. Any reports sent via e-mail will be password protected. You have the right to refuse to receive reports via e-mail. I have been made aware of the risks associated with email transmissions.

____ Payment is due at the conclusion of each session and a fee of $30.00 will be charged for any payment returned for any reason. Any balance that has not been paid within 90 days may be turned over to a collection agency and subject to reporting to a credit bureau. The Serin Center will notify me prior to this occurring to give an opportunity to pay the outstanding balance. I agree to give accurate and current billing information and understand that incorrect information may result in my account being turned over immediately to a collection agency if there is an unpaid balance on my account.

____ For children with divorced parents where there is a joint custody arrangement in place, in all therapy and evaluation cases, although having only one parent's consent for treatment and evaluation may be legal, both parents must provide written consent before the child can be seen at The Serin Center. Further, in order to release any records to a third party, both parents' written consent must be given. The Serin Center does not participate in custody matters, nor does it participate in court ordered therapy or evaluations.

____ The Serin Center will be notified with a **minimum of 2 business days' notice** if a scheduled appointment is cancelled. I understand that if a scheduled appointment is not kept, or notice is not given with a minimum of 2 business days' as required, my credit card will be charged the full fee for that session. I authorize The Serin Center to make such charges if the aforementioned event occurs.

Credit card number: ____________________________ Exp. Date _______ CVV:_____

____ If I am late for a session, the session will end at the regularly scheduled time and may be shortened as a result. If the therapist begins a session late, then the full session time will be given.

____ In case of a life threatening emergency, I will call 911. I understand that the therapist checks messages daily but may not be immediately available if me or my child is in crisis or has an emergency. I will work with the therapist to develop a plan to receive necessary help in a crisis.

____ If my child's therapist is other than Dr. Serin, the therapist may be under the supervision of Dr. Serin. I have discussed any questions I have about the therapist's license, education and training. I understand that I may contact Dr. Serin if I have questions or concerns about our therapist at any time at 623-824-5051. If your child's therapist is Jamie Dana, you understand that she is under the supervision of Dr. Serin and that your child is a client of The Serin Center. In some cases, we may observe or videotape session for supervisory reasons. The video will be deleted as soon as supervision has taken place.

_____I have been made aware that if my child has not had an appointment for a period of 6 months, my child's therapist or doctor may discharge or close the patient file and may opt to re-establish your child as a patient at a later date.

____ If I wish to view my child's records, I can request to do so. If the therapist feels this may negatively impact any progress, he or she will discuss my decision with me.

____ I have the right to participate in treatment decisions and in the development and periodic review and revision of my child's treatment plan.

____ I have the right to refuse any recommended treatment or to withdraw informed consent to treatment and be advised of the consequences of such refusal or withdrawal.

____ I certify that I have legal authority to see and implement actions to obtain services for my child. I am aware that if parents share legal custody of a child, each parent must sign this form.

You have been made aware that The Serin Center is a training site and students and post-doctoral residents at The Serin Center are under the supervision of Dr. Amy Serin. There may be instances where observation is used for training and supervision purposes only. To ensure quality of services, a video recording may be used for our supervision purposes. You are assured that this will not become a part of the patient record and all information gained will be erased as soon as supervision has been completed.

I have read and understand the above and any questions I have about the above have been discussed to my satisfaction and understanding.

REQUIRED SIGNATURES:

________________________________ ______________
Parent or Guardian Signature Date

________________________________ ______________
Parent or Guardian Signature Date

________________________________ ______________
Witness Signature Date

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

PRIVACY INFORMATION

This form is an agreement between you and The Serin Center. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here ____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls Protected Healthcare Information (PHI) about you. This information is needed to decide which treatment should be provided to you in your best interests. We may also share this information with others who provide treatment to you within The Serin Center or to those who need it to arrange payment for your treatment.

By signing this form, you are agreeing to permit us to use your information here and to send it to others as detailed below.

The Serin Center is fully compliant with HIPAA regulations to protect the confidentiality of your information. Dr. Serin is the designated Privacy Officer under Federal HIPAA regulations. You have a right to fully informed consent regarding handling of your privileged information. In general, unless you sign a written release of information, your information will not be released to a third party. Exceptions are:

- The Serin Center may be required to release your information if the withholding of this information could result in harm to either you or another person. This may apply if, for example, you indicate your intent to harm yourself or another person, or in cases of abuse or neglect of a child or a vulnerable adult.

- The Serin Center may be required to release your information by court order or subpoena. An example would be if you were party to litigation and a judge decided this information was needed.

- The Serin Center may be required to release your information to emergency treatment personnel or to your emergency contact if you require immediate medical attention while in session.

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- The Serin Center may release your information to another health care provider if you initiate contact with that provider. Your information may be released with your verbal consent to facilitate a referral. In most cases, a written release of information will be requested for this purpose.

- The Serin Center may release your information to a consultant or supervisor for the purpose of insurance reimbursement, and to provide you with optimal care.

- The Serin Center may release your information anonymously if brief consultation with professional colleagues is necessary to provide you with optimal care. An example might be a description of your situation (without identifying you by name) and asking a colleague for resources to provide to you to assist with your treatment.

- The Serin Center generally will request a written release of information from you whenever possible. Your rights include: access to your records upon request, the safeguarding of your records at all times, and the keeping of accurate financial and clinical records.

If you do not sign this consent form agreeing to what is in this notice of privacy practices, we cannot treat you.

In the future, if The Serin Center changes how your information is used and shared, we will change our notice of privacy practices and a copy will be posted in the waiting room.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. Requests must be in writing and although we will try to respect your wishes, The Serin Center is not required to agree to these limitations.

I, ____, have read and understand the above information. All of my questions have been adequately addressed.

____

Patient or Guardian Signature Date

I have discussed the issues contained herein with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____

Witness Signature Date

_____ Copy given to patient/parent by _________________________________/_________

Signature of Practice Representative Date

PARENT CONSENT FORM

Child's Full Name: ____ Date of Birth: _____________

_____ I understand that if I choose to leave my child or children under the age of 18 in the office without me, I release The Serin Center, Amy Serin, PhD, PLLC from any liability associated with my child or children being left unattended in any part of the office while waiting or attending therapy or assessment.

_____ I understand that in lengthy assessment sessions it may be helpful to provide my child with a snack. My child may be provided with bottled water, fruit juice, natural fruit or fruit leather, crackers, string cheese, or other healthy snacks. During testing, it is sometimes necessary to provide immediate rewards such as hard candy to children to ensure continued performance. Please indicate any restrictions to what can be provided here:

____

_____ My child may be observed by a trainee or might be videotaped for supervisory purposes.

_____ Data obtained from my child's progress may be included in a research project. My child's name will not be furnished.

Signature: ____ Date: _________________________
Parent or Guardian

Signature: ____ Date: _________________________
Parent or Guardian

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FISHER'S AUDITORY PROBLEM CHECKLIST

PATIENT NAME: ___________________________________ Date of Birth: _______

Please place a check mark before each item that is considered to be a concern:

____ 1. Has a history of hearing loss
____ 2. Has a history of ear infection(s).
____ 3. Does not pay attention (listen) to instruction 50% or more of the time.
____ 4. Does not listen carefully to directions – often necessary to repeat instructions.
____ 5. Says "Huh?" and "What?" at least five or more times per day.
____ 6. Cannot attend to auditory stimuli for more than a few seconds.
____ 7. Has a short attention span. If this item is checked, also check the most appropriate time frame:

___ 0-2 minutes ___ 5-15 minutes ___ 2-5 minutes ___ 15-30 minutes

____ 8. Daydreams – attention drifts – not "with it" at times.
____ 9. Is easily distracted by background sound(s).
____ 10. Has difficulty with phonics.
____ 11. Experiences problems with sound discrimination.
____ 12. Forgets what is said within a few minutes.
____ 13. Does not remember simple routine things from day to day.
____ 14. Displays problems recalling what was heard last week, month, year.
____ 15. Has difficulty recalling sequence that has been heard.
____ 16. Experiences difficulty following auditory directions.
____ 17. Frequently misunderstands what has been said.
____ 18. Does not comprehend many words/verbal concepts for age/grade level.
____ 19. Learns poorly through the auditory channel.
____ 20. Has a language problem (morphology, syntax, vocabulary, phonology).
____ 21. Has an articulation (phonology) problem.
____ 22. Cannot always relate what is heard to what is seen.
____ 23. Lacks motivation to learn.
____ 24. Displays slow or delayed responses to verbal stimuli.
____ 25. Demonstrates below average performance in one or more academic areas.

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