

Birth and Developmental History

Place of Birth: _____ Were parents married at time of birth? _____

Was mother under a doctor's care? _____ Were you adopted? _____ If so, at what age? _____

Check any illnesses during your mother's pregnancy:

Anemia Toxemia Herpes Measles German measles Bleeding
 Kidney disease Heart disease Hypertension Abdominal trauma Infection Diabetes

Medications taken during pregnancy: _____

Were drugs or alcohol taken during pregnancy? Yes No If yes, specify: _____

Was there significant emotional stress during pregnancy? Yes No If yes, name stressors: _____

Was the birth: On time Premature (By how long _____) Late (By how long) : _____

Was labor: Spontaneous Induced Duration of labor ____ (Hours) Cesarean required Cesarean planned

Was the presentation: Normal Breach Transverse (Crosswise) Posterior first

Did the baby experience any of these problems: Fetal distress Prolapsed cord Placenta previa

Premature separation of the placenta (Abruptio placenta) Cord wrapped around neck

Any other problems that mother or child had: _____ Was general anesthesia used: Yes No

Were forceps used? Yes No Were there breathing problems? Yes No

Color at birth: Normal Blue Yellow Was oxygen used Yes No (How long)? _____

APGAR Score _____ Birthweight: _____ Length: _____

Check those that apply to the first few weeks after birth:

Excessive sleeping Laziness Irritability Excessive crying Stiffness Limpness Tremors
 Twitching Feeding difficulties Vomiting Jaundice Other: _____

Transfusions required? Yes No

Medication required? Yes No

Surgery required? Yes No (Why) _____

Give approximate ages that developmental milestones were achieved:

Head control _____ Rolled over _____ Sat alone _____ Walked _____ Run _____

Said first word _____ Used sentences _____ Self feeding w/ utensils _____ Toilet trained _____

Dress self _____ Tie shoes _____ Color within lines _____ First menstruation/onset of puberty: _____

Check any problems that occurred in later development:

Hearing Speaking Stuttering Reading Writing Spelling Arithmetic
 Behavior Hyperactivity Seizures Coordination Attention difficulties

List family members with developmental or learning problems: _____

DOCTOR'S NOTES

Medical History

Please check all the conditions that have been diagnosed as a child or an adult.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS, ARC or HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune system | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Enzyme deficiency | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Abscessed ears | <input type="checkbox"/> Fevers (104 or higher) | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Radiation Exposure/Therapy |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Head injury/Concussion | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Senility (Dementia) |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Metabolic disorder | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Hereditary disorder | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Headaches | <input type="checkbox"/> Measles | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Colds (excessive) | <input type="checkbox"/> Huntington's disease | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Carbon monoxide | <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Oxygen deprivation | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hazardous Substance | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Other medical/physical _____ | | | |

Have you ever been diagnosed with epilepsy or a seizure disorder? Yes No If yes, check the one you have been diagnosed with.

PARTIAL

- Simple partial
 Complex partial
 Partial evolving into generalized

GENERALIZED

- Absence (Petit mal)
 Myoclonic
 Clonic
 Tonic
 Tonic-clonic (Grand mal)
 Atonic

UNCLASSIFIED

Medication and dosage:

List any medications currently being taken (over-the-counter or prescription), and the dosage

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List any medications you are ALLERGIC or sensitive to: _____

Past Hospitalizations (When, where and for what):

Outpatient Surgeries (When, where and for what):

Name of family physician: _____

Address: _____

Phone: _____ Date of your last medical check-up: _____

Psychiatric History

Place a check to indicate if any problems apply currently (in the last six months) or in the past.

Current	Past		Current	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts (date? _____)	<input type="checkbox"/>	<input type="checkbox"/>	Homicidal thoughts (date? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Depression/sadness	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss
<input type="checkbox"/>	<input type="checkbox"/>	Visual/auditory hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Apathy
<input type="checkbox"/>	<input type="checkbox"/>	Rapid mood changes	<input type="checkbox"/>	<input type="checkbox"/>	Explosive anger
<input type="checkbox"/>	<input type="checkbox"/>	Decreased need for sleep	<input type="checkbox"/>	<input type="checkbox"/>	Euphoria (feel on top of the world)
<input type="checkbox"/>	<input type="checkbox"/>	Distractible	<input type="checkbox"/>	<input type="checkbox"/>	Racing thoughts
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Feeling worthless
<input type="checkbox"/>	<input type="checkbox"/>	Poor self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest in almost all activities
<input type="checkbox"/>	<input type="checkbox"/>	Overwhelming need to perform certain behaviors/rituals	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent/intrusive disturbing recollections/dreams
<input type="checkbox"/>	<input type="checkbox"/>	Significant concerns with physical problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive fears or phobias

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Death of spouse	<input type="checkbox"/>	<input type="checkbox"/>	Death of family member	<input type="checkbox"/>	<input type="checkbox"/>	Illness of family member
<input type="checkbox"/>	<input type="checkbox"/>	Illness of friend	<input type="checkbox"/>	<input type="checkbox"/>	Personal injury/illness	<input type="checkbox"/>	<input type="checkbox"/>	Marital difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Marital separation	<input type="checkbox"/>	<input type="checkbox"/>	Divorce	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Conflicts with family	<input type="checkbox"/>	<input type="checkbox"/>	Conflicts with friends	<input type="checkbox"/>	<input type="checkbox"/>	Conflicts at work
<input type="checkbox"/>	<input type="checkbox"/>	New Job	<input type="checkbox"/>	<input type="checkbox"/>	Job termination	<input type="checkbox"/>	<input type="checkbox"/>	Retirement
<input type="checkbox"/>	<input type="checkbox"/>	Business difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Academic difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Financial problems
<input type="checkbox"/>	<input type="checkbox"/>	Change in residence	<input type="checkbox"/>	<input type="checkbox"/>	Legal problems	<input type="checkbox"/>	<input type="checkbox"/>	Sexual assault
<input type="checkbox"/>	<input type="checkbox"/>	Incest/sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	Verbal/emotional abuse
<input type="checkbox"/>	<input type="checkbox"/>	Other problems: _____						

Are you currently receiving therapy? Yes No From who? _____

When did you start therapy? _____ For what problem(s)? _____

List current psychiatric medications: _____

Prescribed by who? _____

Have you received therapy in the past? Yes No From who? _____

When (Start and finish): _____ For what problem(s)? _____

List past psychiatric medications: _____

Have you been hospitalized for psychological problems? Yes No When? _____

Where were you hospitalized? _____

Have you ever attempted suicide? Yes No When? _____ How? _____

Have you had a prior psychological or neuropsychological evaluation? Yes No If yes, complete this information:

Name of psychologist: _____

Address: _____

Phone: _____ Date of and reason for this evaluation: _____

Findings of the evaluation: _____

Substance Use History

Current Past (Even if only occasionally or in small amounts):

Alcohol What do you drink? Beer Wine Mixed Drink Hard Liquor
How Often? _____ How Many? _____
DUI? Yes No Accidents? Yes No Missed work or school? Yes No
Risky Behavior Yes No If so, what? _____

Tobacco How Much? _____ How Often? _____ When did you quit? _____

Marijuana

Barbiturates ("Downers")

Tranquilizers

Amphetamines ("Speed")

Crank

Crack

Cocaine

Opiates (Heroin, Opium, Codeine, etc.)

Hallucinogenic (LSD, STP, "Magic Mushrooms", etc.)

PCP ("angel dust")

Ecstasy

Other: _____

DOCTOR'S NOTES

Marital History

Marital Status: Single Married Separated Divorced Widowed

Current Marriage

Date of marriage: _____ Number of years married: _____ Date of separation: _____
Spouse's name: _____ Age: _____ Health: _____
Education: _____ Occupation: _____ Type of marital problems: _____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Prior Marriage

Date of marriage: _____ Date of separation: _____ Date of divorce: _____
Spouse's name: _____ Age: _____ Health: _____
Education: _____ Occupation: _____ Type of marital problems: _____
Names and ages of children: _____
What is the custody arrangement: _____

Prior Marriage

Date of marriage: _____ Date of separation: _____ Date of divorce: _____
Spouse's name: _____ Age: _____ Health: _____
Education: _____ Occupation: _____ Type of marital problems: _____
Names and ages of children: _____
What is the custody arrangement: _____

List any other marriages and children:

List names of spouses or children with the following problems:

Developmental Learning Problems: _____
Emotional/Behavioral problems: _____
Alcohol/Drug abuse: _____
Medical Problems: _____

<p>DOCTOR'S NOTES</p>

Social History

If single or separated, are you currently dating anyone? _____ How long? _____ Is it a serious relationship? _____
First name: _____ Are you currently sexually active? _____ If not dating, when was your last date? _____
How long did you date that person? _____ Was it a serious relationship? _____ First name: _____

Please list "significant others" you have lived with but not married.

Current/Most Recent Cohabitation

Date began: _____ Number of years together: _____ Date ended: _____
Name : _____ Age: _____ Health: _____
Education: _____ Occupation: _____ Type of relationship problems: _____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Prior Cohabitation

Date began: _____ Number of years together: _____ Date ended: _____
Name : _____ Age: _____ Health: _____
Education: _____ Occupation: _____ Type of relationship problems: _____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Have you lived with anyone else in the past? Yes No How many times? _____
Any other children outside of marriage? Yes No Names/Ages: _____
Any aborted pregnancies/miscarriages? Yes No When? _____

List clubs and community business organizations you are involved with and how often you attend: _____

Do you attend church? Yes No (where and how often) : _____

What do you do with your free time (including hobbies and extracurricular interests): _____

When was your last vacation (Please describe): _____

How many close friends do you have in the community: _____ How often do you get together with friends or family: _____

How long have you lived in the community: _____ Where have you lived in the past: _____

DOCTOR'S NOTES

Educational History

Current grade/highest grade or degree completed: _____ Current school: _____
Past schools attended (List in order): _____
Hardest subject(s): _____ Favorite subject(s): _____
Grades in elementary school: _____ Junior High G.P.A. _____ High School GPA _____ College GPA _____
Grades repeated: _____ Learning problems (what subjects): _____
Special education placement (Type): _____ During which grades: _____
Extracurricular activities (Music, Sports, Clubs, etc.) _____
Expulsions/suspensions/conduct problems (Type of problem and date): _____
Additional schooling or non-academic training: _____

DOCTOR'S NOTES

Occupational History

Present employer: _____ Position: _____
Length of employment: _____ Hours worked per week _____ Current responsibilities: _____

List previous employment for last ten years (Include dates and type of work): _____

Have you ever been terminated from a job (Please explain): _____
At any time on the job were you ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)? Yes No If yes, explain: _____
Have you ever been injured on the job? Yes No If yes, explain: _____

DOCTOR'S NOTES

Legal History Not Applicable

Present legal problems (Describe): _____
Past arrests (For what?): _____
Convictions (For what?): _____
Time served in juvenile hall, jail or prison (Give dates and locations): _____

DOCTOR'S NOTES

Military Service Not Applicable

Branch of service: _____ Dates of service: _____ Job(s) within service: _____
Highest rank: _____ Rank at discharge: _____ Discharge status: _____
Were you exposed to any dangerous or unusual substances (e.g. Agent Orange, Radiation, etc.) Yes No
If yes, explain: _____
Did you sustain any physical injuries in the military? Yes No If yes, explain: _____

DOCTOR'S NOTES

General Symptom Checklist

		0	1	2	3	4	N/A			
		Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable			
Self	Other	Descriptor						Not Known		
---	---	Recurrent bothersome thoughts, ideas or images which you try to ignore								
---	---	Trouble getting "stuck" on certain thoughts, or having the same thought over and over								
---	---	Excessive or senseless worrying								
---	---	Others complain that you worry too much or get "stuck" on the same thoughts								
---	---	Compulsive behaviors that you must do or you become very anxious such as excessive hand washing, Checking locks, or counting or spelling								
---	---	Needing to have things done a certain way or you become very upset								
---	---	Others complain that you do the same thing over and over to an excessive degree (e.g. cleaning or checking						OC	3	
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---	---	Recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.)Please list: _____								
---	---	Recurrent distressing dreams of a past event								
---	---	A sense of reliving a past upsetting event								
---	---	A sense of panic or fear to events that resemble an upsetting past event								1
<hr style="border-top: 1px dashed black;"/>										
---	---	You spend effort avoiding thoughts or feelings associated with a past trauma								
---	---	Persistent avoidance of activities/situations which cause remembrance of upsetting event								
---	---	Inability to recall an important aspect of a past upsetting event								
---	---	Marked decreased interest in important activities								
---	---	Feeling detached or distant from others								
---	---	Feeling numb or restricted in your feelings								
---	---	Feels that your future is shortened								3
<hr style="border-top: 1px dashed black;"/>										
---	---	Startles easily								
---	---	Feels like you are always watching for bad things to happen								
---	---	Marked physical response to events that remind you of a past upsetting event (i.e. sweating when getting In a car if you had been in a car accident)						PTS	2	
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---	---	Trembling, twitching or feeling shaky								
---	---	Muscle tension, aches or soreness								
---	---	Feelings of restlessness								
---	---	Easily fatigued								
---	---	Shortness of breath or feeling smothered								
---	---	Heart pounding or racing								
---	---	Sweating or cold clammy hands								
---	---	Dry mouth								
---	---	Dizziness or lightheadedness								
---	---	Nausea, diarrhea or other abdominal distress								
---	---	Hot or cold flashes								
---	---	Frequent urination								
---	---	Trouble swallowing or "lump in throat"								
---	---	Feeling keyed up or on edge								
---	---	Quick startle response of feeling jumpy								
---	---	Difficulty concentrating or "mind going blank"								
---	---	Trouble falling or staying asleep								
---	---	Irritability						GAD	6	

General Symptom Checklist

		0	1	2	3	4	N/A			
		Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable			
Self	Other	Descriptor						Not Known		
---	---	Trouble sustaining attention or being easily distracted								
---	---	Difficulty completing projects								
---	---	Feeling overwhelmed of the tasks of everyday living								
---	---	Trouble maintaining an organized work or living area								
---	---	Inconsistent work performance								
---	---	Lacks attention to detail								
---	---	Makes decisions impulsively								
---	---	Difficulty delaying what you want, having to have your needs met immediately								
---	---	Restless, fidgety								
---	---	Make comments to others without considering their impact								
---	---	Impatient, easily frustrated								
---	---	Frequent traffic violations or near accidents						AAD	5	
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---	---	Refusal to maintain body weight above a level most people consider healthy								
---	---	Intense fear of gaining weight or becoming fat even though underweight								
---	---	Feelings of being fat, even though underweight						AN	3	
<hr/>										
---	---	Recurrent episodes of binge eating large amounts of food								
---	---	A lack of control over eating behavior								
---	---	Engage in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise								
---	---	Persistent over concern with body shape and weight						BN	2	
<hr/>										
---	---	Involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking)								
		How long have motor tics been present? _____ How often? _____								
		Describe: _____								
---	---	Involuntary vocal sounds or verbal tics (such as coughing, puffing, whistling, swearing)								
		How long have motor tics been present? _____ How often? _____								
		Describe: _____								
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---	---	Delusional or bizarre thoughts (thoughts you know others would think are false)								
---	---	Frequent feelings that someone or something is out to hurt you or discredit you								
---	---	Seeing objects, shadows or movements that are not real								
---	---	Hearing voices or sounds that are not real								
---	---	Periods of time where your thoughts or speech were disjointed or didn't make sense to you or others								
---	---	Social isolation or withdrawal								
---	---	Severely impaired ability to function at home or at work								
---	---	Peculiar behaviors								
---	---	Lack of personal hygiene or grooming								
---	---	Inappropriate mood for the situation (i.e., laughing at sad events)								
---	---	Marked lack of initiative						PsD	3	
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---	---	Do you snore loudly (or do others complain about your snoring)								
---	---	Have others said you stop breathing when you sleep								
---	---	Do you feel fatigued or tired during the day						SA		

General Symptom Checklist

		0	1	2	3	4	N/A	
		Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable Not Known	
Self	Other	Descriptor						
----	----	Do you often feel cold when others feel fine or they are warm						
----	----	Do you often feel warm when others feel fine or they are cold						
----	----	Do you have problems with brittle or dry hair						
----	----	Do you have problems with dry skin						
----	----	Do you have problems with sweating						
----	----	Do you have problems with chronic anxiety or tension						ThyA 2
----	----	Impairment in communication as manifested by at least one of the following: (check those that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime) <input type="checkbox"/> In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others <input type="checkbox"/> Repetitive use of language or odd language <input type="checkbox"/> Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level 						
----	----	Impairment in social interaction with at least two of the following (Check those that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interactions <input type="checkbox"/> Failure to develop peer relationships appropriate to developmental level <input type="checkbox"/> Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest) <input type="checkbox"/> Lack of social or emotional reciprocity 						
----	----	Repetitive patterns of behavior, interests, and activities, as manifested by at least one of the following (Check those that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Preoccupation with an area that is abnormal either in intensity or focus <input type="checkbox"/> Rigid adherence to specific, nonfunctional routines or rituals <input type="checkbox"/> Repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements) <input type="checkbox"/> Persistent preoccupation with parts of objects 						

Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, please have another person who knows you well (such as a spouse or roommate) rate you also to help provide a complete picture of you. Name of other person: _____

		0	1	2	3	4	N/A	
		Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable Not Known	
Self	Other	Descriptor						
---	---	Fails to give close attention to details or makes careless mistakes						
---	---	Trouble sustaining attention in routine situations (i.e. homework, chores, paperwork)						
---	---	Trouble listening						
---	---	Fails to finish things						
---	---	Poor organization for time or space (such as backpack, room, desk, paperwork)						
---	---	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort						
---	---	Loses things						
---	---	Easily distracted						
---	---	Forgetful						
---	---	Poor planning skills						
---	---	Lack clear goals or forward thinking						
---	---	Difficulty expressing feelings						
---	---	Difficulty expressing empathy for others						
---	---	Excessive daydreaming						
---	---	Feeling bored						
---	---	Feeling apathetic or unmotivated						
---	---	Feeling tired, sluggish or slow moving						
---	---	Feeling spacey or "in a fog"						8,6,4
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---	---	Fidgety, restless or trouble sitting still						
---	---	Difficulty remaining seated in situations where remaining seated is expected						
---	---	Runs about or climbs excessively in situations in which it is inappropriate						
---	---	Difficulty playing quietly						
---	---	"On the go" or acts as if "driven by a motor"						
---	---	Talks excessively						
---	---	Blurts out answers before questions have been completed						
---	---	Difficulty waiting turn						
---	---	Interrupts or intrudes on others (e.g. butts into conversations or games)						
---	---	Impulsive (saying or doing things without thinking first)						<3 8,6,4
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---	---	Excessive or senseless worrying						
---	---	Upset when things do not go your way						
---	---	Upset when things are out of place						
---	---	Tendency to be oppositional or argumentative						
---	---	Tendency to have repetitive negative thoughts						
---	---	Tendency toward compulsive behaviors						
---	---	Intense dislike for change						
---	---	Tendency to hold grudges						
---	---	Trouble shifting attention from subject to subject						
---	---	Trouble shifting behavior from task to task						
---	---	Difficulty seeing options in situations						
---	---	Tendency to hold on to own opinion and not listen to others						
---	---	Tendency to get locked into a course of action, whether or not it is good						
---	---	Needing to have things done a certain way or you become very upset						
---	---	Others complain that you worry too much						
---	---	Tend to say no without first thinking about question						
---	---	Tendency to predict fear						ACG 10, 7, 4

Brain System Checklist

		0	1	2	3	4	N/A
		Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable Not Known
Self	Other	Descriptor					
---	---	Frequent feelings of sadness					
---	---	Moodiness					
---	---	Negativity					
---	---	Low energy					
---	---	Irritability					
---	---	Decreased interest in others					
---	---	Decreased interest in things that are usually fun or pleasurable					
---	---	Feelings of hopelessness about the future					
---	---	Feelings of helplessness or powerlessness					
---	---	Feeling dissatisfied or bored					
---	---	Excessive guilt					
---	---	Suicidal feelings					
---	---	Crying spells					
---	---	Lowered interest in things usually considered fun					
---	---	Sleep changes (too much or too little)					
---	---	Appetite changes (too much or too little)					
---	---	Chronic low self-esteem					
---	---	Negative sensitivity to smells / odors					
							DLS 10,7,4
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---	---	Frequent feelings of nervousness or anxiety					
---	---	Panic attacks					
---	---	Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)					
---	---	Periods of heart pounding, rapid heart rate or chest pain					
---	---	Periods of trouble breathing or feeling smothered					
---	---	Periods of feeling dizzy, faint or unsteady on their feet					
---	---	Periods of nausea or abdominal upset					
---	---	Periods of sweating, hot or cold flashes					
---	---	Tendency to predict the worst					
---	---	Fear of dying or doing something crazy					
---	---	Avoid places for fear of having an anxiety attack					
---	---	Conflict avoidance					
---	---	Excessive fear of being judged or scrutinized by others					
---	---	Persistent phobias					
---	---	Low motivation					
---	---	Excessive motivation					
---	---	Tics (motor or vocal)					
---	---	Poor handwriting					
---	---	Quick startle					
---	---	Tendency to freeze in anxiety provoking situations					
---	---	Lacks confidence in their abilities					
---	---	Seems shy or timid					
---	---	Easily embarrassed					
---	---	Sensitive to criticism					
---	---	Bites fingernails or picks skin					
							BG 10,7,4

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Welcome

We would like to welcome you to our practice and we are pleased to have you as a patient. We are providing you with the following information to help you understand how this office operates. Every effort will be made to treat you with courtesy and respect. Please read this information carefully and write down any questions that you might have so that you can discuss them with our staff.

General Information

For your convenience, you may download a map to our office from our website www.FresnoMentalHealth.com. Our office is located on the south side of Warner Avenue just past TGI Fridays Restaurant.

It is your responsibility to contact your insurance company to confirm that the doctor is on your insurance panel, acquire pre-authorization for treatment, and confirm benefits for “**Outpatient Mental Health**” services before your first appointment. Be sure to state that this is for “outpatient mental health” benefits; otherwise the insurance personnel may quote you the benefits for major medical services instead.

Please arrive **15 minutes** prior to the first appointment.

You must have your paperwork completely filled out prior to your arrival, along with your insurance card(s) and any other paperwork requested by our office. **YOU WILL NOT BE SEEN BY THE DOCTOR UNLESS ALL FORMS ARE COMPLETELY FILLED OUT PRIOR TO YOUR VISIT.**

Upon arrival at the office, always check in with the receptionist so that the doctor can be informed that you have arrived.

If you have any questions, please feel free to contact our office at 559 227-1977.

Emergencies

In the event of an emergency you should call "9-1-1" to access emergency medical services. Otherwise, free evaluations can be obtained at Community Behavioral Health Center, 7171 N. Cedar Ave, Fresno, California, (559) 449-4434. For children and adolescents, call Exodus Recovery, Inc. at (559) 600-2382. You may also call the Suicide Hot Line at (888) 506-5991.

If you need to contact the doctor between sessions, please leave a message with the office and your call will be returned as soon as possible. **Calls made between 5:00 p.m. and 8:00 a.m. should be of an urgent or emergency nature only.** In the event that the doctor is unavailable due to illness, vacation, or other circumstances, emergency calls will be forwarded to the on-call doctor.

Financial Policy and Code of Conduct Policy

As your mental health provider, we are committed to providing you with the best possible care. In order to achieve this goal, we need your cooperation and your full understanding of our Financial Policy and our Code of Conduct Policy.

Payment is due at the time services are rendered: This office accepts cash, personal checks, Visa and MasterCard. Returned checks are subject to a service charge of \$25.00 and you may lose your privilege to write checks in our office. The patient/responsible party is responsible for payment of co-pays, coinsurance, deductibles and noncovered services at the time of service. For patients without insurance or with insurances that this office is not contracted with, payment is due in full at the time services rendered. **If you are not prepared to pay at the time of your appointment it may be necessary to reschedule your appointment.**

_____ Patient/Responsible Party Initials

For patients with insurance: As a courtesy, this office will bill your insurance, if proper insurance information is provided at the time of service. The patient/responsible party will be held responsible for providing their insurance information at every visit. If your insurance requires a referral or prior authorization, it is your responsibility to assure that one has been provided to our office prior to or at the time of your scheduled appointment. It is the patient/responsible party responsibility to verify you are receiving care from a contracted provider, as we are not a provider for every insurance carrier.

_____ Patient/Responsible Party Initials

Non-covered services: It is the patient/responsible party's responsibility to know their insurance plan benefits. All service charges not covered or denied by your insurance carrier are the responsibility of the patient/responsible party and payment will be due immediately or upon receipt of denial. It is the responsibility of the patient/responsible party to handle denials directly with their insurance carrier.

There are some services that are not covered by insurance that require the doctor's time and must be paid for at the time services are rendered. These include:

- Provide copies of patient records to other than treating physicians: \$25.00
- Fill out forms (other than insurance related forms): \$25.00 / 10 minutes
- Letters and additional reports: \$25.00 / 10 minutes
- Requested telephone contacts with other than with the patient/parents: \$25.00 / 10 minutes

_____ Patient/Responsible Party Initials

Medicare patients: This office will bill Medicare for you. If you have a secondary insurance, we will also bill the secondary insurance as a courtesy as well. All deductibles or payment for noncovered services are due at the time services are rendered.

_____ Patient/Responsible Party Initials

Missed appointments: In fairness to other patients and to the doctors, this office requires 24 hour notice for cancellation of appointments. **There will be a \$100.00 no show fee assessed to your account for missed appointments or in the event you do not provide 24 hour cancellation notice.**

_____ Patient/Responsible Party Initials

Past-due accounts: Accounts unpaid for more than 60 days will result in the prevention of scheduling

any future non-emergency appointments until the account is paid in full or brought to a current status. Accounts unpaid for more than 90 days will be turned over to a collection agency and may result in dismissal from the practice.

_____ Patient/Responsible Party Initials

Accounts referred to collections: If your account is turned over to a collection agency, you are required to direct all correspondence to the collection agency and not our practice. You will also be responsible to pay the collection agency for any additional fees assessed, such as accrued interest fees and legal fees.

_____ Patient/Responsible Party Initials

Assignment of benefits: I hereby assign and authorize payment of any insurance benefits directly to Schuyler Psychological Associates, Inc. and/or its providers. Photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance plan(s). This assignment shall remain in effect until revoked in writing. I hereby authorize said assignee to release all necessary information to secure payment.

_____ Patient/Responsible Party Initials

Medicare beneficiaries: I request that payment of any authorized Medicare benefits be made on my behalf. I assign the benefits payable to Schuyler Psychological Associates, Inc. and/or its providers.

_____ Patient/Responsible Party Initials

Financial agreement: We will gladly discuss any questions relating to your account. However, we must emphasize that, as your mental health care providers, our relationship and concerns are with you and your health, not your insurance company. Not all services are covered by all insurance plans and some insurance carriers will have treatment exclusions. **All charges, including plan exclusion, are the Patient's/Responsible Party's responsibility from the time services are rendered.** We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, we encourage you to contact our office to discuss payment arrangements.

_____ Patient/Responsible Party Initials

Code of Conduct Policy: Our office believes in mutual respect to and from our patients. Therefore, we have established a **Zero Tolerance Policy** against any verbal or physical abuse to our doctors and/or to our staff members. Any form of such abuse or violence will result in immediate dismissal from the practice.

_____ Patient/Responsible Party Initials

I have read the above Financial Policy and Code of Conduct Policy and I fully understand and agree to the terms specified. I also acknowledge that I have been provided with a copy of the signed policy.

Patient or Responsible Party Signature

Date

Print Patient Name

Account Number

Witness Signature (Office Staff Member)

Date

PATIENT AND BILLING DATA

Who referred you to this office? _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: M F
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

What is the **patient's** relationship to the Responsible Party (Person who will pay the balance after insurance pays)?
 Self Daughter Son Granddaughter Grandson Other: _____

If the patient is a minor, where does the minor reside? Both Parents Mother Father
 Both Grandparents Grandfather Grandmother Guardian Other: _____

ACCOUNT RESPONSIBLE: (If other than the patient)

Both Parents Mother Father Both Grandparents Grandfather Grandmother
 Guardian Other: _____

Name: _____ Date of Birth: _____
Title (Please check one): Mr. Mrs. Ms. Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Primary Care Physician: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____

In case of emergency, contact: _____
Relationship of emergency contact to the **patient:** _____
Phone numbers of emergency contact: _____

Is your condition work related? Yes No

If referred by an attorney or litigation is pending:

Attorney: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip Code: _____

PRIMARY INSURANCE COMPANY:

Company: _____ Attention: _____
Mailing Address (for mental health claims): _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Ext: _____ Fax: _____

INSURED: (The person who is the policy holder) Same as Account Responsible

Name: _____ Date of Birth: _____
Title (Please check one): Mr. Mrs. Ms. Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Employer: _____ ID/SS#: _____
Group Claim #: _____ Group Name: _____

Patient's relationship to the insured: Self Daughter Son Granddaughter Grandson
 Other: _____

SECONDDAY INSURANCE COMPANY:

Company: _____ Attention: _____
Mailing Address (for mental health claims): _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Ext: _____ Fax: _____

INSURED: (The person who is the policy holder) Same as Account Responsible

Name: _____ Date of Birth: _____
Title (Please check one): Mr. Mrs. Ms. Other: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Employer: _____ ID/SS#: _____
Group Claim #: _____ Group Name: _____

Patient's relationship to the insured: Self Daughter Son Granddaughter Grandson
 Other: _____

RELEASE OF INFORMATION:

Patient Name: _____

I hereby provide authorization for Schuyler Psychological Associates, Inc. to exchange information regarding the medical and psychological condition, and drug and alcohol treatment of the patient named above with:

(Name of Patient's Personal Physician)

(Name of additional Individual or Agency)

(Name of additional Individual or Agency)

Signature: _____ Date: _____

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CONSENT FOR TREATMENT

I hereby provide consent for Schuyler Psychological Associates, Inc. to perform a psychological or neuropsychological evaluation, and/or provide treatment to myself or my dependent.

Signature: _____ Date: _____

CUSTODY ORDER VERIFICATION

Minor Patient Name: _____

In cases where the patient is a minor and the patient's parents are separated or divorced, or legal guardianship exists, we require that you specify the current Legal and Physical Custody status of your minor child.

Joint Legal Custody can be awarded separate from Joint Physical Custody. Joint Legal Custody means that either parent acting alone may consent to mental health treatment unless the order of Joint Legal Custody has language to the contrary. Orders specifically requiring shared medical decision making responsibilities (barring emergencies) will require the consent of both parents.

If you need help determining your rights to obtain and authorize mental health treatment for your child, please contact your legal representative.

Indicate below the legal and physical custody status of the minor child:

- Joint legal custody allowing either parent to consent to mental health treatment.
- Joint legal custody requiring both parents to consent to mental health treatment.
- Sole legal custody. (Name of person with legal custody: _____)
- Joint physical custody.
- Sole physical custody. (Name of person with physical custody: _____)
- There is **no record of any Custody Order** for this patient.

Your signature below certifies that you have provided correct and accurate information regarding your Custody Order and your ability to authorize mental health services for your minor child in the event of separation, divorce or legal guardianship.

Signature of Parent/Legal Guardian

Date

NOTICE OF PRIVACY PRACTICES

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with this Notice which provides a summary the health information privacy practices of Schuyler Psychological Associates, Inc. A full copy of our current Notice will always be posted in our reception area. You will also be able to obtain your own full copy at our website www.FresnoMentalHealth.com, by calling the office at (559) 227- 1977 or asking for one at any time.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient or receiving treatment or other health-related services from us;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future; or
- information about your health care benefits under an insurance plan;

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); or
- other types of information that may identify who you are.

REQUIREMENT FOR WRITTEN AUTHORIZATION

We will obtain your written authorization before using your health information or sharing it with others outside Schuyler Psychological Associates, Inc., except as we describe in this Notice. Uses and disclosures of health information that require your written authorization include: most uses and disclosures of psychotherapy notes, most uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information. Other uses and disclosures not described in this Notice or otherwise permitted by HIPAA will be made only with your written authorization. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to Schuyler Psychological Associates, Inc. at 1130 E. Shaw Avenue, Suite 105, Fresno, CA 93710.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information.

1. Right To Inspect and Copy Records.
2. Right To Amend Records.
3. Right To an Accounting of Disclosures.
4. Right To Request Additional Privacy Protections.
5. Right To Request Confidential Communications.
6. Right To Have Someone Act On Your Behalf.
7. Right To Obtain a Copy of Notices.
8. Right To File A Complaint.
9. Right To Be Notified Following a Breach of Unsecured PHI.

By signing below, I acknowledge that I have been provided a summary of the Schuyler Psychological Associates, Inc. Notice of Privacy Practices, have been informed how I may obtain a full copy, and have therefore been advised of how health information about me may be used and disclosed by Schuyler Psychological Associates, Inc. and how I may obtain access to and control this information.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority