Consent Form

Welcome to the Center for Counseling and Education, LLC. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail, and our practice is in general accordance with HIPAA policies. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session.

Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICALSERVICES

Therapy is a relationship between people that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to create change. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to know about. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These respective rights are described in the following section.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often involves discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things that we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work may include. At that point, we will discuss your treatment goals and create a personalized, initial treatment plan, if you decide to continue. You should evaluate this information as well as your own assessment about whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have any questions about my procedures, we should discuss them whenever they arise.

APPOINTMENTS

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

CANCELLATION

Psychological services are most effective when meeting times are regular and consistent. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, it is required that you provide more than 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hours' notice, you will be charged our standard fee for the missed session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. In addition, you are responsible for coming to your session on time and at the time scheduled. If you are late, your appointment will still need to end on time.

FEES, BILLING, AND PAYMENT

Psychotherapy sessions are 45 minutes and billed at my standard fee available by request. Session fees are payable at time of service unless alternative arrangements have been arranged. Fees will be reevaluated periodically. Legal fees are not billable to insurance companies and will be charged to the patient directly (eg. court evaluations, court appearances). Should a balance accrue and no payment is received, we reserve the right to seek remuneration by any means legally possible including, but not limited to, the retention of a collection agency.

INSURANCE

The Center for Counseling and Education, LLC is out-of-network with insurance companies. This means that our services may be reimbursable if you have out-of-network coverage. We will provide you with a monthly statement upon your request that you may submit to your insurance to obtain out-of-network reimbursement. We can also submit insurance claims for you. Insurance companies require a formal diagnosis with their claims. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. Please bring up any questions you have about your diagnosis in session.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a mention of the topics discussed. You have the right to a copy of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained in a secure location.

CONFIDENTIALITY

The confidentiality of all communications between a client and a therapist is generally protected by law and I, as your therapist, cannot and will not tell anyone else what you have discussed or even that you are in therapy without your written permission. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. With the exception of certain specific situations described below, you have the right to confidentiality of your therapy. You, on the other hand, may request that information is shared with whomever you choose and you may revoke that permission in writing at any time.

There are, however, several exceptions in which I am legally bound to take action even though that requires revealing some information about a patient's treatment. If at all possible, I will make every attempt to inform you when these will have to be put into effect. The legal exceptions to confidentiality include, but are not limited, to the following:

1. If there is good reason to believe you are threatening serious bodily harm to yourself or others. If I believe a client is threatening serious bodily harm to another, I may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another, I may be

required to seek hospitalization for the client, or to contact family members or others who can provide protection.
2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.
3. In response to a court order or where otherwise required by law.
4. To the extent necessary, to make a claim on a delinquent account via a collection agency.
5. To the extent necessary for emergency medical care to be rendered.
Finally, there are times when I find it beneficial to consult with colleagues and/or experts in particular treatment areas. We strive to provide the best possible service and believe that professional supervision and consultation is an important part of our practice. Your name and unique identifying characteristics will not be disclosed if consultations occur with anyone other than my Clinical Supervisor and our Clinical Director. The consultant is also legally bound to keep the information confidential.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in the office during normal business hours, I do not answer the phone when I am with a client. If you need to reach me between sessions, or in an emergency, you have the right to a timely response. You may leave a message with the office at 856-985-9091 at any time and your call will be returned as soon as possible or by the next business day under normal circumstances. After business hours Monday through Friday, I check my voicemail for messages for the last time at 8:00 PM.

On weekends, I typically check for messages midday and at 8:00 PM for the last time. I will only return a call on a weekend or after 8:00 PM if the matter is urgent and cannot wait until the next business morning. If you require an immediate response and it is before 8:00 PM, please be sure to say so and leave a phone number where you can be reached and I will make every attempt to get in touch with you as soon as possible. But, for any number of unseen reasons, if you do not hear from me or I am unable to reach you, it remains your responsibility to take care of yourself until such time as we can talk. Do no use E-mail for emergency/urgent situations. If you are in a crises, DO NOT HESITATE to call 911 if immediate attention is needed. I will make every attempt to inform you in advance of any planned absences, and provide you with a name and phone number of the Therapist covering the practice. If you are not able to reach me, you may contact our Director, Meg Clark Soriano, MA, LPC, ACS, RPT-S at 856-985-9091 (office) or 609-923-2032 (cell).

OTHER RIGHTS

You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment.

You have the right to ask questions about any aspect of the therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

If you are unhappy with what is happening in therapy, I hope you'll talk with me so that I can respond to your concerns. Such criticism will be taken seriously and with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You are also able to speak with our Director, Meg Clark Soriano, MA, LPC, ACS, RPT-S at 856-985-9091 (office) or 609-923-2032 (cell)

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and agree to its terms. It also serves as an acknowledgment that you have received the HIPAA Notice Form described and attached below.

Date: _____

Name:_____

Signature: _____

1.Please sign and return this page acknowledging your acceptance of the terms and receipt of the Consent and HIPAA notice forms. Keep the Consent and HIPPA Notice forms for you records.

2. Fill out Information and Biographical Forms attached below and return to your therapist at your first appointment.

NOTICE OF PRIVACY PRACTICES

Center for Counseling and Education , LLC
19 E Main Street
Marlton, NJ 08053

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Center for Counseling and Education, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Center for Counseling and Education, LLC , please contact:

Privacy Officer: Meg Clark Soriano
Street Address: 19 E Main Street
City, State, Zip: Marlton, NJ 08053
Phone Number: 856-985-9091

Effective Date of This Notice: April 14, 2003

YOUR INFORMATION IS CONFIDENTIAL

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

'HIPAA PRIVACY RULE"

A federal regulation, known as the "HIPPA Privacy Rule", requires that we provide detailed notice in writing of our privacy practices.

WHO WILL FOLLOW THIS NOTICE

- Any health care professional authorized to enter information into Center for Counseling chart.
- All departments and units of Center for Counseling
- Any member of a volunteer group we allow to help you while you are our patient.
- All employees, staff and other Center for Counseling personnel

OUR PLEDGE REGARDING MENTAL HEALTH INFORMATION

We understand that mental health information about you and your health is personal. We are committed to protecting mental health information about you. We create a record of the care and services you receive at the Center for Counseling. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Center for Counseling, whether made by Center for Counseling personnel or your personal doctor.

This notice will tell you about the ways in which we may use and disclose mental health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of mental health information.

We are required by law to:

- make sure that mental health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to mental health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose mental health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use mental health information about you to provide you with mental health treatment or services. We may disclose mental health information about you to doctors, nurses, technicians, mental health students, or other Center for Counseling personnel who are involved in taking care of you at Center for Counseling. We also may disclose mental health information about you to people outside the Center for Counseling who may be involved in your mental health care after you leave the Center for Counseling, such as family members, clergy or others we use to provide services that are part of your care.

For Payment. We may use and disclose mental health information about you so that the treatment and services you receive at Center for Counseling may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at Center for Counseling; your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a. treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose mental health information about you for Center for Counseling operations. These uses and disclosures are necessary to run Center for Counseling, and make sure that all of our patients receive quality care. For example, we may use mental health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine mental health information about many patients to decide what additional services Center for Counseling should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, mental health students, and other Center for Counseling personnel for review and learning purposes. We may also combine the mental health information we have with mental health information from other Center for Counseling to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of mental health information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders. We may use and disclose mental health information to contact you as a reminder that you have an appointment for treatment or mental health care at Center for Counseling

Treatment Alternatives. We may use and disclose mental health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose mental health information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release mental health information about you to a friend or family member who is involved in your mental health care. We may also give information to someone who helps pay for your care.

As Required By Law. We will disclose mental health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose mental health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans. If you are a member of the armed forces, we may release mental health information about you as required by military command authorities. We may also release mental health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release mental health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose mental health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems as with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose mental health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose mental health information about you in response to a court or administrative order. We may also disclose mental health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release mental health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Center for Counseling; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. We may release mental health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose mental health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release mental health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MENTAL HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding mental health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy mental health information that may be used to make decisions about your care. Usually, this includes mental health and billing records, but does not include psychotherapy notes.

To inspect; and copy mental health information that may be used to make decisions about you, you must submit your request in writing to Center for Counseling If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to mental health information, you may request that the denial be reviewed. Another licensed health care professional chosen by Center for Counseling, will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that mental health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Center for Counseling
To request an amendment, your request must he made in writing and submitted to Center for Counseling In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support, the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the mental health information kept by or for Center for Counseling;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to Request Restrictions. You have the right to request a restriction or limitation on the mental health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the mental health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
To request restrictions, you must make your request in writing to Center for Counseling In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
Right to Request Confidential Communications. You have the right to request that we communicate with you about mental health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Center for Counseling. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice contact our office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for mental health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Center for Counseling, or with the Secretary of the Department of Health and Human Services. To file a complaint with Center for Counseling, contact Meg Clark Soriano at 856-985-9091. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MENTAL HEALTH INFORMATION

Other uses and disclosures of mental health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose mental health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose mental health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Center for Counseling and Education

Today's Date: _____Forms completed by: _____

Client Information

Name:_____
First Last M.I.

Address:_____
Street and Number City State Zip

Date of Birth: ____/____/____ Age: _____Social Security No.:_____-____-_____

Gender: _____ Race: _____ Grade:_____

Home Phone: _____ Cell Phone:_____
Work Phone: _____
Do we have your permission to call the above numbers? _____yes _____no
Do we have your permission to leave a message if necessary? _____yes _____no
If not, please specify: _____

Email address: _____
Did someone refer you? Yes/No If yes, who? _____
May we send a thank you to who ever referred you? Yes/No

Emergency Contact Name: _____

Phone: _____ Relationship to client: _____

Billing Information

Responsible Party #1

Name: _____ _____ _____
First Last M.I.

Address: _____
Street and Number City State Zip

Home Phone: _____ Work Phone: _____ Cell: _____

Responsible Party #2

Name: _____ _____ _____
First Last M.I.

Address: _____
Street and Number City State Zip

Home Phone: _____ Work Phone: _____ Cell: _____

Insurance Information

Our office does not file insurance claims so you will be responsible for filing and obtaining reimbursement. Our office will provide a receipt with the necessary information. You are expected to pay in full at the time of service. We ask that you fill out the insurance portion so that we may have this on file for future reference. Thank you for your cooperation.

Primary Insurance:

Insurance Company: _____ Plan Name: _____

Address: _____
Street and Number

_____
City State Zip

Policy #:_____ Group: _____ Insured's ID #:_____

Phone Number: _____ Fax Number: _____

Insured Information

Name of Person Insured: _____ _____ ____
First Last MI

SSN: ____-____-____ Home Phone: _____ Work Phone: _____

Insured's Address: _____
Street and Number City State Zip

Birth Date: ____/____/____ Gender: ____Male ____Female

Biographical Information Form—Child

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to the child, leave them blank.

Child's Name _____ Date_____

Birth date _____ Age_____ Sex _____

Adopted ___ yes ___ no Is your child aware of adoption? ___ yes ___ no

Others in Household:	Relationship to child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly state your main concerns about your child:

_____
_____
_____
_____

How long has this problem persisted? _____
Under what conditions do the problems usually get worse? _____
_____
Under what conditions are the problems usually improved? _____
_____
Have any of the child's blood relatives experienced similar problems? _____
_____

Has the child and/or family been involved in previous counseling? ____yes ____no
If yes, please provide name of therapist: _____
Was the experience helpful? _____yes _____no

List your child's three greatest strengths:

1. _____
2. _____
3. _____

List three areas that need improvement for your child:

1._____
2._____
3._____

Briefly describe your child's interests, hobbies and/or activities:

_____

_____

_____

MEDICAL

Name of Physician: _____

Physician's address: _____

Physician's telephone: _____

Date of last physical exam: _____

MEDICAL HISTORY Please note the age and any other pertinent information. Use back if necessary.

Childhood diseases: _____

Operations: _____

Other hospitalizations: _____

Head injuries: _____

Convulsions/seizures: _____

Persistent high fevers: _____

Eye problems: _____

Tics (eye blinking, sniffing, or any repetitive movement): _____

Ear problems: _____

Allergies or asthma: _____

Sleep problems (restless, night waking, sleepwalking): _____

Bedwetting or soiling pants in daytime: _____

Describe the child's appetite: _____

Describe the child's diet: _____

Current medications and dose: _____

_____

FAMILY

Mother's age: ____ If deceased, how old was the child when she passed away? _____

Father's age: ____ If deceased, how old was the child when he passed away? _____

If parents are separated or divorced, how old was the child when this occurred? _____

List any siblings (and ages) that are not living in home with the child? _____

_____

_____

Briefly describe your child's relationship with brothers and sisters:

_____

_____

_____

Mother's occupation: _____

Hours of work: _____

Father's occupation: _____

Hours of work: _____

FAMILY/SOCIAL HISTORY

Include any brothers or sisters you (the parent) have/had as well as your (the parent) biological parents (In other words, YOUR childhood history). Be sure to include PAST or PRESENT behavior.

Birth Mother Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness

Birth Father Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness

Step-Mother Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness

Step-Father Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness

Adopted Mother Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness

Adopted Father Childhood History (Check all that apply)

__ Alcoholism
__ Physical Abuse
__ Sexual Abuse
__Criminal Activity
__ Drug Usage
__ Domestic Violence
__ Mental Illness

Which family member has the best relationship with the patient? _____

INFANCY – TODDLERHOOD

Did the child's mother or the child experience any complications during pregnancy/delivery?

Was any of the following present during the first few years?

_____ did not enjoy cuddling
_____ was not calmed by being held
_____ difficult to comfort
_____ colic
_____ excessive restlessness
_____ excessive irritability
_____ frequent head banging
_____ constantly into everything

TEMPERAMENT: please rate the following as your child appeared in infancy and toddler hood:

Activity level: ____ under active _____ average activity level _____ overactive
Adaptability: ____ adapted easily to change _____ resisted change
Intensity: ____ average _____ feelings were often intense
Mood: ____ often happy ___ average range of moods ___ often dissatisfied/irritable

DEVELOPMENTAL MILESTONES

As best you can recall, list age of development, or check item at right:

	Age or	Early	Normal	Late
Crawled	_____	_____	_____	_____
Walked without assistance	_____	_____	_____	_____
Spoke first words	_____	_____	_____	_____
Any speech/articulation problems?				
Toilet trained daytime	_____	_____	_____	_____
Toilet trained nighttime	_____	_____	_____	_____

COORDINATION Rate your child on the following skills:

	Good	Average	Poor
Walking	_____	_____	_____
Running	_____	_____	_____
Throwing	_____	_____	_____
Catching	_____	_____	_____
Shoelace tying	_____	_____	_____
Writing	_____	_____	_____
Athletic abilities	_____	_____	_____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his/her age?

_____

How would you rate your child's overall level of intelligence?

_____ Below average _____ Above average _____ Average

PEER RELATIONSHIPS

How does your child get along with others his/her age? Describe any problems.

_____

_____

SCHOOL HISTORY

School currently attending: _____Grade level _____

Name of Guidance Counselor: _____Telephone:_____

Is your child in any resource or special classes? _____

Has your child had any special testing in school? _____
(If yes, please bring copies of reports.)
Has your child ever repeated a grade? If so, which? _____

Briefly describe your child's school progress. Note usual grades, any problems or successes, strong subjects and weak subjects:

Preschool - K _____

1st - 5th _____

6th - 8th _____

9th - 12th _____

Describe any conduct problems your child has had in school:

How would you rate your child's homework/study skills? ___ Good ___ Average ___ Poor

Describe difficulties: _____

Has your child had tutoring or remedial work? _____

Does your child like to read? _____ How often (circle one) Never Seldom Occas. Often

Please rate reading ability as _____ good _____ fair _____ poor

In school, how many friends does child have: ____a lot ____ a few ____none

Any other comments on your child's performance and behavior:

HOME BEHAVIOR AND MOOD

Check which of the following applies to your child:

_____ frequently irritable or moody
_____ can't seem to enjoy doing anything
_____ sad spells
_____ crying spells

_____ easily bored

_____ poor or low motivation
_____ acts like driven by a motor
_____ low self-esteem (makes negative statements about self)
_____ can't seem to concentrate
_____ has had thoughts of or made comments about suicide

_____ eats (too much) or (too little)
_____ frequent arguing at home
_____ fearfulness

_____ nervous, anxious
_____ frequent headaches
_____ frequent stomachaches
_____ has had a panic attack (rapid heartbeat, sweaty palms, feeling something bad about to happen)
_____ difficulty sleeping:
___ goes to sleep very late
___ hard to get up in morning
___ very restless sleep
___ bad dreams
___ sleeps with parent

_____ doesn't seem to learn from experience
_____ very disorganized (loses things, has very messy room)
_____ has been physically or sexually abused
_____ drug or tobacco use: _____
_____ argues with or rude to teachers
_____ other: _____

If you child experienced any stressful or traumatic situations in the past few months or in the last few years please describe: _____
_____
_____

How many hours of sleep does child receive each night? _____
How is your child disciplined? _____
_____
For what reasons is your child disciplined? _____
_____
Any additional comments you would like to make about your child (mood, behavior, personality, etc.):_____
_____
_____
_____
_____
_____
_____
_____

Thank you for the time and effort you gave in completing this form. Please also complete any check lists which accompany this history form.

ATTENTION CHECKLIST

Name _____

Please circle the number corresponding to the degree the following characteristics have been experienced.

	None	Just A little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.	0	1	2	3
Often has difficulty sustaining attention in tasks or play activities	0	1	2	3
Often does not seem to listen when spoken to directly	0	1	2	3
Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace	0	1	2	3
Often has difficulty organizing tasks and activities	0	1	2	3
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
Often loses things necessary for tasks or activities (in play, school, or work)	0	1	2	3
Is often easily distracted by sounds, noises, movements unrelated to the task at hand (listening in class, studying)	0	1	2	3
Is often forgetful in daily activities	0	1	2	3
Often fidgets with hands or feet or squirms in seat	0	1	2	3
Often leaves seat in classroom or in other situations in which it is inappropriate	0	1	2	3
Often has difficulty playing or engaging in leisure activities quietly	0	1	2	3
Is often "on the go" or often acts as if "driven by a motor"	0	1	2	3
Often talks excessively	0	1	2	3
Often blurts out answers before questions are completed	0	1	2	3
Often has difficulty awaiting turn	0	1	2	3
Often interrupts or intrudes on others	0	1	2	3

How long have the above marked symptoms been evident?

___ by school age (6 or 7) ___ by high school Other:

Does your child show these symptoms in more than one setting (i.e. home, school, public)?

_____ yes _____no

MOOD RATING SCALE

Name _____
Carefully consider which apply to your child or teenager.
Circle the corresponding number.

Depressed mood (sad, gloomy, forlorn)
1. None
2. Mild
3. Moderate (brief periods of unhappiness or no emotion
4. Severe (often looks sad or withdrawn)

Weeping
1. None
2. Normal for age
3. Seems to cry more frequently than peers
4. Cries frequently

Self Esteem
1. Child describes self in mostly positive terms
2. Little or no evidence of lowered self esteem
3. Describes self in some positive, some negative terms
4. Positive and negative terms, but mostly negative
5. Refers to self in derogatory terms, or avoids the question

Morbid thinking (death, violence)
1. None apparent
2. Some morbid thoughts - related to actual events
3. Somewhat more than usual morbid thoughts
5. Elaborate or extensive morbid thinking

Suicide and Suicide Ideation
1. None apparent
2. Has thought of suicide - usually when angry
3. Recurrent thoughts of suicide
4. Thinks about suicide and names methods
5. Has recently attempted suicide

Irritability (whining, chip on shoulder, hostility)
1. None
2. Normal amount
3. Occasional-slightly more than normal
4. Episodic - comes and goes
5. Frequent
6. Constant

Schoolwork
1. Performing at or above expected level
2. Not working to capacity or recent disinterest
3. Doing poorly in most subjects or major decline

Capacity to have fun
1. Interests & hobbies appropriate for age
2. Some interests but mostly passive, lacks enthusiasm
3. Easily bored, "Nothing to do"
4. No initiative, watches others or only TV. has to be coaxed to be involved in any activities1.

Social Withdrawal
1. Enjoys good friendships with peers
2. Has several friends, not very close
3. Is passive in getting friends
4. Rejects opportunities for interaction
5. Does not relate to other children

Expressive communication
1. Expresses self fairly well
2. Not very talkative, but will talk
3. Withdrawn, very reluctant to talk

Sleep
1. Occasional or no difficulty sleeping
2. Mild but frequent difficulty sleeping
3. Moderate difficulty sleeping almost every night
    a.. problem getting to sleep
    b. problem waking at night
    c. Problem waking in morning

Disturbance of eating
1. No problem
2. Mild____ Too little____ Too much____
3. Moderate____ Too little____ Too much____

Frequent Physical Complaints (head, stomach)
1. No complaints
2. Mild, occasional complaints
3. Frequent complaints,
4. Preoccupies with aches and pains

General Somatic
1. Normal
2. Occasional complaints of fatigue
3. Frequent complaints of being tired

Activity Level
1. Activity at usual level
2. Slight reduction of activity level
3. Activity greatly reduced from usual

Completed by: _____

Comments:

TAYLOR SCREENING CHECKLIST

Name _____

Please rate your child's natural tendencies for each trait listed.

More Like This		**No Trend**		**More Like This**
A.		B.		C.
	A quiet person		A noisy and talkative person	
	Voice volume is soft or average		Voice generally is too loud	
	Few mouth or body noises		Makes lots of sounds with mouth or body	
	Walks at appropriate times		Flits around, runs ahead, jumpy	
	Keeps hands to self		Pokes, touches, feels, grabs	
	Appears calm, can be still		Always moving, fidgets, squirmy	
	Can just sit		Has to be doing something; quickly bored	
	Slow to react; deliberate; not impulsive		Too quick to react, engages mouth or muscles	
	Understands why parents or teachers are displeased after misbehavior		Feels picked on, is surprised and confused about why others are displeased	
	Planful; thinks ahead to consequences before acting		Does things without considering consequences	
	Avoids other children's mischief		Gets involved in mischief; attracted to or starts	
	Concerned about punishment and consequences		Pretends to have an "I don't care" attitude	
	Obeys directions and follows orders		Disobeys; needs supervision or reminding	
	Constant mood with mild or slow mood changes		Mood unpredictable; quick to anger or tears	
	Easygoing; handles frustration without much anger		Irritable; impatient; easily frustrated	
	Emotions are reasonable and controlled, are not extreme, and don't disrupt relationships		Emotions are extreme and poorly controlled; no damper on emotion; explosive tantrum-like	
	Cooperates with, obeys and enforces rules		Argues and gripes about the rules; wants to be the exception	
	Gives up when denied a requested privilege, item, or activity		Badgers, pesters, won't give up or take no for an answer	
	Concentrates and blocks out distraction when working on something of medium interest		Easily distracted by noises and people nearby; short attention span	
	Follows through, has an organized approach		Flits from activity to activity, does not finish things	
	Does not try to bother or hurt others with words		Needles, teases, has to have the last word	

Most children exhibit, at one time or another, one or more of the symptoms listed below. Place a P next to those that your child has exhibited in the PAST and N next to those that your child exhibits NOW. Only mark those symptoms that have been or are present to a significant degree over a period of time. Only check as problems behavior that you suspect is unusual or atypical when compared to what you consider to be the normal for your child's age.

_____ Thumb-sucking
_____ Baby Talk
_____ Overly dependent for age
_____ Frequent temper tantrums
_____ Excessiveness silliness and clowning
_____ Excessive demands for attention
_____ Cries easily and frequently
_____ Generally immature
_____ Eats non-edible substances
_____ Overeating with overweight
_____ Eating binges with overweight
_____ Under eating with underweight
_____ Long periods of dieting and food abstinence with underweight
_____ Preoccupied with food--what to eat and what not to eat
_____ Preoccupation with bowel movements
_____ Constipation
_____ Encopresis (soiling)
_____ Insomnia (difficulty sleeping)
_____ Enuresis (bed wetting)
_____ Frequent nightmares
_____ Night terrors (terrifying night time out bursts)
_____ Sleepwalking
_____ Excessive sexual interest and preoccupation
_____ Frequent sex play with other children
_____ Excessive masturbation
_____ Frequently likes to wear clothing of the opposite sex
_____ Exhibits gestures and intonations of the opposite sex
_____ Frequent headaches
_____ Frequent stomach aches
_____ Frequent nausea and vomiting
_____ Often complains of bodily aches and pains
_____ Worries over bodily illness
_____ Poor motivation
_____ Apathy
_____ Takes path of least resistance
_____ Ever trying to avoid responsibility
_____ Poor follow through
_____ Low curiosity
_____ Open defiance of authority
_____ Blatantly uncooperative
_____ Persistent lying
_____ Frequent use of profanity to parents, teachers, and other authorities
_____ Truancy from school
_____ Runs away from home
_____ Violent outbursts of rage
_____ Stealing
_____ Cruelty to animals, children, and others
_____ Destruction of property
_____ Criminal and/or dangerous acts

_____ Trouble with the police
_____ Violent assault
_____ Fire setting
_____ Little, if any, guilt over behavior that causes others pain and discomfort
_____ Little, if any, response to punishment for antisocial behavior
_____ Few, if any, friends
_____ Does not seek friendships
_____ Rarely sought by peers
_____ Not accepted by peer group
_____ Selfish
_____ Argumentative
_____ Does not respect the rights of others
_____ Wants things own way with exaggerated reaction if thwarted
_____ Trouble putting self in other person's position
_____ Egocentric (self-centered)
_____ Frequently hits other children
_____ Excessively critical of others
_____ Excessively taunts other children
_____ Ever complaining
_____ Is often picked on and easily bullied by other children
_____ Suspicious, distrustful
_____ Aloof
_____ "Wise-guy" or smart aleck attitude
_____ Brags or boasts
_____ Bribes other children
_____ Excessively competitive
_____ Often cheats when playing games
_____ "Sore Loser"
_____ "Does not know when to stop"
_____ Poor common sense in social situations
_____ Often feels cheated
_____ Feels others are persecuting him when there is no evidence for such
_____ Typically wants his or her own way
_____ Very stubborn
_____ Obstruction-istic
_____ Negativistic (does just the opposite of what is requested)
_____ Quietly. or often silently, defiant of authority
_____ Feigns or verbalizes compliance or cooperation but does not comply with requests
_____ Drug abuse
_____ Alcohol abuse
_____ Very tense
_____ Nail biting
_____ Chews on clothes, blankets, etc.
_____ Head banging

_____ Hair pulling
_____ Picks on skin
_____ Speaks rapidly and under pressure
_____ Irritability, easily "flies off the handle"

FEARS/PHOBIAS

_____ dark
_____ new situations
_____ strangers
_____ being alone
_____ death
_____ separation from parent
_____ school

_____ visiting other children's homes
_____ going away to camp
_____ animals
_____ other fears (name)
_____ Anxiety attacks with palpitations (heart pounding), shortness of breath, sweating, etc.
_____ Disorganized
_____ Excessive worrying over minor things
_____ Tics such as eye blinking, grimacing, or other spasmodic repetitious movements
_____ Involuntary grunts, vocalizations (understandable or not)
_____ Stuttering
_____ Depression
_____ Frequent crying spells
_____ Suicidal preoccupation, gestures, or attempts
_____ Excessive desire to please authority
_____ "Too Good"
_____ Often appears insincere and/or artificial
_____ Too mature, frequently acts older than actual age
_____ Excessive guilt over minor indiscretions
_____ Asks to be punished
_____ Low self-esteem
_____ Excessive self-criticism
_____ Very poor toleration of criticism
_____ Feelings easily hurt
_____ Dissatisfaction-ion with appearance or body part(s)
_____ Excessive modesty or exposure
_____ Perfectionist, rarely satisfied with performance
_____ Frequently blames others as a cover up for own short comings
_____ Little concern for personal appearance or hygiene
_____ Little concern for or pride in personal property
_____ "Gets hooked" on certain ideas and remains preoccupied

_____ Compulsive repetition of seemingly meaningless physical acts
_____ Shy
_____ Inhibited self expression in dancing, singing, laughing, etc.
_____ Recoils from affectionate physical contact
_____ Withdrawn
_____ Fears asserting self
_____ Inhibits open expression of anger
_____ Allows self to be easily taken advantage of
_____ Frequently pouts and/or sulks
_____ Mute (refuses to speak) but can
_____ Gullible/naive
_____ Passive and easily led
_____ Excessive fantasizing, "lives in his (her own world"
_____ Flat emotional tone
_____ Speech is non- communicative or poorly communicative
_____ Hears voices
_____ Sees visions

Authorization and Consent for Video Recording(s) and use thereof

(Name of participants) _____

_____

authorize Meg Clark Soriano, MA, LPC, RPT-S, to videotape all therapy sessions for the duration of the time that my child _____ is receiving therapy. I understand that we will not receive compensation for our participation in these recordings. Videotapes will be used for the purpose of supervision of the therapist's skills by a professional for purposes of enhancing treatment. I further authorize Meg Clark Soriano to use these recordings in her role as a consultant for education of other professionals. I understand that these tapes and the content of these sessions are confidential.

I understand that I may withdraw my permission to videotape with a written notification to Meg Clark Soriano at 19 East Main St, Marlton, NJ 08053.

Signatures of participants, parent, or legal guardian if participant is a minor.

Signature _____

Name _____

Address _____

City, State, Zip _____

Telephone _____

Date _____