North Scottsdale Pediatrics

CLIENT INFORMATION

If you are completing this form on behalf of a minor child, the "client" is that child. If you are filling this out as an adult (ages 18 and over) seeking services for yourself, the "client" is you.

Client Name: ____ ______________________________
Last First Date of Birth: (MM/DD/YYYY) Age

Address: ____
City State Zip

Place of birth: ________________________

Client's race (circle which applies) African-American Caucasian Native American Hispanic Asian Latino
Other (specify)
____

Was the client adopted? Yes____ No ____ If yes, at what age? _____ From where?
____

I wish to be contacted in the following manner (initial all that may apply):

______ Home Telephone: ________________________
______Okay to leave a message with detailed information
______ Okay. to leave a message with call-back number only

______ Cell Telephone: ______________________
______ Okay to leave a message with detailed information
______ Okay to send appointment reminder via text message
______ Leave message with call-back number only

______ **Okay to be contacted through email. If so, please provide your email address: _________________________**

IN CASE OF EMERGENCY

Name: ____
Name Relationship Home Number Cell Number

How did you hear about us? ____

If online what website or search words did you use? ____________________________________

Were you referred? Circle YES or NO If so, who referred you? ______________________________________

____

____

Do you have any particular time/day preference for appointments?

____

North Scottsdale Pediatrics

ASSESSMENT

DEVELOPMENTAL HISTORY

Were there any complications with the client during the pregnancy? If yes, please explain:

____

____

Any feeding problems?

____

Sleeping problems?

____

Any problems with growth or development of the client?

____

Has the client ever been diagnosed with a developmental disorder?

____

Other developmental concerns?

____

Please write at what age the client first demonstrated each behavior. If you do not remember, please write a question mark:

Showed response to parent ___	Put several words together ___	Stayed dry at night ___
Rolled over ___	Spoke first word___	Fed self ___
Sat alone ___	Became toilet trained ___	Rode tricycle ___
Crawled ___	Babbled ___	Dressed Self ___

MEDICAL HISTORY

Medical problems:

____

Any allergies? Please list: ____

Nutritional problems? ____

Any disability or handicap? ____

North Scottsdale Pediatrics

Has the client ever suffered from a concussion, head injury or had a seizure? If so, please describe:

Any hospitalizations? If so, when and for what? ____

Please list all medications taken by the client at this time:

Name of the client's Primary Care Provider:

____

Date of last appointment with Primary Care Provider and for what was the client seen?

____

MENTAL/BEHAVIORAL HEALTH HISTORY

Has the client or anyone in your family been diagnosed with a mental/behavioral health disorder? If so, what was the diagnosis, when was it given and by whom? ____

Has the client or anyone in your family received psychiatric, psychological or mental/behavioral health counseling previously? If so, please explain: ____

Is the client currently experiencing any auditory or visual hallucinations? If yes, please explain:

Is the client experiencing any bizarre or strange thought patterns? If yes, please explain:

____

____

EDUCATIONAL HISTORY

Name of your child's school:

____

Highest grade level completed: _______________

Has the client ever been held back a grade level? If so, please explain:

____

Has the client ever been suspended or expelled from school? If so, please explain:

____

Any problems with school attendance? If so, please explain:

___

Please circle the answer that best describes your child's current academic performance:

Excellent (mostly A's)	Good (mostly B's)	Average (mostly C's)	Below Average (mostly D's)	Poor (mostly F's)

Do you have any concerns about the client's academic performance at this time? If so, please explain:

___

___

Does the client have an IEP/504 plan at school or receive any special education support? If yes, please explain: ___

Does the client have a job at this time? If so where and doing what? ___

___

HISTORY OF ABUSE?

Have as the client or a family member ever experienced physical or sexual abuse or witnessed violence?

Please explain if you feel comfortable or you can leave it blank if you're not comfortable explaining:

___

___

LEGAL PROBLEMS?

___

___

___

DRUG USE OR ALCOHOL CONSUMPTION PAST OR PRESENT?

Does the client or anyone in the family consume alcohol or any drugs? If so, what and how often? (This information is confidential):

___

___

North Scottsdale Pediatrics

FAMILY HISTORY OF ADDICTION?

Has the client or anyone in your family ever had an addiction including addictions to alcohol, drugs, gambling, sex, pornography, video gaming, or struggled with an eating disorder? If yes, please explain:

____

SUICIDAL OR ASSAULTIVE IDEATIONS?

Has the client or a family member ever tried to commit suicide or been involved in physical violence? If so, please explain: ____

RELIGIOUS OR SPIRITUAL AFFILIATION?

Does the client or your family practice a formal religion or find strength from spiritual beliefs? If yes, please explain:

____

FAMILY HISTORY

Parents/Step-Parents

Mother's name: ______________________ Education: __________________________

Occupation: _________________________ Age: ____

Father's name: _______________________ Education: __________________________

Occupation: _________________________ Age: ____

Marital status of parents: _______________________

If parents are separated/divorced, how old was the client at the time of the separation? ______

Step-Parents Name: ____

Step-Parents Name: ____

With whom does the client live? ____

North Scottsdale Pediatrics

Does the client have any siblings? If so, please list:

Name: ___________________________ Age: ______

Name: ___________________________ Age: ______

Name: ___________________________ Age: ______

Name: ___________________________ Age: ______

Please list all people living in the home with the client at this time:

HISTORY OF PRESENTING PROBLEM

What are the issues or problems that brought you to seek counseling at this time? Why now? Please explain:

How long has this problem been a concern to you?

What seems to help the problem? ____

What seems to make it worse? ____

Has the client received evaluation or treatment for the current problem or similar problem? If so, when and where? ____

North Scottsdale Pediatrics

If you are the parent of minor child filling this form out on their behalf:

On a scale of 1-10 (1 being not very important and 10 being extremely important) how important is resolving this problem to your child? Please circle the number that applies:

1 2 3 4 5 6 7 8 9 10

How receptive is your child to coming to counseling (1 being not very receptive to 10 very receptive) Please circle the number that applies:

1 2 3 4 5 6 7 8 9 10

Is there anything not covered in this form that you would like for me to know about the client or presenting problem? If yes, please explain here:

____

____

____

____

____

____

____

____

____

____

If you are the parent of a minor child completing this form on their behalf, please complete the following Child Behavior Checklist.

North Scottsdale Pediatrics

CHILD BEHAVIOR CHECKLIST

Child's Name:______________________________ Date:____________ Completed By:____________________

Please circle **Y** = yes for behaviors that are a concern for your child, **S** = sometimes for behaviors that are sometimes a concern for your child and **N** = no for behaviors that are not a concern for your child.

ATTENTION

When symptoms began (date)______________________

Careless mistakes	Y	S	N
Poor attention span	Y	S	N
Doesn't listen	Y	S	N
Doesn't finish tasks	Y	S	N
Problems organizing	Y	S	N
Avoids tasks requiring concentration	Y	S	N
Loses needed items	Y	S	N
Easily distracted	Y	S	N
Trouble remembering/forgetful	Y	S	N
Fidgets, squirms	Y	S	N
Leaves seat when required to sit	Y	S	N
On the go, seems driven	Y	S	N
Runs, climbs excessively/restless	Y	S	N
Talks all the time	Y	S	N
Problems waiting turn	Y	S	N
Interrupts	Y	S	N

OPPOSITIONAL BEHAVIORS

When symptoms began (date)______________________

Touchy, easily annoyed	Y	S	N
Argues	Y	S	N
Defiant	Y	S	N
Angry	Y	S	N
Tantrums	Y	S	N
Bothers others deliberately	Y	S	N
Spiteful/mean	Y	S	N
Blames others for own mistakes	Y	S	N

CONDUCT

When symptoms began (date)______________________

Bullies/threatens others	Y	S	N
Starts fights	Y	S	N
Used a weapon	Y	S	N
Physically cruel to people/animals	Y	S	N
Forcibly stolen from victim	Y	S	N
Stolen without confronting victim	Y	S	N
Forces sexual activity	Y	S	N
Deliberately sets fires to cause damage	Y	S	N

MOOD

When symptoms began (date)______________________

Weight changes/appetite changes	Y	S	N
Energy level changes	Y	S	N
Sleep disturbances	Y	S	N
Difficulty concentrating	Y	S	N
Crying spells	Y	S	N
Loss of interest/pleasure	Y	S	N
Hopeless feelings	Y	S	N
Guilty feelings	Y	S	N
Isolates self	Y	S	N
Low self-esteem/self-hate	Y	S	N
Gives things away	Y	S	N
Wishes to be dead	Y	S	N
Injures self	Y	S	N
Thinks about death/violence often	Y	S	N
Rage outbursts	Y	S	N
Bizarre behaviors, hallucinations	Y	S	N
Rapid, hard to follow speech/thoughts	Y	S	N
Thinks s/he is the smartest, best person in the world	Y	S	N

ANXIETY/WORRY

When symptoms began(date)______________________

Worries something terrible will happen to self or important adults	Y	S	N
Frequently refuses or is reluctant to go somewhere fear of separation	Y	S	N
Avoids being alone	Y	S	N
Nightmares about separation	Y	S	N
Physical complaints about the time of separation transition	Y	S	N
Worries about parent(s) leaving	Y	S	N
Fearfulness of new situations, people or objects	Y	S	N
Engages in repeated behaviors (counting, cleaning organizing, hand washing, etc.)	Y	S	N
Excessive worry about everyday things	Y	S	N
Fear/excessive worry about social situations	Y	S	N

Further comments about any of the above:______________________

____

____

____

____

CHILD'S STRENGTHS:

In school setting:______________________________________

____

In social setting:______________________________________

____

In home setting:______________________________________

____

Special Interests/Hobbies:______________________________________

____

North Scottsdale Pediatrics

Fee Agreement

By signing, I agree to have my visit for behavioral health services with Lauren Chatellier, MSW, LMSW, BHP be a cash visit. There will be no discount for the office visit and any administration fees. Payment is due at the time of service. I understand North Scottsdale Pediatrics will not be submitting the claim to my insurance, or I will not be submitting this claim to my insurance company.

1. Initial Consultations ($100)
2. Individual/Family Therapy ($150)
3. Missed appointments without 24-hour prior notification ($50.00)

Authorization for Debit/Credit Card Charges

I ______________________________ understand that North Scottsdale Pediatrics requires to have my credit card or debit card information on file in order to receive therapy services. Below is list of services provided by North Scottsdale Pediatrics that may be charged to my card if the services are provided. If a different method of payment is preferred, payment will be taken care of at the time of services. If payment is not made at the time of service, the amount of the service will be charged to the credit or debit card.

Name as it appears on the card: ____________________________ Phone #: _______________

Email Address: ____________________________________

Debit/Credit Card #: ________________________________ Expiration Date: ____/____

CVV (CSC) # _________ (For MasterCard or Visa, it's the last three digits in the signature area on the back of your card. For American Express, it's the four digits on the front of the card.)

Billing Address: ____

Street Address Apt #

____

City State Zip Code

_______________________________________ _________________

Signature Date

For billing questions, please call our Practice Administrator, Tricia Juba, at (480) 860-8488 ext. 1040.