NEW OBJECTIVES
Psychology, Counseling & Neurofeedback Center

SOCIAL HISTORY QUESTIONNAIRE—CHILD FORM

This form is designed to provide your therapist with an overview of your child's experiences and history to assist with his/her treatment. All information on this form is completely confidential.

Please fill out the form as completely as possible, giving details. If a question does not apply to your child, please indicate by writing N/A on the line provided.

Date form completed:_________________

Child's Name:____ Sex: M / F

Age:________ Birth Date:________________ Race:________________

Home Address:____
(Street) (City) (Zip)

Home Phone:___________________________ Parent's Cell Phone:_______________________

School:_____________________________________ Grade:_______ Special Classes:_________________

Mother's Name:______________________________ Age:_________ Education:______________________

Occupation:____

Father's Name:_______________________________ Age:_________ Education:____________________

Occupation:____

Are the child's mother and father still married:_______________

Date of Marriage:____________________ Date of Separation/Divorce (if applicable):_________________

If child was adopted, give age of child at time of adoption:_______________

Step-Parents (if applicable):

Name	Age	Occupation	Date of Marriage

This child is in legal custody of:____________________________________

Other Children in Family:
First & Last Name Age

____

____

____

____

Others living in home:______________________________________

Place a star (*) next to the names of the people who live in the child's home.

MAIN CONCERN: (Tell us about your child's difficulties, when/how they began & what you hope we can do to help):

____

____

____

____

____

____

____

____

Age at onset of problems:____________

What have you tried, thus far, to correct the problems (please be specific):

____

____

____

____

OTHER PROBLEMS: (nervous, fearful, depressed, peculiar behaviors, etc.)

____

____

____

FAMILY PROBLEMS OR MAJOR CHANGES
(Include marital problems, change in family structure, or any upsetting events):

____

____

____

PERSONALITY OF THE CHILD

Describe your child's personality:____

____

____

Describe any recent changes in your child's personality:_________________________

____

Describe any stressors or incidents in your child's life that has affected his/her present behavior:

____

____

Who is the child very close to:____

Describe his/her relationship with:

Mother:____

____

Father:____

____

Stepparents (if applicable):____

____

Siblings:____

____

What Kinds of discipline work best with this child (be specific):___________________

____

Describe discipline style of Mother:____

Describe discipline style of Father:____

DEVELOPMENTAL HISTORY

Were there any complications during the pregnancy or delivery:____

____

During the pregnancy, did the mother: Drink?______ Smoke?______ Use drugs?_______ How much?_________

List medications the mother took during pregnancy:____

How active was the baby in the womb?____

How was the mother's emotional state during the pregnancy?____

As best you can remember, give the age at which your child was able to do each of the following things:

First smile_________
Pulled up__________
Sat alone__________
Crawled__________
Sat up___________
Walked with help_________
Walked alone____________
Used 4-10 words__________
Used sentences__________
Talked clearly_________

Said "No! No!" to everything________
Held up arms to be picked up_________
Held cup to drink_________
Fed self__________
Used fork_________
Helped dress__________
Dressed self except for buttons________
Stopped wetting at night________
Toilet trained____________
Dry during the day_________

Please check any of the following that are presently problems:

Temper Tantrums_____
Impulsiveness________
Sleep_______________

Bedwetting__________
Dangerous Acts______
Over-talkative________

Messing in pants______
Unusual Fears________
Appetite_____________

MEDICAL HISTORY

Name of your child's pediatrician:____

Describe any illnesses, disorders or diseases your child currently has:____________________________________

List any prior major illnesses:____

Was he/she ever hospitalized (if so, when & why):____

____

Has he/she ever had any head injuries:____________ When:____

Was there a concussion:________________________

Has the child ever had seizures:__________________ How often:_________________________________

At what age did they start:________________ When was the last one:______________________

List current medications your child is taking:

Name	Reason	Dose	Prescribing Physician

Does your child have any allergies? If yes, please list:____

To your knowledge has your child ever used, or is presently using street drugs or alcohol (if so, which ones):

____

MENTAL HEALTH HISTORY

Has your child ever seen by a mental health professional:_______________________________________

When:_________________________ Therapist seen:______________________________

For what problem(s):____

____

List any previous psychological diagnosis (i.e. ADHD, Depression, Learning Disabilities):___________________

____

Has your child ever attempted suicide:_________ When:_______________ How:____________________

Has any immediate or extended family ever attempted suicide:___________ Committed suicide:___________

Who:____________________ When:____________________ How:_______________________

List any family members who have been in therapy and for what reasons:_____________________________

____

____

If any immediate or extended family member has been diagnosed with a mental illness, list their relationship to the child and their diagnosis:

____

____

Describe any family member who exhibits problematic or odd behaviors:_______________________________

____

List any family members who have presently or in the past abused drugs or alcohol:______________________

Were they treated:___________________ Are they presently in recovery:____________________________

ABUSE HISTORY

To your knowledge, has your child ever been abused:____

Physically:__________ Sexually:_______ By whom:______________________ When:______________

What was don't to the abuser:____

To your knowledge, is your child sexually active:________________________________

LEGAL ISSUES:

Has your child ever been in trouble with the law:____________

What occurred:____

Age of child at time of event:_________

Has your child ever been in juvenile court (state reason and outcome):__________________________________

____

EDUCATIONAL HISTORY

Is your child in any special classes:________________ What type:______________________________

What grade were those classes begun:______________ Is you child in a POD classroom:______________

Describe any difficulties your child has had during his/her schooling or adjusting to school:_________________

____

Have there been any traumatic events that have happened to your child while at school (if yes, describe):

____

How many days has your child been absent this year:______ Reason:_________________________________

Has there ever been a time when he/she missed a great deal of school (if yes, explain):____________________

____

Describe any academic difficulties (give details):____

____

Has your child ever been evaluated for a learning disability, ADHD, or gifted:___________________________

When:________________ By whom:______________ Results:____________________________

Has your child ever been retained in any grade (if yes, what grade & reason)____________________________

What are your child's typical grades (circle one):

A&B B&C C&D D&F F

Describe any changes in your child's academic performances in the last year or two:________________________

____

____

SOCIAL HISTORY

Describe how your child interacts with other children:____

____

____

How many friends does he/she play with:_________________

Are his/her friends mainly: (circle one):

Same age Older Younger

Describe activities he/she enjoys doing:____

____

WHO REFERRED YOU TO THIS OFFICE:____

Below is a list of items that describe children. As you read each item, please decide whether it has been true of your child at any time during the past few months. Then circle the number that best describes your child.

0=not at all **1=just a little** **2=quite a bit** **3=very much**

Item	Rating
Always on the go	0 1 2 3
Can't concentrate long	0 1 2 3
Acts confused (in a fog)	0 1 2 3
Acts without thinking	0 1 2 3
Doesn't like books	0 1 2 3
Moods change quickly	0 1 2 3
Shows off or clowns	0 1 2 3
Stares or daydreams	0 1 2 3
Talks too much	0 1 2 3
Squirms or fidgets	0 1 2 3
Gets overly excited	0 1 2 3
Takes dangerous chances	0 1 2 3
Needs constant watching	0 1 2 3
Overactive	0 1 2 3
Keeps at you forever	0 1 2 3
Bites fingers or nails	0 1 2 3
Afraid of many things	0 1 2 3
Feels worthless/inferior	0 1 2 3
Gets teased a lot	0 1 2 3
Irritable	0 1 2 3
Lacks self-confidence	0 1 2 3
Looks very unhappy	0 1 2 3
Nightmares	0 1 2 3
Not liked by children	0 1 2 3
Not interested in much	0 1 2 3
Prefers to be alone	0 1 2 3
Wants everything just so	0 1 2 3
Acts shy or timid	0 1 2 3
Worries about sickness	0 1 2 3
Too fearful or anxious	0 1 2 3
Looks sad or depressed	0 1 2 3
Talks of killing self	0 1 2 3
Too neat and clean	0 1 2 3
Slow moving/low energy	0 1 2 3
Whines a lot	0 1 2 3
Cries easily	0 1 2 3
Feelings easily hurt	0 1 2 3
Highstrung, tense	0 1 2 3
No interest in children	0 1 2 3
Eats too much	0 1 2 3
Withdrawn/uninvolved	0 1 2 3
Cruel to animals	0 1 2 3
Destroys own things	0 1 2 3
Runs away from home	0 1 2 3
Steals at home	0 1 2 3
Cusses or talks dirty	0 1 2 3
Refuses to go to school	0 1 2 3
Sets fires	0 1 2 3
Steals away from home	0 1 2 3
Drinks alcohol	0 1 2 3
Skips school/truant	0 1 2 3
Uses tobacco	0 1 2 3
Abuses drugs	0 1 2 3
Lack of bowel control/soils	0 1 2 3
Deliberately hurts self	0 1 2 3
Twitching or jerking	0 1 2 3
Plays with self sexually	0 1 2 3
Says strange things	0 1 2 3
Shows little affection	0 1 2 3
Speech is unclear	0 1 2 3
Acts seductively	0 1 2 3
Wets self during day	0 1 2 3
Acts like opposite sex	0 1 2 3
Wishes to be younger	0 1 2 3
Wishes to be older	0 1 2 3
Feels unliked by others	0 1 2 3
Accident prone	0 1 2 3
Trouble making friends	0 1 2 3
Sex play with others	0 1 2 3
Wets the bed	0 1 2 3
Wishes to be opposite sex	0 1 2 3
Acts like much younger	0 1 2 3
Acts like much older	0 1 2 3
Acts overly modest	0 1 2 3
Acts disrespectful	0 1 2 3
Argues	0 1 2 3
Bossy	0 1 2 3
Bullies or acts mean	0 1 2 3
Defiant	0 1 2 3
Demanding own way	0 1 2 3
Hits others	0 1 2 3
Tells lies	0 1 2 3
Punishment doesn't help	0 1 2 3

____
Signature of person(s) completing form

____
Relationship/Title

<u>CLIENT INFORMATION</u>

CLIENT NAME**:** ____

ADDRESS**:** ____
STREET

____
CITY **STATE** **ZIP**

HOME PH:________________ CELL PH:____________________ WRK PH:______________

MALE ( ) FEMALE ( ) S.S.#**:**____________________________________
(if minor, Mom & Dad's #)

AGE:________________ DATE OF BIRTH**:**____________________________

MARITAL STATUS: S_______ M_______ D________ W________ SEPARATED______

EMPLOYER: ____
(if minor, parent's employers)

OCCUPATION:____

NEXT OF KIN:_____________________ RELATIONSHIP:_________ PHONE:________________

Who may we thank for referring you to this office?

____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS ANY INSURANCE FORM OR TO OBTAIN AUTHORIZATION FOR SERVICES.

SIGNATURE:____________________________________ DATE:_________________________

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize New Objectives Psychology, Counseling & Neurofeedback Center, Inc. and its associates to administer an evaluation and/or therapy services.

I realize at the initial evaluation the nature, purpose, and course of my treatment will be discussed. I further understand that this consent can be revoked orally or in writing prior to or during the treatment period.

I have read and fully understand the above Consent For Treatment. No guarantee or assurance has been made to me as to the results that may be obtained.

____ ____________________

Client's Name (please print) Date of Birth

____ ____________________

Client's Signature (**or parent/guardian, if client is a minor**) Today's Date

OFFICE FEE AND INSURANCE POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are happy to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our policy.

Billing of Insurance/Assignment of Benefits/Payments
If we are a provider for your insurance company, we will file your claim for you. You will be responsible for any deductible, co-pays and any denied claims. If we are not a provider for your insurance, we will provide you with the necessary documentation you will need to file your claim with your insurance company.

Insurance benefits vary among plans. We will verify your insurance information for you, but insurance companies will NOT guarantee to us that this information is accurate until the claim has been submitted for review. Also, please know that, over time, your insurance plan may change your benefits. They do not notify us of these changes so please inform us if there are any changes to your plan.

If after receiving payment from your insurance company, there is a balance due, we will apply that balance to your credit card given below. This may include a co-pay, deductible, claim denial or a recovery of funds from your insurance company.

Missed Appointment Policy
A *significant* amount of time is blocked out of the therapist's schedule for each session. When appointments are not cancelled in advance, it prevents us from being able to offer that appointment time to others. Therefore, a fee of $25.00 is charged for each missed session NOT cancelled by the business day PRIOR to the appointment (if you have two scheduled sessions on the same day, the charge will be $50.00).

Please Note: *If 3 missed appointment occur within a 12-month period, your account will be charged for any further missed appointments at the regular session rate.*

Credit Card Authorization: Permission is granted to charge my card for any remaining balance after insurance has paid their portion that remains due on the account.

MC / Visa / Discover # ____

Exp___________ Security Code on Back_________ Billing Address Zip Code___________

Name on Card____

Cardholder's Signature______________________________________ Today's Date________

I have read and understand the office fee policies and assign insurance benefits to New Objectives Psychology, Counseling and Neurofeedback Center.

_______________________________________ _______________________________________
Patient Name Patient Signature (parent signature if minor)

LIMITS OF CONFIDENTIALITY

Although confidentiality and privileged communication remain rights of all clients of psychologists according to state law, some courts have held that if an individual is at risk of harming another human being, or themselves, it is the therapist's duty to warn the person or family of the client, other responsible party, or the authorities (e.g. police) of risk in order to prevent harm to self or others.

The therapist will not, if at all possible, inform such parties without first sharing that intention with the client. Every effort will be made to resolve the issue before such a breach of confidentiality takes place. It is also the legal responsibility of the therapist to report any known or suspected cases of neglect or abuse of minors or the elderly.

I have read the above and understand the legal responsibility and agree that New Objectives Psychology, Counseling and Neurofeedback Center, Inc. and its associates to make such decisions to disclose information when necessary.

____   ________________________

Client's Name   Date of Birth

____   ________________________

Client's Signature (**or parent/guardian, if client is a minor**)   Today's Date