

## Client Information

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Referred by: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Current Medication: \_\_\_\_\_

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Allergies to Medication: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Responsible Party: ( ) Self ( ) Spouse ( ) Parent

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Social Security Number of Responsible Party: \_\_\_\_\_

His/Her Employer: \_\_\_\_\_ Address: \_\_\_\_\_

His/Her Job Title: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Group No: \_\_\_\_\_

Please list each professional, program, or hospital that has provided behavioral health services to you or your family. If you don't have their current addresses, please bring this information to the next appointment.

Professional/Program or Hospital	Address/Location	Dates
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Close Family Members (Parents, Siblings, Spouse, Children, etc.)

Name	Relationship	Age	Any Mental Health, Drug/Alcohol Problems
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Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Client Information

Reason for seeking help. Current problems experienced by the Client. Please circle any relevant problems.

Sadness Anxiety Drug Abuse Parenting Spouse Stress Limited Communications  
Behavior problems Sexual behavior Anger control Work conflicts Lonely Nightmares  
Lack of energy Confused thinking Sexual dysfunction Marriage problems Family conflicts  
Stealing Sibling conflicts Physical abuse Criminal/delinquent behavior Assertiveness  
Co-dependency Panic attacks Fears Compulsive behavior Underachievement Hyperactivity  
Short Attention Eating disorder Stuttering Apathy Job Stress Learning disability  
Financial problems Physical disability Death/loss Spirituality Weight/appearance Legal  
problems

My Goals for Treatment:

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# PATIENT LETTER OF AGREEMENT

## INSURANCE BILLING AND PAYMENT POLICY

PLEASE INITIAL EACH ITEM BELOW

\_\_\_\_\_ I request Dr. Daniel J. Christiano, Ph.D to submit billing on my behalf directly to my Insurance Carrier.

\_\_\_\_\_ I acknowledge that payment for services will be forwarded directly to your provider.

\_\_\_\_\_ I authorize the release of any information necessary to process the claim for payment.

\_\_\_\_\_ Payment liability for Non-insured patients and for charges of DENIED services rests with the patient, or responsible party, who is the beneficiary of those services.

\_\_\_\_\_ I agree to be personally responsible for payment of those services, as well as, any legal fees, court costs, collection fees, and late fees connected with collection of payment.

\_\_\_\_\_ I agree to pay a **\$25.00** fee for any personal checks returned for insufficient funds.

\_\_\_\_\_ I agree that the person who brought the child in to see the doctor, is responsible for all the fees associated with the visit.

## APPOINTMENT POLICY

\_\_\_\_\_ The cooperation of each patient is necessary to assure that everyone's needs are met. Frequently, patients are placed on a "waiting list" for appointment cancellations. It is therefore necessary that every consideration be given to avoid missed appointments that could be used by someone else.

\_\_\_\_\_ Each patient is responsible for keeping appointments with his or her provider. If it becomes necessary to break an appointment, it is EXPECTED that a patient contact this office 24 hours in ADVANCE of scheduled appointment.

\_\_\_\_\_ If a patient misses his or her scheduled appointment or fails to provide **24 hours advance notice**, there will be a charge of **\$50.00**. This charge will not and cannot be billed to your insurance company. You are personally responsible for this charge. **In the event my account is turned over for collection. I understand that I will be responsible for all collection costs.**

SIGNATURE OF AGREEMENT

WITNESSED BY:

\_\_\_\_\_

\_\_\_\_\_

DATE \_\_\_\_\_

DATE \_\_\_\_\_

**INFORMED CONSENT FOR TREATMENT**

I \_\_\_\_\_ DOB \_\_\_\_\_ SSN: \_\_\_\_\_

1. I have been informed of my rights and responsibilities as a patient of Dr. Daniel J Christiano, Ph.D.
2. I have been informed about the limits of confidentiality of my records.
3. I have been informed of the cost of services from Dr. Daniel Christiano I understand that I am responsible to pay a co-pay and that it is payable each time I come for treatment.
4. I have been informed about Dr. Daniel J Christiano’s qualifications.
5. I understand that I may address any concerns or grievances with my therapist/doctor at any time. I understand that I may also contact the licensing board which regulates therapist’s/doctor’s professional practice.
6. I am freely choosing to enter into treatment, and I understand that I may Discontinue treatment at any time however, I agree to let Dr. Christiano Know before stopping treatment.
6. I agree that if at any time I feel that I may be a threat to myself or others I will call Dr. Christiano or Banner Helpline (602) 254-4357 before calling 911
8. I give my authorization and consent to receive outpatient diagnostic and treatment services from Dr. Daniel J Christiano. I understand that my therapist/doctor believes that this treatment will help me and there is no guarantee as to the result. I also understand that on occasion there are negative consequences to treatment and I agree to inform Dr. Daniel Christiano if there are unexpected changes in my condition.

\_\_\_\_\_  
Signature of patient or legal consenter

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of staff providing the information

**Daniel J. Christian, Ph.D.**

**Consent For Treatment of Minors (Under 18)**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I/We \_\_\_\_\_ am/are the legal custodial  
parents/guardians of \_\_\_\_\_ and give my/our  
permission to Dr. Daniel J. Christiano, Ph. D to provide psychological services to my/our child.

**If the child's biological parents are not together, please complete:**

What is the custody arrangement of this child? (Joint or sole Custody?) \_\_\_\_\_

Who is primary custodian? \_\_\_\_\_

If applicable, please describe the child's current visitation schedule: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Signatures:**

\_\_\_\_\_  
Parent Signature                      Parent Printed Name                      Date

\_\_\_\_\_  
Parent Signature                      Parent Printed Name                      Date

**Daniel J. Christiano, Ph.D.**

**CHILDHOOD HISTORY FORM**

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_

Street

Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Area Code \_\_\_\_\_

Child's School \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Grade \_\_\_\_\_ Special Placement (if any) \_\_\_\_\_

Child is presently living with

Natural Mother  Natural Father  Stepmother  Stepfather  Foster Mother  Foster Father

Adoptive Mother  Adoptive Father  Other (Specify) \_\_\_\_\_

Non-residential adults involved with this child on a regular basis:

\_\_\_\_\_

\_\_\_\_\_

Source of Referral: Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Briefly state the main problem of this child:

\_\_\_\_\_

\_\_\_\_\_

**PARENTS**

Mother \_\_\_\_\_ Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Age \_\_\_\_\_ Age at time of pregnancy with patient \_\_\_\_\_

School: Highest grade completed \_\_\_\_\_

Any learning problems/Attention problems/behavior problems \_\_\_\_\_

Medical Problems \_\_\_\_\_

Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe: \_\_\_\_\_

\_\_\_\_\_

Father \_\_\_\_\_ Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Age \_\_\_\_\_

School: Highest grade completed \_\_\_\_\_

Any learning problems/Attention problems/behavior problems \_\_\_\_\_

Medical Problems \_\_\_\_\_

Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe: \_\_\_\_\_

\_\_\_\_\_

**SIBLINGS**

Name \_\_\_\_\_ Age \_\_\_\_\_ Medical, Social, or School Problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Pregnancy- Complications**

Excessive vomiting \_\_\_\_\_ Hospitalization required \_\_\_\_\_

Excessive staining/Blood loss \_\_\_\_\_ Threatened miscarriage \_\_\_\_\_

Infection(s) (specify) \_\_\_\_\_  
Toxemia \_\_\_\_\_ Operation(s) (specify) \_\_\_\_\_  
Other illness(es) (specify) \_\_\_\_\_  
Smoking during pregnancy? \_\_\_\_\_ # cigarettes per day \_\_\_\_\_  
Alcoholic consumption during pregnancy Yes/No \_\_\_\_\_ If yes, how often? \_\_\_\_\_  
Medication taken during pregnancy \_\_\_\_\_  
X-ray studies during pregnancy \_\_\_\_\_  
Duration of pregnancy (weeks) \_\_\_\_\_

**DELIVERY**

Type of labor: \_\_Spontaneous \_\_Induced Duration (hrs.) \_\_\_\_\_  
Type of delivery: \_\_Normal \_\_Breech \_\_Caesarean  
Complications: \_\_Cord around neck \_\_Hemorrhage \_\_Infant injured during delivery  
Other \_\_\_\_\_ Birth Weight \_\_\_\_\_

**POST DELIVERY PERIOD**

Jaundice \_\_ Cyanosis (turned blue) \_\_ Incubator Care \_\_ Infection(specify) \_\_\_\_\_  
Number of days infant was in the hospital after delivery \_\_\_\_\_

**INFANCY PERIOD**

Were any of the following present, to a significant degree, during the first year of life? If so, describe:

Did not enjoy cuddling \_\_\_\_\_  
Was not calmed by being held or stroked \_\_\_\_\_  
Difficult to comfort \_\_\_\_\_  
Colic \_\_\_\_\_ Excessive restlessness \_\_\_\_\_  
Excessive irritability \_\_\_\_\_  
Diminished sleep \_\_\_\_\_  
Frequent head banging \_\_\_\_\_  
Difficult nursing \_\_\_\_\_  
Constantly into everything \_\_\_\_\_

**TEMPERAMENT**

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity level: \_\_\_\_\_  
Distractibility: \_\_\_\_\_  
Adaptability: \_\_\_\_\_  
Approach/Withdrawal: \_\_\_\_\_  
Intensity: \_\_\_\_\_  
Mood: \_\_\_\_\_

**MEDICAL HISTORY**

If you child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases: \_\_\_\_\_  
Operations: \_\_\_\_\_  
Hospitalizations: \_\_\_\_\_  
Head injuries: \_\_\_\_\_  
Convulsions \_\_\_\_\_ With fever \_\_\_\_\_ Without fever \_\_\_\_\_  
Coma \_\_\_\_\_ Persistent high fever \_\_\_\_\_ Eye Problems \_\_\_\_\_  
Tics (i.e., eye blinking, sniffing, any repetitive, no-purposeful movements) \_\_\_\_\_  
Ear Problems \_\_\_\_\_ Allergies or Asthma \_\_\_\_\_  
Poisoning \_\_\_\_\_  
Sleep – Does your child settle down to sleep? \_\_\_\_\_ Sleep through the night without disruption? \_\_\_\_\_  
Experience nightmares, night terrors, sleep walking, sleep talking? \_\_\_\_\_  
Is your child a very restless sleeper? \_\_\_\_\_ Does you child snore? \_\_\_\_\_  
Appetite - \_\_\_\_\_

**PRESENT MEDICAL STATUS**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Present illness child is being treated for \_\_\_\_\_  
Medicine child takes regularly \_\_\_\_\_

**DEVELOPMENTAL MILESTONES**

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall exactly, check items at right:

	Age	Early	Normal	Late
Smiled _____				
Sat without support _____				
Crawled _____				
Stood without support _____				
Walked without assistance _____				
Spoke first words _____				
Said phrases _____				
Said sentences _____				
Bladder trained, day _____				
Bladder trained, night _____				
Bowel trained, day _____				
Bowel trained, night _____				
Rode tricycle _____				
Rode bicycle (without training wheels) _____				
Buttoned clothing _____				
Tied shoelaces _____				
Named colors _____				
Named coins _____				
Said alphabet in order _____				
Began to read _____				

**COORDINATION**

Rate your child on the following skills:

	Good	Average	Poor
Walking _____			
Running _____			
Throwing _____			
Catching _____			
Shoelace Tying _____			
Buttoning _____			
Writing _____			
Athletic Abilities _____			
Excessive number of accidents compared to other children _____			

**COMPREHENSION AND UNDERSTANDING**

Do you consider your child to understand direction and situation as well as other children his or her age?  
If not, why not? \_\_\_\_\_

How would you rate your child's overall intelligence compared to other children?  
Below \_\_\_\_\_ Above Average \_\_\_\_\_ Average \_\_\_\_\_

**SCHOOL HISTORY**

Were you concerned about your child's ability to succeed in kindergarten? If so, please explain:  
\_\_\_\_\_

Rate you child's school experience related to academic learning:

	Good	Average	Poor
Pre-school _____			
Kindergarten _____			

Current grade \_\_\_\_\_

To the best of your knowledge, at what grade level is your child functioning:

Reading \_\_\_\_\_ Spelling \_\_\_\_\_ Arithmetic \_\_\_\_\_

Has your child ever had to repeat a grade? If so, when? \_\_\_\_\_

Present class placement: Regular class \_\_\_\_\_ Special Class (if so, specify) \_\_\_\_\_

Kinds of special counseling or remedial work your child is currently receiving \_\_\_\_\_

Describe briefly any academic school problems \_\_\_\_\_

Rate your child's school experiences related to behavior

Good

Average

Poor

Pre-school \_\_\_\_\_

Kindergarten \_\_\_\_\_

Current grade \_\_\_\_\_

Does your child's teacher describe any of the following as significant classroom problems?

Doesn't sit still in his or her seat \_\_\_\_\_

Frequently gets up and walks around classroom \_\_\_\_\_

Shouts out. Doesn't wait to be called on \_\_\_\_\_

Won't wait his/her turn \_\_\_\_\_

Doesn't cooperate well in group activities \_\_\_\_\_

Typically does better in one-to-one relationship \_\_\_\_\_

Doesn't respect the rights of others \_\_\_\_\_

Doesn't pay attention during storytelling or show and tell \_\_\_\_\_

Any other classroom behavioral problems \_\_\_\_\_

### PEER RELATIONSHIPS

Does your child seek friendships with peers? \_\_\_\_\_

Is your child sought by peers for friendship? \_\_\_\_\_

Does your child play with children primarily his or her own age? \_\_\_\_\_

Describe any problems your child is having with peers? \_\_\_\_\_

### HOME BEHAVIOR

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her own age.

Fidgets with hands feet or squirms in seat \_\_\_\_\_

Has difficulty remaining seated when required to do so \_\_\_\_\_

Easily distracted by extraneous stimulation \_\_\_\_\_

Has difficulty awaiting his turn in games or group situations \_\_\_\_\_

Blurts out answers to questions before they have been completed \_\_\_\_\_

Has problems following through with instructions (usually not due to opposition or failure to comprehend) \_\_\_\_\_

Has difficulty paying attention during tasks or play activities \_\_\_\_\_

Shifts from one uncompleted activity to another \_\_\_\_\_

Has difficulty playing quietly \_\_\_\_\_

Often talks excessively \_\_\_\_\_

Interrupts or intrudes on others (impulsive) \_\_\_\_\_

Does not appear to listen to what is being said \_\_\_\_\_

Does things necessary for tasks or activities in home \_\_\_\_\_

Boundless energy and poor judgment \_\_\_\_\_

Impulsivity (poor self-control) \_\_\_\_\_

History of temper tantrums \_\_\_\_\_

Temper outbursts \_\_\_\_\_

Frustrates easily \_\_\_\_  
Sloppy table manners \_\_\_\_  
Sudden outbursts of physical abuse of other children \_\_\_\_  
Acts like he or she is driven by a motor \_\_\_\_  
Wears out shoes more frequently than siblings \_\_\_\_  
Excessive number of accidents \_\_\_\_  
Doesn't seem to learn from experience \_\_\_\_  
Poor memory \_\_\_\_  
A "different child" \_\_\_\_  
How well does your child work for rewards? \_\_\_\_\_  
Does your child create more problems, either purposeful or non-purposeful, within the home setting than his or her siblings? \_\_\_\_\_  
Does your child have difficulty benefiting from his experiences? \_\_\_\_\_  
Types of discipline used with your child \_\_\_\_\_  
Is there a particular form of discipline that has proven effective? \_\_\_\_\_  
Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? \_\_\_\_\_

**INTERESTS AND ACCOMPLISHMENTS**

What are you child's main hobbies and interests? \_\_\_\_\_  
\_\_\_\_\_  
What are your child's greatest accomplishments? \_\_\_\_\_  
\_\_\_\_\_  
What does your child enjoy doing most? \_\_\_\_\_  
\_\_\_\_\_  
What does your child dislike doing most? \_\_\_\_\_  
\_\_\_\_\_  
What do you like most about your child? \_\_\_\_\_  
\_\_\_\_\_

**LIST ANY OTHER PROFESSIONALS CONSULTED (including family doctor)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL REMARKS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_