

Client Information

Date: _____

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Referred by: _____

Primary Physician: _____ Current Medication: _____

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:

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:

