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Patient Information

Date: ____________________ Name: ____________________________________ Birth Date: _____________________________

Address: ____ City: ______________________ Zip: ______________________

Home Phone: _______________________ Cell Phone: _______________________ email: ___________________________________

Referred by: ___________________________________ Primary Physician: ____

Current Medication(s): ____

Emergency Contact Name: ____ Relationship: _____________________________

Phone: ___________________________ Cell Phone: __________________________ Work Phone: _________________________

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

Address: ____

Social Security Number of Responsible Party: _________________________________ His/Her Employer: ____________________

Address: ____

His/Her Job Title: ____ Work Phone: ______________________________________

I UNDERSTAND THAT ALTHOUGH DR. LaMORGESE DOES ACCEPT SOME INSURANCE, THIRD PARTY CARRIERS MAY NOT BE CONTRACTING DR. LaMORGESE AND I HAVE VERIFIED WHETHER THESE SERVICES ARE COVERED AND IF NOT, I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT.

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 Close Family Members (Parents, Siblings, Spouse, Children, etc.)
Name Relationship Age Any Mental Health, Drug/Alcohol Problems

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____

____

____

____

Patient or Parent Signature: ____ Date: ___________________________________

Patient or Parent Printed Name: ____

Patient Information

Name: ______________________________ Date: ______________________

Reason for seeking help and/or Current problems experienced.
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

(If the minor is age 7-9, guardian answers, 10-12 please answer these questions together, 13+ answer should answer independently)

In a few words, what do you think therapy is all about? ______________________________

____

____

How long do you think your therapy should last? ______________________________

____

My/Our Goals for Treatment: ______________________________

____

____

What personal qualities do you think the ideal therapist should possess? ______________________________

____

____

Anything else you would like your doctor/therapist to know? ______________________________

____

____

____

PATIENT/RESPONSIBLE PARTY LETTER OF AGREEMENT
NON-INSURANCE BILLING AND PAYMENT POLICY
PLEASE INITIAL EACH ITEM BELOW

____________ I authorize Dr. LaMorgese to bill my/our insurance carrier for services and provide any information regarding services or treatment requested by said carrier.

____________ I acknowledge that all copays/coinsurance/not covered charges for services will be paid by

me: __________________________.

____________ 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.

Responsible Party Name and Relationship: ____

Responsible Party Signature: ______________________________ Date: ________________________

Witness to Signature: ____________________________________ Date: ________________________

CHILDHOOD HISTORY FORM

Child's Name____ Birth Date____________________ Age___________ Sex_________

Home Address____

Home Phone (_____)__________________ Child's School/City____

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: ____

____

Referral Source: Name ____ Phone ________________________________

Address ____

Briefly state the main problem of this child: ____

____

____

PARENTS

Mother ______________________________________ Occupation _________________________ Bus. Phone____________________

Current Age ___________ Age and marital status 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____________________

Current Age ___________ School: Highest grade completed ____

Any learning problems/Attention problems/behavior problems ____

Medical Problems ____

Have any of Father's blood relatives experienced problems similar to those your child is experiencing? If so, describe: ____________

____

____

SIBLINGS

Names, ages, medical/psychological/learning issues:

____

____

____

Pregnancy- Complications

Excessive vomiting (circle) YES / NO Hospitalization required YES / NO Excessive staining/Blood loss YES / NO

Threatened miscarriage) YES / NO Infection(s) (specify) YES / NO Toxemia) YES / NO

Operation(s) (specify) ____

Other illness(es) (specify) ____

Smoking during pregnancy?) YES / NO #cigarettes/day____________ Alcohol during pregnancy YES / NO Amt ___________

Medication taken during pregnancy ____

X-ray studies during pregnancy ___________________________________ Duration of pregnancy (weeks)____________________

DELIVERY

Type of labor: Spontaneous YES / NO Induced Duration YES / NO #hrs.________ Type of delivery: Normal YES / NO

Breech YES / NO Caesarean YES / NO Cord around neck YES / NO Hemorrhage YES / NO Infant injured in delivery YES / NO

Other __________________________ Birth Weight ___________ Inches ___________ APGAR Scores ________________________

POST DELIVERY PERIOD

Jaundice YES / NO Cyanosis (turned blue) YES / NO Incubator Care YES / NO 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 YES / NO With fever YES / NO Without fever YES / NO Coma YES / NO Persistent high fever YES / NO

Eye Problems YES / NO Tics (i.e., eye blinking, sniffing, any repetitive, no-purposeful movements) YES / NO Type:____________

Ear Problems YES / NO Type: ___________ Allergies or Asthma YES / NO Poisoning YES / NO Type: _________________

Sleep – Does your child settle down to sleep? YES / NO Sleep through the night without disruption? YES / NO

Experience nightmares, night terrors, sleep walking, sleep talking? YES / NO Is your child a very restless sleeper? YES / NO

Does you child snore? YES / NO Appetite ____

PRESENT MEDICAL STATUS

Height __________ Weight __________ Present illness(es) 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. Please note their age, if you cannot recall exact age, please note if you think it was early, normal, or 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 as Good, Average, or Poor :

Walking ___________________________ Running _______________________________ Throwing ___________________________

Buttoning _________________________ Writing _______________________________ Athletic Abilities ____________________

Excessive number of accidents compared to other children: YES / NO Types: ____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand direction and situation as well as other children his or her age? YES / NO

If no, why not? ____

How would you rate your child's overall intelligence compared to other children? Below____ Average_____ Above 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 as Good, Average, or Poor:

Pre-school ______________________ Kindergarten __________________________ Current grade __________________________

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

Reading ________________________ Spelling _______________________________ Arithmetic______________________________

Has you child ever had to repeat a grade? YES / NO If so, when and what grade? ____

Present class placement: Regular class _______________ Special Class (if so, specify) YES / NO ____________________________

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 as Good, Average, or 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 as Good, Average, or Poor:

Pre-school ______________________ Kindergarten __________________________ Current grade __________________________

Frequently gets up and walks around classroom YES / NO Shouts out YES / NO Doesn't wait to be called on YES / NO

Won't wait his/her turn YES / NO Doesn't cooperate well in group activities YES / NO

Typically does better in one-to-one relationship YES / NO Doesn't respect the rights of others YES / NO

Doesn't pay attention during storytelling or show and tell YES / NO Any other classroom behavioral problems_ YES / NO

Describe: ____

PEER RELATIONSHIPS

Does your child seek friendships with peers? YES / NO Is your child sought by peers for friendship? YES / NO

Does your child play with children primarily his or her own age? YES / NO 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 on purpose or not, within the home setting than his or her siblings? YES / NO

Does your child have difficulty benefiting from his experiences? YES / NO

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)(we need signed releases to speak to them)

____

____

____

ADDITIONAL REMARKS:

____