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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 DR. LaMORGESE DOES NOT ACCEPT INSURANCE, THIS SERVICE ARE PRIVATE PAY ONLY

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

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 understand that Dr. Stacy E. LaMorgese does not accept insurance payments.

_____ I acknowledge that payment 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 your 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: