

CHILDREN'S HISTORY FORM

Instructions to Parents: Please fill out to the best of your knowledge. Write N/A if not applicable to your child. Circle appropriate answers where indicated. Add any additional comments if you wish.

Child's Name: _____ Date of Birth: _____

Home Address _____

Home Phone _____

Pediatrician _____

Address _____

Phone _____

School Currently Attending _____ Grade _____

Address _____

Phone _____

Referred By _____

Name of Person Filling Out This Form _____

Relationship to Child _____

Today's Date _____

Pregnancy with This Child- (Check Appropriate Answer)

	<u>No</u>	<u>Yes</u>	<u>Don't Know</u>	<u>Comments</u>
Anemia	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Toxemia	_____	_____	_____	_____
Swollen Ankles	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Bleeding	_____	_____	_____	_____
Virus	_____	_____	_____	_____

	<u>No</u>	<u>Yes</u>	<u>Comments</u>
Rh Incompatibility	_____	_____	_____
Hospitalization	_____	_____	WHEN? _____ WHY? _____

Birth History

Name of Hospital _____

	<u>No</u>	<u>Yes</u>	
Were You Given Medication?	_____	_____	
Did You Have Natural Childbirth?	_____	_____	
Were You Under Anesthesia?	_____	_____	
Was Labor Induced?	_____	_____	Why? _____

	<u>No</u>	<u>Yes</u>
Was This A Breech Delivery?	_____	_____
Did You Have a Caesarian?	_____	_____
Why? _____		

Any Complications? _____

Infancy

No Yes

Did You Have Problems With Feeding? ___ ___

Describe _____

Was The Baby Colicky? ___ ___

How Many Months? _____

Did The Baby Require Formula Change? ___ ___

Describe _____

Difficulty Sucking? ___ ___

Difficulty Chewing? ___ ___

Fail To Gain Weight? ___ ___

NO YES

Fail To Grow Normally? ___ ___

Describe _____

Was the Baby Normally Active? ___ ___

Describe _____

Did The Baby Have Tremors? ___ ___

NO YES

Did The Baby Have Convulsions? ___ ___

Describe _____

Development

Motor

	<u>Age in Months</u>	<u>Years</u>
Sat Alone	_____	_____
Walked Without Holding On	_____	_____
Fed Self	_____	_____
Dressed Self	_____	_____
Tied Shoes	_____	_____
Pedaled Tricycle	_____	_____
Rode Bicycle	_____	_____
Swam	_____	_____

Language

	<u>Age in Months</u>	<u>Years</u>
Spoke First Words	_____	_____
Put 2 to 3 Words Together	_____	_____
Good Sentence Structure	_____	_____

Toileting

	<u>Age in Months</u>	<u>Years</u>
Trained for Urine	_____	_____
Trained for Bowels	_____	_____
Bed Wetting	NO _____ YES _____	
Age Started	_____	
How Many Times A Month?	_____	
Age Controlled	_____	

Behavior

No Yes

Shy _____

Immature _____

Well Behaved _____

Stubborn _____

Impulsive _____

Temper Tantrum _____

Thumb Sucking _____

Head Banging _____

Nail Biting _____

Average Intelligence _____ _____

More Active Than Other Children _____ _____

Clumsy In Using Hands _____ _____

Poor Handwriting _____ _____

Clumsy In Walking _____ _____

Tics and Twitching _____ _____

Excessively Fidgety Or Have
Trouble Staying In Seat _____ _____

Difficulty Paying Attention _____ _____

Has Difficulty Staying At One Activity
For Reasonable Length Of Time _____ _____

Sleep Problems

No Yes

Difficulty Staying Asleep _____

Frequent Wakening _____

Early A.M. Wakening _____

No Yes

Sleep Walking _____

Nightmares _____

Past Medical History

No Yes

Has Child Had Meningitis Or Encephalitis? _____

At What Age in MONTHS _____ YEARS _____

Head Injury? _____

At What Age in MONTHS _____ YEARS _____

Loss of Consciousness? _____

Present Medications:

<u>NAME</u>	<u>DOSE</u>	<u>TIME GIVEN</u>	<u>REASON GIVEN</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

No Yes Results

Have Any Special Tests Done? _____

Eye Exam? _____

Age in MONTHS _____ YEARS _____

Hearing Exam? _____

Age in MONTHS _____ YEARS _____

Other? _____

Name of Test _____

Have You Consulted Any Other Medical Specialists For The Child? NO ___ YES ___

If So, Whom? _____ At What Age? _____

Reason _____ Results _____

Has The Child Had Any Emotional Adjustment or Behavioral Problems? NO ___ YES ___

Describe At What Age And What Type _____

Has the Child Received Any Psychological or Psychiatric Treatment? NO ___ YES ___

By Whom? _____ When? _____

Place _____

School History (if applicable)

		AGE STARTED	
	<u>No</u>	<u>Yes</u>	
			<u>Months</u> <u>Years</u>

Did Child Attend Nursery School? ___ ___ ___ ___

Any Problems? ___ ___ Describe: _____

Did Child Attend Kindergarten? ___ ___ ___ ___

Any Problems? ___ ___ Describe: _____

First Grade – Age Started _____

Any Problems? ___ ___ Describe: _____

Present School Attending: _____ Grade _____

Has The School Reported Problems With:

	<u>No</u>	<u>Yes</u>
Reading	_____	_____
Spelling	_____	_____
Arithmetic	_____	_____
Writing	_____	_____
Behavior	_____	_____
Social Adjustment	_____	_____
Attention Span	_____	_____
Distractibility	_____	_____
Hyperactivity	_____	_____
Following Directions	_____	_____
Getting Along With Children	_____	_____

Describe Any Problems Noted Above In the Space Below:

	<u>NO</u>	<u>YES</u>
Does Your Child Like School?	_____	_____
Has Any Psychological Testing Been Done?	_____	_____
If So, Where? _____ By Whom? _____		
What Recommendations Were Made? _____		
Is This Child In Special Education Classes?	_____	_____
What Kind? _____		
At What Age Was (S)he Placed There? _____		

	<u>No</u>	<u>Yes</u>
Does Your Child Receive Any Special Services In School? (Resource Room, Tutoring, Remedial Reading, Speech, etc.)	_____	_____

Has The Child Received Special Help Privately? _____

What Type? _____

By Whom? _____ AGE: _____

How Often? _____

Family History (Under Parents List Names Of Children In Order Of Birth)

	Grade			SCHOOL OR
AGE	EDUCATION	OCCUPATION	HEALTH	BEHAVIORAL PROBLEMS

Father _____

Mother _____

Social History

Who Lives At Home? _____

What Language Is Spoken At Home? _____

	<u>NO</u>	<u>YES</u>
Are There Significant Marital Conflicts?	_____	_____
Are There Significant Conflicts Between Child and Parents?	_____	_____
Are There Significant Conflicts Between The Children?	_____	_____
Do Parents Agree On How To Discipline The Child?	_____	_____

Who Disciplines and How? _____

How Does Child Respond To Discipline? _____

Does Child Have Difficulty Getting Along with Children His Own Age? NO ___ YES ___

Does Child Have Difficulty Getting Along with Adults? NO ___ YES ___

Does Child Have Difficulty Getting Along with Brothers/Sisters? NO ___ YES ___

Does Child Have A Best Friend? NO ___ YES ___ Same Sex? NO ___ YES ___

What Special Interest Does The Child Have? _____

Financial Policy

Thank you for choosing me as your mental health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of the Financial Policy, which you are *required to read and sign prior to any treatment*.

All patients must complete our Information and Insurance form before seeing the doctor.

**- FULL PAYMENT IS DUE AT THE TIME OF SERVICE -
- WE ACCEPT CASH, CHECKS, OR CREDIT CARDS -**

Appointments are scheduled for the same day and time each week unless altered by the doctor or yourself in advance.

Timely Payment

I understand that *payment is expected upon receipt of service*. I agree to pay 1.5% per month if I am delinquent in my account and have to be re-billed. I also understand that should any action need to be taken to collect for professional services rendered, the professional provider shall be entitled to recover any attorney fees.

Regarding Insurance

We do not accept insurance.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid by credit card or cash.

Missed Appointments

We require, at least 24 hours in advance, to cancel an appointment. Any calls made after 5:00pm or on Saturdays and Sundays to cancel appointments will **not** be accepted. Thus, if your appointment is after five o'clock, *you must call before five o'clock on the previous day*. If your appointment is on a Monday, *you must call before 5:00pm on the previous Friday*. **Please help us serve you better by keeping scheduled appointments.**

Telephone Time

Unless it is an emergency, all therapeutic contacts take place in the office. Should you request therapeutic interventions on the telephone you will be charged \$225 per hour prorated in .10 hours. Most insurance companies will not reimburse telephone time.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

X _____
Signature of Patient or Responsible Party

Date _____

Wade H. Silverman, Ph.D.

American Board of Professional Psychology Diplomate

Notice of Privacy Practices – Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP and you may have a copy of this to read and refer to it for more information. However, we can't cover all possible situations so please talk to our Office Manager (see the end of this pamphlet) about any questions or problems.

We will use the information about your health, which we get from you or others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities, which are called, in the law, health care operations. After you have read this NPP, we will ask you to sign a consent form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If you or we want to use or disclose (send, share release) your information for any other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Of course we will keep your health information private, but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place, which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you such as your medical billing records. You can even get a copy of these records, but we may charge you. Contact our Office Manager to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kind of changes (called amending) to your health information. You have to make this request in writing and send it to our Office Manager. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NNP, we will post the new version in our waiting area and you can always get a copy of the NPP from our Office Manager.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Office Manager and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact the Psychologist who is **Dr. Wade H. Silverman** and can be reached by phone at 786-536-7033.

The effective date of this notice is April 30, 2003.

Also, you may have other rights, which are granted to you by the laws of our state and these may be the same or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

Signature: _____

Date: _____

Wade H. Silverman, Ph.D.

Diplomate American Board of Professional Psychology
(786)-536-7033 ; (561)-999-9890

Aventura

1031 Ives Dairy Road
Suite 228
Aventura, FL 33179

Boca Raton

4710 NW 2nd Avenue
Suite 104
Boca Raton, FL 33431

Patient Rights

- The right to refuse and/or terminate treatment at any time;
- The right to a complete description and explanation of any treatment;
- The right to refuse any electronic and/or visual recording of my treatment;
- The right to confidentiality whereby information revealed to me during treatment will be kept strictly confidential and will not be revealed to anyone without authorization. However, **knowledge of child abuse, intent to harm others or myself will be reported.**

I hereby certify and I understand the above and have been informed of policies and procedures regarding appointments and fees. Furthermore, I authorize treatment by Wade H. Silverman.

Signature of Patient

Date

Signature of Guardian (if applicable)

Date

Wade H. Silverman, Ph.D.

Child Clinical Fees

OUTPATIENT PSYCHOTHERAPY

SERVICE:

FEE:

Diagnostic Interview

\$250.00/hr.

Individual Psychotherapy

\$200.00/45 min.
\$250.00/1 hr.

Assessment

SERVICE:

FEE:

Behavioral Assessment System for Children (BASC-3)

\$325.00

Millon Adolescent Clinical Inventory (MACI)

\$225.00

Minnesota Multiphasic Personality Inventory (MMPI-A)

\$375.00

Millon Pre-Adolescent Clinical Inventory (MPACI)

\$225.00

Reynolds Adolescent Depression Scale-2 (RADS-2)

\$100.00

Piers-Harris 3

\$150.00

Reynolds Child Depression Scale-2 (RCDS-2)

\$150.00

Reynolds Child Manifest Anxiety (RMAS-2)

\$100.00

Wechsler Intelligence Scale for Children (WISC-IV)

\$650.00