PATIENT INFORMATION

Date / / **Clinician** Amy Sheinberg, Ph.D.

Patient's Name _____ **Date of Birth** ___/___/___
Last First M.I.

Home Address _____
Street City State Zip Code

Appointment reminders are sent via email, please print email address you want to use for reminders and other health care information. **Email** (Self / Parent / Guardian) _____

Email (Self / Parent / Guardian) _____

Home Phone (Self / Parent / Guardian) _____ **Work Phone** (Self / Parent / Guardian) _____

Mobile Phone (Self / Parent / Guardian) _____ **Other Phone** (Self / Parent / Guardian) _____

Drivers License # (Self / Parent / Guardian) _____ **SS#** (Patient) _____ - - _____

Gender M F **Race** African American Asian Caucasian Hispanic Native American Other _____

Marital Status (Self / Parents / Guardians) Single Married Partnered Separated Divorced Widowed

Employer (Self / Parent / Guardian) _____ **Occupation** (Self / Parent / Guardian) _____

Work Address (Self / Parent / Guardian) _____
Street City State Zip Code

If Child, Parent's Name _____ **Parent's Name** _____

Stepparent's Name _____ **Stepparent's Name** _____

Person to notify in case of emergency _____ **Relationship to patient** _____

Address _____ **Phone** _____
Street City State Zip Code

GUARANTOR INFORMATION (where statement will be sent, if different from above)

Name _____ **Relationship to patient** _____
Last First M.I.

Address _____
Street City State Zip Code

Home Phone _____ **Work Phone** _____

Date of Birth _____ **SS#** _____ - - _____

Employer _____ **Occupation** _____

Address _____
Street City State Zip Code

REFERRAL INFORMATION

Referred by _____

CONSENT FOR TREATMENT

GENERAL CONSENT FOR TREATMENT: I authorize and request my practitioner carry out diagnostic procedures, psychological exams, and/or therapeutic treatment, which may be required at the time or during the course of my treatment. I understand the purpose of these procedures and recommendations will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Furthermore, this process may bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response in the process of feeling better and that my practitioner will help me work through these. The success of our work together depends on the quality of the efforts on both parts, and the realization that I am responsible for lifestyle choice/changes that may result from therapy, specifically, one risk of marital therapy is the possibilty of exercising the divorce option.

I am aware that I may stop my treatment with this practitioner at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (For example, if my treatment has been court-ordered, I will have to answer to the court).

Signature of Patient/Parent/Guardian/Conservator	Social Security Number	Date

GENERAL CONSENT FOR THE TREATMENT OF A CHILD OR DEPENDENT: _____ Not Applicable

I am the legal guardian or representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health care services to the patient.
I understand that all policies described in this statement apply to patient, _____, who I represent.

Signature of Legal Guardian/Parent	Relationship to Patient	Date

CONSENT FOR TREATMENT OF CHILD OR DEPENDENT OF DIVORCED PARENTS: _____ Not Applicable

Psychotherapy can be a very important resource for children of separation and divorce. Establishing a therapeutic alliance outside of the home can:

- Facilitate open and appropriate expression of the strong feelings, which routinely accompany family transitions, including guilt, grief, sadness and anger
- Provide an emotionally neutral setting in which children can explore these feelings
  Help children understand and accept the new family composition and the plans for contact with each member of the family
- Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities

However, the usefulness of such therapy is extremely limited when the therapy itself becomes simply another matter of dispute between parents. With this in mind, and in order to best help your child, I strongly recommend that each of the child's caregivers (e.g., parents, step-parents, day-care workers, Guardian Ad Litem [GAL]) mutually accept the following as requisites to participation in therapy.

1. As your child's psychotherapist, it is my primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician should matters of your child's physical health be relevant to this therapy.

2. I ask that all caregivers remain in frequent communication regarding this child's welfare and emotional well being. Open communication about his or her emotional state and behavior is critical. In this regard, I invite each of you to initiate frequent and open exchange with me as your child's therapist.

3. I ask that all parties recognize and, as necessary, reaffirm to the child, that I am the child's helper and not allied with any disputing party.

4. I strongly recommend that all caregivers involved choose to participate in The Guardian Angels psycho-educational groups and/or read the book, Mom's House, Dad's House: Making Two Homes For Your Child, by Isolina Ricci. These resources help separating and divorced parents learn basic strategies for conducting a divorce in the best interests of the child.

5. Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child in these circumstances:
   - I keep records of all contacts relevant to your child's well being. These records are subject to court subpoena and may, under some circumstances, be solicited by parties to your divorce, including your attorneys.
   - Any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters, which are brought to my attention, that are irrelevant to the child's welfare may be kept in confidence.
   - **I am legally obligated to bring any concern regarding health and safety to the attention of relevant authorities. When possible, should this necessity arise, I will advise all parties regarding my concerns.**

6. This psychotherapy will not yield recommendations about custody. In general, I recommend that parties who are disputing custody strongly consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than try to settle a custody dispute in court.

7. Payment for my services is due, in full, at the time of service in a manner agreed to by all parties involved. Any outstanding balance accrued (for example, in conference with attorneys, the GAL, or teachers), must be paid promptly and in full. I will either bill you or ask for an initial retainer of $ TBD prior to commencing this therapy to be held against charges incurred and subject to reimbursement at the conclusion of this therapy, as appropriate.

Your understanding of these seven points and agreement in advance of starting this therapy may resolve difficulties that would otherwise arise and will help make this therapy successful. Your signature, below, signifies that you have read and accept these points.

Caregiver name	Printed name	Date
Caregiver name	Printed name	Date
Caregiver name	Printed name	Date
Caregiver name	Printed name	Date
Child's name (printed)	Date of birth	Age

CONDITIONS OF SERVICES

Initial

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation, and professional communication where appropriate and only when specified by a signed release of information form (see attached forms).

Initial

AUTHORIZATION TO RELEASE INFORMATION TO THE INSURANCE COMPANY: I authorize the release of information to the assigned insurance company for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

Initial

ASSIGNMENT OF INSURANCE BENEFITS: The practitioner does not accept assignment of insurance benefits.

FINANCIAL AGREEMENT, CO-PAYMENTS AND OFFICE POLICIES

Initial

At the time of your appointment, please have your driver's license available for us to photocopy for our records. It is important for you to understand that your charges are your responsibility.

Initial

I will immediately notify the practitioner or the office staff of any changes in my address, phone numbers and payment information.

Initial

I understand that I am responsible for obtaining prior authorization for treatment from my insurance carrier, if necessary. If I have not done so before treatment is rendered, I am aware that my insurance may not reimburse me.

Initial

If choosing to file for my insurance benefits, I understand that I must verify and obtain authorization for services unless otherwise specified. I understand that if my insurance benefits are managed by a managed care organization (MCO) that they can refuse to allow my practitioner to treat me. The MCO can refuse to pay for any of my treatment or may pay only a very small part of its cost. Finally, it can limit the kinds of treatments that can be provided to me. Even if the MCO does give the go-ahead, I understand that it can limit the number of times I am allowed to meet with the practitioner and may have a maximum dollar amount or set number of appointments that are allowed for therapy. I understand that the MCO is not obligated to let me use all of these appointments.

Initial

I understand that the business office may contact me in order to assist me in the coordination of treatment.

Initial

If my account with the practitioner is unpaid and arrangements have not been made for a payment plan, the practitioner can use legal means to get paid. The only information the practitioner will give to the court, a collection agency, or a lawyer will be my name and address, the dates we met for professional services, and the amount due to the practitioner.

Initial

I understand that payment is due at the time of service. A deductible may first have to be met before I will start receiving reimbursements. The practitioner accepts cash, personal checks, and major credit cards. The charge for a returned check is $25. When a NSF check is returned to the practitioner, it is the office policy that the patient will no longer be able to write checks to this practitioner. Cash or major credit cards will be accepted as an alternative unless other arrangements are made with the practitioner.

APPEALS AND GRIEVANCES

Initial

I understand that my insurance company does not delegate appeals and/or grievances to my practitioner. I acknowledge my right to request reconsideration (an appeal) in the case that my outpatient visits are denied certification. I understand that I would request an appeal through my practitioner who can assist me in obtaining information on contacting my insurance company and that I risk nothing in exercising this right.

Initial

I understand that I may submit a complaint or grievance to my practitioner at any time to register a complaint about my care. I may also send the complaint directly to the appropriate governing board.

THERAPEUTIC RELATIONSHIP

Initial

My relationship with the practitioner is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the practitioner not have any other type of relationship with me. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The practitioner's care is about helping me, but is not in a position to be my friend or to have a social or personal relationship with me. Gifts, bartering or trading services are not appropriate and should not be shared between me and the practitioner.

PRACTITIONER'S INCAPACITY OR DEATH

Initial

I acknowledge that in the event the identified practitioner becomes incapacitated or dies, it will become necessary for another practitioner to take possession of my files and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by my practitioner to take possession of my file and records and provide me with copies upon request, or to deliver them to a practitioner of my choice.

OFFICE HOURS AND AFTER HOURS EMERGENCIES

Initial

Office hours (subject to change) are Monday -Thursday, 8 a.m.- 6 p.m. Should emergencies occur after hours, please call the main number and instructions will be given for how to contact the practitioner.

APPOINTMENTS

Initial

I understand that each practitioner has an individual policy about reminder calls, emails or texts. However, whether a confirmation call, email or text is placed, I am still held responsible for remembering my appointment time and day.

Initial

I give consent for the practitioner or a member of the office staff to leave me a voicemail, email or message should they not be able to directly reach me.

Initial

I understand that I am responsible for remembering my appointment date and time. If an appointment is missed or cancelled with less than 24 hours notice (or by noon on Friday if appointment is on Monday), I will be billed according to the practitioner's fee schedule. Insurance may not be billed for these late cancellations or no-shows. Repeated no-show appointments could result in referring me for reassignment to another practitioner.

Initial

Therapy sessions are, in general, 45 minutes in length. The practitioner will discuss the length of the session as well as a fee schedule. The number of sessions needed depends on many factors, including designanted goals and will be discussed by the practitioner.

CONFIDENTIALITY

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about, in other words, the "confidentiality" of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret.

1. **When you or other persons are in physical danger**, the law requires me to tell others about it. Specifically:

   a. If I come to believe that you are threatening serious harm to another person, I am not required by law to try to protect that person. However, hospitalization may be considered for you.

   b. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.

   c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.

   d. If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

   In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. In general, **if you become involved in a court case or proceeding**, you can prevent me from testifying in court about what you have told me. This is called "privilege," and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

   a. In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.

   b. In cases where your emotional or mental condition is important information for a court's decision.

   c. During a malpractice case or an investigation of me or another therapist by a professional group.

   d. In a civil commitment hearing to decide if you will be admitted to a psychiatric hospital.

   e. When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.

3. There are a few other things you must know about confidentiality and your treatment:
   a. I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you.

   b. I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.

4. **Children and families create some special confidentiality questions.**

   a. When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal-rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have he right to general information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told. This is especially true if these others' actions put them or others in any danger.

   b. In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist.

c. If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this.

d. If you and your spouse have a custody dispute, or a court custody hearing is coming up, I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.

e. If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.

f. At the start of family treatment, we must also specify which members of the family must sign a release form for the common record I create in the therapy or therapies. (See point 6b, below.)

5. **Confidentiality in group therapy is also a special situation.**
In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws that I have to work under. You cannot be certain that they will always keep what you say in the group confidential.

6. Finally, here are a few other points:

a. I will not record our therapy sessions on audiotape or videotape without your written permission.

b. If you want me to send information about our therapy to someone else, you must sign a REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION form. I have copies, which you can see so you will know what is involved.

c. Any information that you share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Situations that are not mentioned here come up only rarely in my practice. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally.

In the event that the undersigned practitioner resonably believes that I am a danger, physically or emotionally, to myself. I specifically consent for the practitioner to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name	Telephone number
_____	_____
_____	_____
_____	_____

The signatures here show that we each have read, discussed, understand, and agree to abide by the points presented above.

_____ _____
Signature of patient (or person acting for client) Date

_____
Printed name

_____ _____
Signature of practitioner Date

Amy Sheinberg, Ph.D.
8333 Douglas Ave., Suite 1240 Dallas, TX 75225
214 361 0660

Notice of Privacy Practices

To my patients: This notice describes how health information about you (as a patient in my practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Commitment to Your Privacy

My practice is dedicated to maintaining the privacy of your health information. I am required by law to provide you with the following important information explaining your rights and my obligation to maintain your privacy.

Uses and Disclosures Requiring Authorization

Your signature on the agreement to enter into treatment with me provides consent for me to use or disclose your protected health information (PHI) in the course of treatment, payment and health care operations purposes. This would include consultations with other professionals who are also legally bound to keep the information confidential; any clinical or administrative personnel responsible for billing; and any contract I may have with an agency associated with your care and health service, which promises to maintain confidentiality except as specifically allowed in the contract or otherwise required by law.

With your permission and written authorization, I may release information for other purposes. When I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain authorization from you before releasing this information. You may revoke all such authorizations at any time, in writing, unless 1) I have taken action in reliance on it; or 2) if the authorization was obtained as a condition of obtaining insurance coverage; or 3) if you have not satisfied any financial obligations you have incurred.

Uses and Disclosures Requiring Neither Consent Nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Harm or Abuse: When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual, or the public. I am required to report any suspicion of child abuse, adult or domestic abuse to the appropriate authorities.
- Health Oversight: To public health authorities and health oversight agencies that are authorized by law to collect information.
- Judicial or Administrative Proceedings: Privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered, and I am required to release information.
- National Security: If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities; to federal officials for intelligence and national security activities authorized by law.
- Law Enforcement Officials: To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- Worker's Compensation: I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier for Worker's Compensation or similar programs.

Your Rights Regarding Your Health Information

Communications: You can request that my practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that I contact you at home rather than at work. I will accommodate reasonable requests.

Restrictions: You can request a restriction in my use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that I restrict disclosure of your health information to only certain individuals involved in your care or the payment of your care. I am not required to agree with your request. However, if I do agree, I am bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Inspect and Copy: You have the right to inspect or obtain a copy of the health information that may be used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.

Amend: You have the right to request an amendment of your health information if you believe it is incorrect or incomplete, as long as this information is kept by and for my practice. Your request must be made in writing and submitted to me at the address on the letterhead. You must provide a reason that supports your request. I may deny your request, however.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with my practice or with the Secretary of the Department of Health and Human Services. To file a complaint with my practice, contact me at the address on the letterhead. All complaints must be in writing. You will not be penalized for filing a complaint.

Other Authorizations and Accounting: My practice will obtain your written authorization for uses and disclosures not identified by this notice or permitted by applicable law. You generally have the right to receive an accounting of any disclosures of your information, which were made without your consent or authorization.

If you have any questions regarding this notice or my health information privacy policies, please contact me at the phone number on the letterhead. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

Receipt of Notice of Privacy Practices

ACKNOWLEDGEMENT

I hereby acknowledge that I have received/been offered a copy of the Notice of Privacy Practices for Amy Sheinberg, Ph.D., LLC.

SIGNATURE _____ DATE _____

NAME (printed) _____

8333 Douglas Ave., Suite 1240
Dallas, TX 75225

CONSENT FOR EMAIL/TEXT COMMUNICATION

Amy Sheinberg, Ph.D. 8333 Douglas Ave., Suite 1240 Dallas, TX 75225

I will be happy to respond to your query within reason, but to do so via email you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any protected health information that may be contained in an email may be disclosed to, or intercepted by, unauthorized third parties. I will use the minimum necessary amount of protected health information to respond to your query. Communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-psychologist relationship. Patient-psychologist electronic mail is defined as computer-based communication between psychologists and patients within a professional relationship, in which the psychologist has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between psychologists and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

Communication Guidelines:

I will return email as soon as possible, but within 24 hours of receipt during business hours. If I am on vacation, email may or may not be returned until I return. I will have a practitioner on call for emergencies, but you will need to call my office for that information.

All email/text communication will be retained either by paper and/or electronic copies for the term applicable to paper records. I will back-up all communication weekly.

Therapeutic communication (sensitive subject matters) should be kept at a minimum. Please call to set up an appointment for therapeutic matters.

E-mail correspondence will not be used to establish a patient-psychologist relationship. E-mail should supplement other, more personal encounters. Without the benefit of face-to-face interaction, email can be misinterpreted in tone and meaning.

Email or text communication to change an appointment is acceptable.

Please put in subject line the nature of the communication (e.g., appointment, advice, billing question), and please make sure your name and/or identifying information about the patient is in the body of the message.

Please be concise in your email. If the matter cannot be written in a concise fashion, please call to schedule an appointment.

I will also send you a message to inform you of completion of request.

You will be reminded if you do not adhere to these guidelines, if necessary, I will terminate the email/text relationship.

Encrypted messages are the most protected form of communication, however, I do not presently use an encrypted program.

My computer(s) is/are password protected.

Your email/text will not be forwarded to a third party without your expressed permission, unless you have already signed a release for me to communicate with a professional.

Your email address will not be used in any marketing scheme.

My office manager and I are the only ones with access to my email address and/or mobile number.

I will double-check all "To" fields prior to sending messages.

These policies also apply to facsimile communications.

A. General email risks include but are not limited to the following:

- Email can be immediately broadcasted worldwide and received by many intended and unintended recipients;
- Recipients can forward email messages to other recipients without the original sender's permission or knowledge;
- Users can easily send an email to the incorrect address;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.

B. Specific email risks include but are not limited to the following:

- Email containing information pertaining to a patient's diagnosis and/or treatment must be included in the patient's medical records, thus, all individuals who have access to the medical record will have access to the email messages
- If you are sending your email from your employer's computer, your employer does have access to your email.
- While it is against the law to discriminate and Texas subscribes to a "no cause" termination policy, an employer who has access to your email can use the information to discriminate against the employee. Additionally, the employee could suffer social stigma from a workplace disclosure.
- Insurance companies who learn of your Personal Health Information (PHI) could deny you coverage.
- Although practitioners will endeavor to read and respond to email correspondence promptly, they cannot guarantee that any particular email message will be read and responded to within any particular time frame. The exception would be that the email is part of a scheduled time frame for a prepaid email counseling session.

C. Conditions for use of email: All email sent or received that concern your diagnosis or treatment or that are part of your medical record will be treated as part of your PHI. Reasonable means will be used to protect the security and confidentiality of the email. Because of the risks outlined above the security and confidentiality of email cannot be guaranteed, your consent to email correspondence includes your understanding of the following conditions:

- All email to and from you concerning your PHI will be a part of your file and can be viewed by health care and insurance providers, and the practitioner's office support staff.
- Your email will not be forwarded outside the office without your consent or as required by law.
- Though all efforts will be made to respond promptly this may not be the case. Because the response cannot be guaranteed please do not use email in a medical emergency.
- You are responsible for following up with the practitioner or support staff if you have not received a response.
- Medical information is sensitive and unauthorized disclosure can be damaging. You should not use email for communications concerning diagnosis or treatment of AIDS/HIV infection, other sexually transmissible diseases, mental health, and developmental disability or substance abuse issues.
- Since employers do not observe an employee's right to privacy in their email system, you should not use your employer's email system to transmit or receive confidential email.
- The practitioner will take reasonable steps to ensure that all information shared through email is kept private and confidential. However, Amy Sheinberg, Ph.D. is not liable for improper disclosure of confidential information that is not a result of our negligence or misconduct. Patient information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2 Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate any alcohol or drug abuse.

INFORMED CONSENT

- If you consent to the use of email, you are responsible for informing your practitioner of any type of information that you do not want sent to you by email other than the information detailed in Section B.
- You are responsible for protecting your password and access to your email account and any email you send or you receive from Amy Sheinberg, Ph.D. to ensure your confidentiality. Your practitioner cannot be held liable if there is a breach of confidentiality caused by a breach in your account security.
- Any email that you send that discussed your diagnosis or treatment constitutes informed consent to the information being transmitted. If you wish to discontinue emailing information, you must submit written consent or an email informing your practitioner that you are withdrawing consent to email information.

_____ Yes, I have read the above and consent to unencrypted, but confidential email/text correspondence.

_____ No, I am not interested in email/text correspondence.

Patient Signature _____ Date _____

Patient Printed Name _____

If parent is signing on behalf of a patient under 18, please complete the information:

Signature of Parent/Legal Guardian _____ Date _____

Printed Name of Parent/Legal Guardian _____

Psychologist signature _____ Date _____

CREDIT CARD AUTHORIZATION

Date _____ Clinician(s) Dr. Sheinberg

Patient Name _____

Cardholder Name _____

Billing Address (of credit card) _____

Credit Card ( ) Visa ( ) MasterCard ( ) AMEX ( ) Discover

(HSA card, if applicable)
Card Number _____ Exp. Date _____ CVC Code _____ Zip Code _____

(Non-HSA card required)
Card Number _____ Exp. Date _____ CVC Code _____ Zip Code _____

Card Number _____ Exp. Date _____ CVC Code _____ Zip Code _____

Card Number _____ Exp. Date _____ CVC Code _____ Zip Code _____

Card Number _____ Exp. Date _____ CVC Code _____ Zip Code _____

Card Number _____ Exp. Date _____ CVC Code _____ Zip Code _____

Authorizied signature to use credit card(s) _____

Please notify us as soon as possible if credit card information changes.

F3023

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

Patient Name: _____ Birth date: _____ S.S.#: _____

Address: _____

Parent/Guardian (if applicable): _____ Phone: _____

Address of parent/guardian: _____

I hereby authorize Amy Sheinberg, Ph.D. to receive/send psychological, psychiatric, educational and/or personal information on the above named patient to/from the following individual and/or facility.

Person or Facility: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

A. I hereby authorize the source named above to send, as promptly as possible, the records on inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug/alcohol abuse.

B. I authorize the named above to communicate with the Dr. Sheinberg about the reasons for patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

C. I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my/the patient's treatment.

D. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 s. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

E. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

F. This request/authorization is valid during the pendency of any claim or demand made by or on behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive.

G. I agree that a photocopy of this form is acceptable, but I, the releaser must sign it.

H. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

Signature of Patient _____ Printed Name _____ Date _____

Signature of Parent/Guardian _____ Printed Name _____ Date _____

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Practitioner _____ Printed Name _____ Date _____

TELETHERAPY SERVICES AGREEMENT AND INFORMED CONSENT

Amy Sheinberg, Ph.D. 8333 Douglas Ave., Suite 1240 Dallas, TX 75225

1. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. Any personal information you choose to share with me will be held in the strictest confidence. I will not release your information to anyone without your prior approval or I am required to do so by law. In Texas we are not required to notify authorities if we become convinced you are about to physically harm someone. We do, however, have a duty to inform the authorities if there is suspicion or evidence of abuse of children, the elderly (over 65) or people with disabilities.

2. You understand that our teletherapy occurs in the state of Texas, and is governed by state laws. I, the practitioner, am accountable to and agree to abide by the ethical and legal guidelines prescribed by the state of licensure and residence. The patient agrees to these terms. If you do not understand, or have any questions regarding this issue, please feel free to ask for clarification. In a manner of speaking, you use modality to visit me in my Texas office.

3. Either of us is free to terminate teletherapy at any time and for any reason. If you decide to terminate, please send a short note stating the reasons for terminating. In the unlikely event I become convinced our teletherapy is not in your best interests, I will explain it to you and suggest some alternative options better suited to your needs.

4. You understand that teletherapy is neither a universal substitute, nor the same as face-to-face psychotherapy treatment. You accept the distinctions made using teletherapy vs. face-to-face psychotherapy. In particular, you accept that teletherapy does not provide emergency services.

5. You are responsible for information security on your computer. Skype and Facetime are encrypted, so they are confidential.

6. Teletherapy is a means by which you can receive counseling, information and guidance from an experienced psychologist. It is perhaps most accurately perceived as a process creating, over time, a trusting and collaborative relationship. You retain the right to determine which topics we cover and the depth of consideration each receives. You are free to contribute or withhold any information you choose. Teletherapy therapy is best considered experimental until it's efficacy has been validated scientifically.

Telecommunication: Teletherapy is the use of electronic transmissions to treat the needs of a patient. I offer both video and audio forms of communication via the Internet and/or telephone. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

The risks involved with teletherapy include the potential release of private information due to the complexities and abnormalities involved with the Internet. Viruses, Trojans, and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, there is the risk of being overheard by anyone near you if you do not place yourself in a private area. The advantages of teletherapy include the benefit of continuity of care in the absence of your therapist as well as the ability to be treated from any location at any time. It is YOUR responsibility to create an environment on your end of the teletherapy transmission that is not subject to unexpected or unauthorized intrusion of your personal information. It is MY responsibility for me, the practitioner, to do the same.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Practitioner's Signature: _____

Amy Sheinberg, Ph.D.
8333 Douglas Ave., Suite 1240 Dallas, Texas 75225
214-361-0660 • amysheinbergphd.com

FORENSIC MATTERS:
AGREEMENT CONCERNING PSYCHOLOGIST'S TESTIMONY AND RECORDS

This agreement ["Agreement"] is made between Amy Sheinberg, Ph.D. ["Psychologist"], and [the "Client"] _____, this _____ day of _____, 20___, in order to state certain conditions under which the Psychologist will provide professional mental health services for the Client. In the event that this Agreement is signed after treatment of the Client has begun, the Client agrees that this Agreement shall be treated as if signed and effective immediately prior to the first day of treatment of the Client.

TESTIMONY

The Psychologist has determined, and the Client agrees, that the Client's emotional health and need to know the sessions are confidential outweigh the need for the Psychologist or her records to be available for any current or future litigation concerning the Client. The Client agrees that he/she will not require the Psychologist to testify (deposition, courtroom testimony, or otherwise), concerning Client's treatment in any current or future litigation. Further, the Client will not request or subpoena the records of the Psychologist concerning her treatment of the Client for use in any current or future litigation.

In the event Client either attempts to subpoena or workout a separate agreement with the Psychologist or her records, Client agrees to pay all costs and attorney's fees incurred by the Psychologist, including fees for her time in defending any attempt to defeat this Agreement and results in her testifying or producing her records. In the event the Psychologist's deposition is taken, whether by court order or otherwise, the Client agrees to compensate the Psychologist for 8 hours of her time, regardless of the length of the deposition (unless it lasts longer than 8 hours), at an hourly rate of $600 per hour. The $4800 deposition fee will be paid in advance of the commencement of the deposition. The Client further agrees that any deposition of the Psychologist will take place in Dallas County, Texas at a location of the Psychologist's choosing, on a date convenient with her work and personal schedule.

Additionally, the Client shall also compensate the Psychologist's attorney of her choosing for his/her time in defending this Agreement, either by representing and protecting the rights' of the Psychologist or in contesting the Client's right to request a deposition and/or records, including but not limited to motion drafting and hearing attendance, deposition preparation time, actual time in the deposition, courtroom testimony preparation time, and actual time spent presenting and defending the Psychologist in court, all at the attorney's then-prevailing hourly rate. Payment of the Psychologist's attorney's fees shall be made upon presentment of same, either to the attorney of record or to the Psychologist who will forward to the attorney. This bill is to be paid by the Client within three (3) business days upon receipt. Failure to pay within that time frame could result in added late fees.

The Client acknowledge that:

- the Psychologist's testimony will in no way be influenced by the fact that the Client is paying the fee; and
- The Client understands that the Psychologist's testimony may be prejudicial to the Client's legal position.

The Client acknowledges and understands that litigation is time-consuming and takes up the Psychologist's time that could otherwise be applied to treating the Psychologist's other clients. Thus, the Client further agrees to compensate the Psychologist for her time spent (1) reviewing records in preparation for any hearing, deposition, or trial; (2) in responding to any written discovery requests; and (3) rescheduling any clients inconvenienced by said litigation. Time for the aforementioned will be billed separately to the Client at the same $600 hourly rate, and is to be paid within three (3) business days upon receipt. Failure to pay within that time frame could result in added late fees.

RECORDS
Should production of records be requested, the Client understands that the following applies for document production:

- The Psychologist will produce records only if Court-ordered (subpoenas for same will be challenged);
- The Client agrees to pay the full amount of the fees listed in the following section;
- The Client understands that the Psychologist's records will in no way be influenced by the fact that the Client is paying the fee; and
- The Client understands that the Psychologist's records may be prejudicial to Client's legal position.

The fees to be paid and received in full prior to the Psychologist's production of the records are:

a. Three (3) hours ($1800) of preparation time for review and gathering of clinical records and supporting documents;

b. If a summary of such records is requested, time spent preparing the summary will be charged at the rate of $600 per hour;
c. An administrative fee of $0.50 cents per page for any records copied and produced;
d. Any time spent preparing responses to any written discovery requests will be charged at the same hourly fee rate ($600) noted above; and
e. Any time spent by the Psychologist's attorney, at his/her hourly rate at the time the work is performed, in reviewing and/or objecting/responding to the records requests or other written discovery requests.

The reason the fee is paid up front reflects the reality that the Psychologist could not go into Court with the Client owing a large bill. This would leave the Psychologist open to a question as to whether the financial situation had influenced the Psychologist's judgment. This is not an acceptable situation for the Client and the Psychologist will adhere strictly to this policy.

The Client further acknowledges that mental health professionals have a duty to deny access to the Client's records if the professional determines that release of said records would be harmful to the Client's physical, mental, or emotional health and therefore the Client may be denied access to information concerning treatment of the Client if such a determination is made by the Psychologist. If court ordered, could be reviewed by the appointed judge who will have the knowledge that these records have be withheld from the Client due to the aforementioned reasons.

This Agreement has been explained to the Client; the Client has been given the opportunity to have it reviewed by counsel of Client's choosing; the Client agrees that this Agreement was mutually negotiated between Client and Psychologist and shall not be construed against any signatory hereto; and the Client agrees to abide by this Agreement and has been offered a copy of this Agreement which will be kept on file by the Psychologist.

Date: _____ Signature of Client _____

Printed name of Client _____

I have reviewed this Agreement with the Client prior to Client's signing this Agreement.

Dated this _____ day of _____, 20____.

Signature of Psychologist: _____

Amy Sheinberg, Ph.D.

PATIENT INFORMATION

Name: _____ Date of Birth: _____

CHIEF COMPLAINT

What is your primary reason for seeking this psychological consultation: _____

_____

_____

_____

HISTORY OF PRESENTING ILLNESS:

When did these symptoms begin? _____

_____

When did family members first note these? _____ Did something occur to precipitate them? _____

Have there been symptom free periods? _____ What has the course of symptoms been? _____

PAST PSYCHIATRIC HISTORY:

When were you (your child) first in treatment? _____

What kind of treatment have you (your child) had?

Individual Psychotherapy? If yes, with whom and when? _____

Group Psychotherapy? If yes, with whom and when? _____

Family/Couples Therapy? If yes, with whom and when? _____

PAST PSYCHIATRIC MEDICATIONS:

Name of Medication	Dose Taken	Why Taken	Who Prescribed	Comments (helpfulness / side effects)

CURRENT PSYCHIATRIC MEDICATIONS:

Name of Medication	Dose Taken	Why Taken	Who Prescribed	Comments (helpfulness / side effects)

Have you or your child (if child is being treated) ever been psychiatrically hospitalized? If yes, when, where, and for what reason?

Name of Facility	When and how long?	Precipitating Factors

Have you or your child (if child is being treated) ever thought of committing suicide? If yes, when was the last time and what was the thought? Did you (your child) have a plan?

Have you or your child (if child is being treated) ever attempted to commit suicide? If yes, when, how and under what circumstances?

Have you or your child (if child is being treated) ever hurt yourself in any way? If yes, do you (your child) still do so and how often?

Do you or your child (if child is being treated) now or have you in the past used any alcohol or drugs? If yes, please specify below.

What?	When did you start?	How much did you use?	Last use?	What did it do for you?

MEDICAL HISTORY:

Primary Care Physician _____ Phone _____

Address _____

Current Medical Problems: _____

Prior Illness: _____

Medical Hospitalizations: _____

Surgeries: _____

PLEASE CHECK IF YOU HAVE EVER RECEIVED MEDICAL ATTENTION FOR

	ABNORMAL BLEEDING		FEVER		PALPITATIONS
	ABDOMINAL SWELLING		FREQUENT AWAKENING TO URINATE		RASH
	ANEMIA		HEADACHE		SEIZURES OR BLACKOUT SPELLS
	ASTHMA OR WHEEZING		HEART MURMUR		SENSITIVITY - HEAT OR COLD
	BACKACHE		HIGH BLOOD PRESSURE		SEXUALLY TRANSMITTED DISEASES
	BLEEDING GUMS		HOARSENESS		SHORTNESS OF BREATH
	BLOOD IN STOOL		INCOORDINATION		SINUS PROBLEMS
	BREAST LUMPS		INCREASE IN URINARY FREQUENCY		SORE THROATS
	CALF CRAMPS WHEN WALKING		JAUNDICE		STOMACH PAINS
	CHEST PAIN		LIP SORES		SWELLING OF ANKLES / FEET
	CONSTIPATION		LOSS OF HEARING		SWELLING, STIFFNESS
	COUGH		MIGRAINES		TICS OR TREMOR
	DIARRHEA		MUSCLE /JOINT PAIN		ULCER DISEASE
	DIFFICULTY STARTING URINE STREAM		MUSCLE WEAKNESS OR PARALYSIS		UNUSUAL APPETITE
			NAUSEA / VOMITING		UNUSUAL THIRST
	DIZZINESS		NECK SWELLING		URINARY INFECTIONS
	EARACHE		NERVOUS BREAKDOWN		VISUAL PROBLEMS
	EASY BRUISING		NIGHT SWEATS		WEIGHT LOSS
	EYE IRRITATION		NOSEBLEEDS		WEIGHT LOSS
	EYE PAIN		NUMBNESS		

MEDICATION ALLERGIES List here: _____

_____

Are you allergic to any: ☐ Environment ☐ Foods ☐ Animals ☐ Household Chemical Products

Have you ever been exposed to any toxic substances or radiation? ☐ Yes ☐ No

DAILY LIVING

Exercise: Do you exercise regularly? Yes No If Yes, Describe: _____

Current weight in pounds: _____ Highest past year: _____ Lowest past year: _____ Ideal weight: _____

Height: _____

Caffeine: Do you drink coffee? ☐ Yes ☐ No Tea? ☐ Yes ☐ No Cola? ☐ Yes ☐ No

Tobacco: Do you smoke? ☐ Yes ☐ No How much daily? _____ When did you start? _____

Alcohol: Do you drink alcohol? ☐ Yes ☐ No How many drinks daily? _____

Please describe any change in your alcohol consumption: _____

Street drugs: ☐ Yes ☐ No Please list any you have taken: _____

Pets: ☐ Yes ☐ No Please list your pets, If any _____

IMMUNIZATIONS (CHECK IF UP TO DATE)

☐ DPT or TD ☐ polio ☐ rubella ☐ measles ☐ mumps ☐ booster ☐ booster

Date of most recent physical exam: _____ **Results:** _____

WOMEN

DATE OF LAST NORMAL MENSTRUAL PERIOD?	ARE YOUR PERIODS REGULAR? ☐ YES ☐ NO	NUMBER OF PREGNANCIES?	NO. OF CHILDREN?	MISCARRIAGES?
ABNORMALITIES WITH MENSTRUATION? ☐ YES ☐ NO	EXCESSIVE BLEEDING? ☐ YES ☐ NO	IRREGULAR BLEEDING? ☐ YES ☐ NO	PAINFUL MENSTRUATION? ☐ YES ☐ NO	
ABNORMAL VAGINAL DISCHARGE? ☐ YES ☐ NO	TYPE OF BIRTH CONTROL?		ABORTIONS?	

MEN

Age of onset of puberty: _____

Do you have any difficulty with sexual functioning? ☐ YES ☐ NO

Do you have any burning or discharge from your penis? ☐ YES ☐ NO

Do you have difficulty with erection? ☐ YES ☐ NO

Do you have swelling or lumps on your testicles? ☐ YES ☐ NO

IF ANY ABOVE ANSWERS ARE YES, GIVE FULL DETAILS

_____

_____

_____

FAMILY HISTORY:

1. Give the names, ages, and relationships of people **living in the home:**

Parent or Spouse Name: _____ Age: _____ Relationship: _____

Parent Name(s): _____ Age: _____ Relationship: _____

Siblings or Children's Name(s):

_____ Age: _____ Grade/Occupation: _____

_____ Age: _____ Grade/Occupation: _____

_____ Age: _____ Grade/Occupation: _____

2. Who are other immediate family members not living in the home? _____

_____

_____

FAMILY PSYCHIATRIC HISTORY:

Has any family member had any of the following? Please indicate which family member.

ADHD _____

Alcohol Abuse _____

Anxiety _____

Autism/ Asperger's Disorder/PDD _____

Coordination Problems _____

Depression _____

Drug Use _____

Eating Disorder _____

Learning Disability _____

Legal Problems _____

Mania/Bipolar Disorder _____

Mental Retardation _____

Movement Disorders _____

Obsessions/Compulsions _____

Panic _____

Psychiatric Hospitalizations _____

Psychosis _____

Rituals _____

Sleep Disorder _____

Suicidal thoughts/ urges/behaviors _____

Tics _____

Unusual noises/ vocalizations _____

Other: _____

Please elaborate on above as needed: _____

_____

_____

FAMILY MEDICAL HISTORY:
Please provide information about significant medical issues on the BIOLOGICAL FATHER'S side:

_____

_____

Please provide information about significant medical issues on the BIOLOGICAL MOTHER'S side:

_____

_____

PRENATAL HISTORY:

Was the pregnancy healthy? Yes No Problems: _____

Were medications used during the pregnancy? Yes No If yes, what kind? _____ How Often? _____

Were drugs/alcohol used during the pregnancy? Yes No If yes, how much/often? _____

Did the mother smoke during the pregnancy? Yes No If yes how much? _____

Was the pregnancy full term? Yes No Was delivery normal? Yes No If no, problems? _____

Any feeding problems? Yes No Gain weight well? Yes No

Was there any problem in the first week? _____ First month? _____ First year? _____

Total number of pregnancies: _____ Live births: _____ Birth order of this child: _____

DEVELOPMENTAL HISTORY:

1. Describe yourself or child (if child is being treated) as an infant:

a) active / active but calm / passive / other: _____

b) cuddly / irritable / withdrawn / other: _____

c) cried easily and frequently / reasonable amount / seldom

d) response to changes: severe / moderate / mild

(e) response to being held (describe): _____

_____

(f) reaction to strangers: friendly / indifferent / fearful

(g) soothed easily / difficult to soothe / average

2. Describe your or child's (if child is being treated) eating habits:

Problems: _____

_____

3. Describe your or child's (if child is being treated) sleeping habits:

Problems: _____

_____

4. Developmental Milestones (only mark if significantly early or late):

MOTOR: LANGUAGE: ADAPTIVE:

____ rolled front/back (4 mo)
____ sit with support (6 mo)
____ sit alone (9-10)
____ pull to stand (10 mo)
____ crawling (10-12 mo)
____ walks alone (10-18 mo)
____ running (15-24 mo)
____ tricycle (3 yrs)
____ bicycle (5-7 yrs)

____ smiling (4-6 wks)
____ cooing (3 mo)
____ babbling (6 mo)
____ jargon (10-14 mo)
____ first word (12 mo)
____ follows 1-step command (15 mo)
____ 2 word combo (22 mo)
____ 3 word sentence (3 yrs)
____ speech problem? Y/N

____ mouthing (3 mo)
____ transfers objects (6 mo)
____ picks up raisin (11-12 mo)
____ scribble (15 mo)
____ drinks from cup (10 mo)
____ uses spoon (12-15 mo)
____ wash hands
____ undresses
____ bowel trained

SCHOOL: (TO BE FILLED OUT OF PATIENT IS A CHILD/ADOLESCENT OR IN COLLEGE)

Name of child's current school: _____ Grade/Major: _____ Repeat Grade? Y/N Which? _____

Special/resource classes Y/N? If yes, what classes? _____

Other special services? (speech/OT) _____ IEP? _____ 504 Plan? _____ Academic grades received: _____

Evaluations performed:

Date _____ Type _____ Reasons _____ Results _____

Date _____ Type _____ Reasons _____ Results _____

Relationships with teachers? _____ With peers? _____

Ability to work independently? good / average / poor Organize self? good / average / poor Attendance? good / average / poor

Have you or your child (if child is being treated) ever had truancy proceedings? Y/N If Yes, please describe.

_____

Have you or your child (if child is being treated) had any other legal proceedings? Y/N If Yes, please describe.

_____

Have you or your child (if child is being treated) received counseling at school?

_____

Describe your or your child's (if child is being treated) activities, interests, hobbies, skills, strengths:

_____

_____

_____

PROBLEM BEHAVIOR CHECKLIST: DO YOU OR YOUR CHILD (IF YOUR CHILD IS BEING TREATED) HAVE ANY OF THE FOLLOWING PROBLEMS?

	Never	Occasionally	Often	Very Often		Never	Occasionally	Often	Very Often	
Catastrophic fears										Irritable, poor frustration tolerance
Compulsive behaviors										Isolates self from others
Cries easily										Lack of interest in activities
Cruel to animals										Other specific fears (heights, etc)
Deliberately annoy people										Picks on others, bullies
Early morning awakening										Poor appetite
Easily angered, bad temper										Problems getting to sleep
Easily riled up										Reluctance to go to school
Excessive concerns (body defects)										Repeated unwanted thoughts
Excessive sleepiness										Rituals (has to repeat same action)
Fear of the dark										Sadness
Feels picked on										Self-injurious/abusive behaviors
Fire Setting										Short Attention Span
Frequent accidents										Steals
Gets giddy and silly										Teases others unmercifully
Gets out of control										Tiredness/listlessness
Gets violent and aggressive										Weight gain/loss
Hair pulling										Won't follow rules/directions
Impulsivity (acts before thinking)										Worries a lot