Razzino and Associates, LLC

Therapy and Assessment Services (since 2004)

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CHILDREN/ADOLESCENT INTAKE FORM AND
DEVELOPMENTAL HISTORY QUESTIONNAIRE

(To be completed by parent(s) about child being brought for counseling)

Referred by:_____Today's Date: _____

Child's Name_____Age__Birthdate_____Home Phone_____
Home Address_____City_____Zip_____
Mother/Guardian_____Employer_____Occupation_____
Father/Guardian_____Employer_____Occupation_____
Mother/Guardian Phones_____Father/Guardian Phones_____
Parent's Marital Status: __Married__Single__Divorced__Widowed
Pediatrician/Family Physician_____ Physician's Phone_____
Child's School_____Grade____Teacher_____
In case of Emergency, Please Contact_____Phone_____
Social Security Number_____

☐ **Yes, I would like to learn about Alpha-Stim® (www.alpha-stim.com) treatment for Anxiety, Depression, Insomnia**

Current Family Structure: (residing in the home)

Name	Age	Relationship	Job/School	MentalHealthHistory	RelationshipwithChild (positive, conflicted, etc.)

Other Children: (not in home)

Name	Age	Relationship	Job/School	MentalHealthHistory	RelationshipwithChild (positive, conflicted, etc.)

Current Concerns (Please describe briefly)_____

_____

Prenatal History:

1. Prenatal care:

2. Mother's health during pregnancy:

3. Implications, abnormal test results or medical concerns during pregnancy:

4. Fetal exposure to alcohol, cigarettes, or drug use during pregnancy:

5. Infant's health/weight at birth:

6. Unusual aspects to the delivery (e.g. prematurity, lack of oxygen…)

Early Development:

7. List ages your child reached the following developmental milestones:

Sitting___	Crawling___	Walking___
Using Single Words___	Using sentences___	Toilet Trained___

8. My child's temperament as an infant and toddler were: (check as many as apply)

Easy___	Cautious___	Excitable___
Fussy___	Slow to warm up___	Colicky___
High Energy___	Shy___	Alert___

9. History of articulation problems or regression in language skills: _____

10. History of motor problems or regression in motor skills: _____

11. History of social problems or regression in social-relatedness skills: _____

Family History:

12. Child's primary caretaker(s) throughout childhood:_____

13. Significant family stressors or changes in your child's lifetime (e.g. death, divorce, traumatic event)___

_____

Medical History:

14. Medical or mental health conditions:_____

15. Previous hospitalizations and dates:_____

16. Current Medications: Medication Dose TreatingPhysician

_____

_____

_____

_____

17. History of Psychotherapy: PreviousTherapist Dates IssuesAddressed

_____

_____

18. Hearing and/or vision problems: _____

School/Job:

19. Typical grades earned by your child, including any significant or recent chances in grades:_____

20. History of learning disability or concerns:_____

21. Repeated any grades:_____

22. Child's style of interacting with teachers:_____

23. Child's style of interacting with peers:_____

24. Behavioral concerns at school:_____

25. Extracurricular activites:_____

For parents/guardians of teenagers:

26. Your goals for your teenager after graduation from high school:_____

27. Your teenager's job history:_____

Child's Personal Characteristics:

28. Strengths:_____

29. Weaknesses:_____

30. Hobbies/Interests:_____

31. Child's usual mood:_____

32. Child's relationship with neighborhood friends:_____

33. Types of discipline that are effective with your child:_____

Current Symptoms: Please check all that apply:

__Irritability
__Aggression
__High activity level
__Staring spells
__Trouble expressing him/herself
__Frequent fatigue
__Low energy level
__Trouble falling asleep
__Trouble getting up in the morning
__Frequent awakenings
__Easily frustrated
__Recent weight gain/loss
__Appetite changes
__Excessive fears/worries
__Social isolation
__Depressed mood
__Mood swings
__Hopelessness
__Anxiety
__Anger/rage
__Guilt
___Grief/mourning
__Coping with pain
__Sexual abuse history
__ Physical abuse history
__Suicidal thoughts/actions
__Desire to hurt someone
__Drug/alcohol use
__Tobacco use
__ Self-harm
__ Problems in thinking
__ Problems with memory

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NOTICE OF OUR PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH RECORD & INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of Razzino and Associates, P.C. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your mental health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your mental health record. You may obtain an accounting of disclosures of your mental health information, request communications of your mental health information by alternative means or at alternative locations, revoke your authorization to use or disclose mental health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: Razzino and Associates, P.C. is required to maintain the privacy of your mental health information, and in addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected mental health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. We will not use or disclose your mental health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

***We will use your mental health information for treatment*:** Information obtained by your therapist will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your mental health information for payment. For example: A bill may be sent to you and the information on or accompanying the bill may include information that identifies you, as well as your diagnosis, relevant history, and treatment given.

Law enforcement: We may disclose mental health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your mental health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public. We will attempt to contact you first to see if you consent to such release.

Child Abuse: If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services. We will discuss this with you as appropriate.

Abuse of Elderly or Incapacitated Adults: When we have reason to suspect that an incapacitated adult (e.g. someone who is not able to advocate for himself or herself) is being abused, neglected or exploited, we are required by law to make a report and provide relevant information to the Virginia Department of Social Services. You will be notified of this action unless your therapist believes that it would put you at risk of serious harm.

Health Oversight: The Virginia Board of Health Professions, including the Boards of Psychology, Social Work, and Counseling, has the power to subpoena relevant records should we be the focus of an inquiry.

Judicial or Administrative Proceedings (Court Orders): If you are involved in a court proceeding and a request is made for information about your treatment, we will not release information without your written authorization. If we receive a Subpoena for your records (of which you have been served, along with the proper notice required by state law) we are required to respond. We will attempt to contact you first to see if you consent to such release. If you object, you may file a motion, with the clerk of the court to move to quash (block) the subpoena. If you pursue this, notify your therapist as soon as possible. We are then required to place your records in a sealed envelope and provide them to the clerk of the court so that the court can determine whether the records should be released.

Serious Threat to Health or Safety of Others: If you communicate to us a specific and immediate threat to cause serious bodily injury or death to an identified or to a readily identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect the threatened person.

Danger to Self: Your therapist can break confidentiality if you (or your child) are in imminent danger of hurting yourself, in order to keep you (or your child) safe. This may include notifying emergency personnel.

Debt Collection: Your name can be reported to a collection agency and/or a credit bureau if you fail to pay your bill. You will be notified before such a report is made.

Legal Defense: Disclosure may be made if a therapist must arrange for legal consultation if a patient takes legal action against a therapist.

Effective Date: This notice will be effective on July 1, 2015

Modification & Amendment: This notice may be modified or amended by other documents, upon notification from your healthcare provider.

To obtain more information, or if you have any questions about this form, please contact our privacy officer:

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Consent for Release and Use of Confidential Information

And

Acknowledgement of Notice of Privacy Practices

I,_____hereby
(Name of Patient or Authorized Agent)
give my consent to Razzino and Associates, P.C. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of:_____.

I acknowledge the review and/or receipt of the Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to my therapist. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my mental health information. Written revocation of consent must be sent to our office.

I understand that I have the right to request that the practice restricts how my individually identifiable mental health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Signed:_____Date:_____

If you are not the patient, please specify your relationship to the patient_____