

GESTATIONAL HISTORY

Full Term: Yes No	Premature: Yes No If yes, how many weeks?_____
Low Birth Weight: Yes No _____lb(s)_____oz	Breech Birth: Yes No
Type of delivery: Vaginal C-section Emergency	Forceps Assisted: Yes No
Vacuum Assisted: Yes No	Preeclampsia: Yes No
Gestational Diabetes: Yes No	Multiple Ultrasounds: Yes No
Oxygen Deprivation: Yes No	NICU Stay: Yes No If yes, how many weeks?_____

Please list any other significant prenatal or birth history (exposure to substances, complications, etc):

DEVELOPMENTAL AND MEDICAL HISTORY

Sat up:	On Time	Delayed	Rolled Over:	On Time	Delayed
Pulled to Stand:	On Time	Delayed	Belly Crawled:	On Time	Delayed
Hands & Knees Crawled:	On Time	Delayed	Walked:	On Time	Delayed
Spoke First Word:	On Time	Delayed	Spoke First Sentence:	On Time	Delayed

My child communicates using: Non-verbal Single words 2-3 word phrases Sentences

Bladder Control Accidents at night? Yes No If yes, how often?_____

Accidents during the day? Yes No If yes, how often?_____

Bowel Control Accidents at night? Yes No If yes, how often?_____

Accidents during the day? Yes No If yes, how often?_____

Has your child's physical development been normal? Yes No

If no, please explain:

Please list any other chronic conditions/history including illnesses, hospitalizations, or surgeries:

MEDICATIONS

Is your child currently on any medications? If so please list the medications below.

Medication:_____ Dosage:_____

Medication:_____ Dosage:_____

Medication:_____ Dosage:_____

Has any medication been effective? Please explain: _____

THERAPEUTIC HISTORY

Has your child had any previous counseling, occupational, physical, and/or speech therapy service? If yes, please list:

Has your child ever had any mental health treatment? Yes No

If so, please indicate which type and age/date at the time of treatment:

- Psychological Testing: _____ Age _____ Date _____
- Individual/Group/Family Therapy: _____ Age _____ Date _____
- Psychiatric Hospitalization: _____ Age _____ Date _____
- Residential Treatment: _____ Age _____ Date _____

Please provide any additional details regarding these services:

ACADEMIC HISTORY

Please check any that may apply:

- Oppositional Disrupt Class Inattentive Refuse to go to school
 Detention Disorganized School suspension Fail to turn in work regularly

Has your child ever had problems with their learning ability? Yes No

If yes, please explain: _____

Have instructional modifications been attempted? Yes No

If yes, please explain: _____

Has your child ever completed educational testing? Yes No

If yes, please explain: _____

Summarize your child's progress (eg. Experience, Academics, Social Skills) within each of the following grade levels.

Preschool: _____

Kindergarten: _____

Grades 1-3: _____

Grades 4-6: _____

Middle School/JR High: _____

High School: _____

Please briefly summarize your child's academic strengths: _____

Please briefly summarize your child's academic weaknesses: _____

SOCIAL HISTORY

Check the most appropriate answer:

1. How does your child get along with their sibling(s)?

Better than average

Average

Worse than Average

Doesn't have any

2. How easily does your child make friends?

Better than average

Average

Worse than Average

3. How many close friends does your child have?

None

1-2 Friends

3-5 Friends

5+ Friends

4. On average, how long does your child keep friends?

Less than 6 months

6-12 months

2 years+

5. Describe your child socially:

Withdrawn

Insecure

Outgoing

Passive

Oppositional

Aggressive

Other: _____

What extra-curricular activities is your child involved in?

What responsibilities does your child have at home?

Has your child ever had any legal difficulties: Yes No If yes, please explain:

Are you aware of any alcohol, tobacco and/or other drug use by your child? Yes No If yes, please explain:

BEHAVIORAL AND SOCIAL CHECKLIST *(please check any that apply within last 6 months)*

- Excessive crying
- Decreased Energy
- Feelings of being worthless
- Thoughts of suicide
- Feeling overwhelmed
- Trouble making decisions
- Avoids going places
- Isolating self from others
- Afraid of being judged/ rejected
- Sensitive to criticism
- Self-harm or cutting
- Apathetic, doesn't seem to care
- Needs things to be perfect
- Excessive anxiety about separation
- Obsessive behaviors or thoughts
- Abruptly changing moods
- Angry, easily irritated
- Difficulty controlling temper
- Skin picking, hair pulling, nail biting
- Inflexible, trouble handling change
- Difficulties with sleep
- Concerns related to life change
- Memory problems
- Attention problems
- Full of energy, little need for sleep
- Talking fast and excessively
- Impulsive acts without thinking
- Can't sit still, antsy
- Always on the go, hyper
- Problems following the rules
- Difficulty with authority
- Unmotivated, procrastinating
- Trust issues
- Abusive towards others
- Feeling overly important
- Feels bullied/ picked on
- Few or no friends
- Considered "weird" by others
- Problems with boundaries
- Problems in relationships with parents
- Problems with friends, siblings, roommates
- Threatens or bullies others
- LGBTQ+
- Abused or neglected by others
- Lying, stealing
- Avoid conflict
- History of traumatic experiences
- Hoarding food or objects
- Poor body image
- Financial concerns
- Sexual concerns
- Suspicious, paranoid
- Hearing or seeing things others do not

Other: _____

FAMILY MEDICAL HISTORY

Check if there is any history of any of the following in the family. If yes, please list the family member (eg. Mother, grandfather, sibling etc.)

Learning Disabilities _____ ADHD _____ ASD _____
Depression _____ Anxiety _____ Tics or Tourettes _____
Diabetes _____ Arrests _____ Alcohol or Drug Abuse _____
Psychosis or Schizophrenia _____ Suicide Attempts or Suicide _____

HOME ENVIRONMENT

Who has legal custody of your child? _____

Primary living situation for the past year:

Both parent's home

Relative's home

One parent's home

Friends home

Legal guardian's home

Other

Please describe the family home: House Apartment Condo Trailer (mobile home/RV camper)

Please indicate who sleeps in each room:

Please describe your neighborhood:

Who has taken care of the child most of their life? _____

Who is the primary disciplinarian in the family? _____

Are they: Strict Lenient

Do the parents usually agree on the issues of parenting, rules and discipline?

Always Usually Sometimes Rarely

Do the parents get along with each other?

Always Usually Sometimes Rarely

What strategies have been used to address problems? (check those that apply and circle those that have been successful)

Verbal Reprimands Time out Removal of privileges Rewards

Physical Punishments Giving in to the child Avoiding the child Other

On the average, what percentage of the time does your child comply with initial commands?

0-20% 20-40% 50% 60-80% 80-100%

On the average, what percentage of the time does your child eventually comply with commands?

0-20% 20-40% 50% 60-80% 80-100%

Have there been any major stressors or changes in the family home where the child was raised? Yes No

Yes If yes, check all that apply:

Past Current (6 months or less) Past Current (6 months or less)

- | | |
|----------------------------|---------------------------------------|
| Financial problems | Separation from Sibling(s) |
| Frequent Moves | Mental Illness in Family |
| Job Changes | Physical Illness in Family |
| Drinking/Drug Problems | Psychiatric Hospitalization of Parent |
| Arguments between Parents | Death in the Family |
| Separation between Parents | Incestuous Behavior in Family |
| Remarriage of Parent(s) | Other: _____ |

What are the family's strengths?

What are the family's challenges?

What are the child's strengths/challenges?

How has the family been changed by the child's difficulties?

What does the family see as their role in treatment? Which family members are willing and able to participate?

Is there anything else about this child or family that we should know in order to be more helpful?

** please bring this form, as well as psychological or educational test results, report cards, behavior modification charts and any other pertinent documents to your next appointment**

RELIGIOUS/FAITH HISTORY

What is your family's religious/faith background:

Does your child attend a place of worship? Yes. If yes, where? _____ No

Please list anything (positive or negative) that is important and may have affected your child in regard to faith:

PATIENT INFORMATION AND INFORMED CONSENT TO TREAT

Thank you for choosing Functional Kids Therapy for your counseling needs. We are committed to giving you the best care possible. To familiarize you with the policies and procedures of our clinic, we are providing the following information.

Emergencies: In case of an AFTER-HOURS emergency, go to the nearest emergency room. Functional Kids Therapy does not have an emergency number.

Confidentiality: Your patient records are the property of Functional Kids Therapy LLC and shall be treated as confidential, to insure quality record maintenance and patient confidentiality. Functional Kids Therapy LLC will conduct routine patient record audits. To comply with state and federal laws regarding confidentiality your records will not be released without written consent. Everything about your care will be held in the strictest confidence (with the exception of situations which we are required by law to report: such as suspected or reported child abuse, etc.). If you choose to have your Functional Kids Therapy LLC providers(s) keep a third party informed of your progress in counseling, it will be necessary to complete a "Release of Information" form that will be kept on file.

Non-Voluntary Discharge from Treatment: A patient may be terminated from Functional Kids Therapy LLC non- voluntarily, if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment/ payment arrangements in a timely manner. The patient will be notified of the non-voluntary discharge by letter. The patient may appeal this decision with the Functional Kids Therapy Clinic Director or request to reapply for services at a later date.

Consent and Acknowledgement:

I have read and understood the information above. I give my consent for the patient named above to receive tutoring services from the tutor or tutoring organization named in this form.

Parent/Guardian Signature (if minor): _____

Relationship to Patient: _____ Date: _____

FUNCTIONAL KIDS PARENT/GUARDIAN CONDUCT POLICY

By signing below all parents and guardians are agreeing to adhere to the Functional Kids Conduct Policy which prohibits the use of any and all negative behaviors to intimidate, harass, belittle, or threaten staff members in this place of business. Any violations with the above mentioned behaviors are grounds for immediate dismissal from counseling services. Be advised that any extreme situation experienced by a staff member can be immediately reported to the local authorities and your care will be immediately terminated from our practice without verbal or written advanced warning.

Parent/Guardian Signature: _____ Date: _____

DIVORCE/LEGAL SEPARATION COLLECTION POLICY

It is the policy of Functional Kids Therapy LLC that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for payment of the child/adolescent's treatment regardless of any financial arrangement for payment for medical care, either oral or written, with the child/adolescent's other parent or responsible party. Functional Kids Therapy LLC assumes NO responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child/adolescent's medical care.

Parent/Guardian Signature: _____ Date: _____

FUNCTIONAL KIDS INSURANCE POLICY

You are responsible for knowing your benefits outlined in your specific insurance plan including your co-insurance, co-pay, and deductible amounts if applicable. Please be advised that many insurance providers do not cover therapy due to most developmental disorders. **Functional Kids Therapy Center LLC** is NOT responsible for these costs that are dictated by your insurance carrier and if coverage is denied you will be responsible for payment of care, including any evaluations.

Should you be delinquent in paying your bill past 3 months and have not made arrangements for a payment schedule, you are legally responsible for the amount outlined by your insurance carrier and will be sent to collections if the account goes unpaid. You are responsible for any finance charges & fees **Functional Kids Therapy Center LLC** incurs in collecting therapy service fees from you including legal costs for actions that may be needed to collect on you account(s).

My signature below is confirmation that I have been informed of and agree to the insurance policy of Functional Kids Therapy Center LLC.

Insurance Information:

Primary Insurance: _____	Secondary Insurance : _____
Subscriber: _____	Subscriber: _____
Subscriber date of birth: _____	Subscriber date of birth: _____
Relationship: _____	Relationship: _____
Contract/ID# _____	Contract /ID# _____
Group# _____	Group# _____
Employer: _____	Employer: _____

I, _____, hereby give my consent for **Functional Kids Therapy Center LLC** to bill my/my child's insurance carrier for the services rendered to me/my child/family by the above-mentioned provider. In addition, I agree to pay **Functional Kids Therapy Center LLC** deductibles or uncovered charges in accordance with my health care plan.

<i>Parent/Guardian Signature</i>	<i>Relationship to client</i>	<i>Date</i>
_____	_____	_____

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

I consent to the use of electronic communication to contact me as needed. I understand that my service provider may charge me for such communication and also that electronic communication, while very convenient, may not always be secure.

I authorize to be contacted via text-message at _____

I authorize to be contacted via electronic mail at _____

I prefer to be only contacted via US Mail and telephone number on file.