

CARI FOOTE, M.A., LPC, LMFT & ASSOCIATES, PLLC

606 Avenue J
Marble Falls, TX 78654
830-693-0530

www.professionalcounseling.us

TIN: 51-0668504

NPI: 1720251606

925 N Goliad Street
Rockwall, TX 75087
214-548-1220

Client and Financial Information and Agreement to Pay for Professional Services

Today's date: _____

A. Identification

Client's name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security: _____

Home street address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell: _____ Work: _____

E-mail address: _____ Preferred form of communication: _____

Employer: _____ Occupation: _____

Address of Employer: _____

Marital status Single Divorced Married Widowed Separated Partner Other _____

Legal Gender for Insurance Purposes Male Female Identified Gender _____

If client is a dependent for insurance purposes, enter the following information for the insured parent or spouse:

Insured's name: _____ Date of birth: _____ Age: _____

Nicknames of aliases: _____ Social Security: _____

Home street address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Address of Employer: _____

Marital status Single Divorced Married Widowed Separated Partner Other _____

If applicable, enter the following information about the dependents other parent or client's spouse:

Name: _____ Date of birth: _____ Age: _____

Nicknames of aliases: _____ Relationship to client: _____

Home street address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell: _____ Work: _____

Emergency Contact:

Name: _____ Relationship to client: _____

Home street address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell: _____ Work: _____

Please list everyone living in the home with the client:

Name	Age	Relationship

Please list any medications, vitamins or supplements that you are currently taking:

Please list any medical conditions that you have:

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

How did this person explain how I might be of help to you? _____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No (if you indicate "yes" I will not make any contact until you complete a release of information.)

D. Insurance Coverage: If you are covered by insurance for psychological services, please fill in the applicable information below if known.

Name of subscriber or policy holder : _____

Name of Insurance Co. or HMO: _____

Identification/ policy #: _____ Group #: _____

Deductible _____ Out of Pocket Limit _____ Co-pay amount: _____

E. If you do not have insurance, how will you pay for services from this office? _____

F. Release to insurance company: I give this office permission to release any information obtained during examinations or treatment of this client that is necessary to support any insurance claims on this account and secure timely payments due to the assignee.

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G. Agreement to Pay for Professional Services and Cancellation Policies:

I request that Cari Foote & Associates, PLLC provide professional services to me or to _____, who is my _____. I agree that I am responsible for services provided by this therapist to me (or this client) at the fee of \$ 100.00 per 55 minute session (or agreed rate of _____) although other persons or insurance companies may make payments on my (or this client's) account at the insurance companies contracted rate. As of date signed below I am covered under _____ Insurance company and they have quoted my coverage with this therapist to be _____ and my out of pocket for each ongoing appointment is _____.

I am responsible for notifying the therapist immediately if my insurance changes or I am responsible for any insurance charges that later become uncollectible from the insurance company due to late filing limits set by the insurance company.

I understand that that if I must cancel an appointment, I must do so 24 hours in advance of the appointment. If I do not, I understand that I am financially responsible for the missed appointment at the full session rate if my insurance company allows the therapist to bill for this. I understand that my insurance company or EAP is not financially responsible for missed appointments. I also understand that accounts that are past due more than 30 days must be paid in full or payment arrangements made. **If payment efforts are not made at that time, 35% will be added to the balance & accounts will be forwarded to a collection agency.**

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or in writing; that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

A. Assignment of Benefits:

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

Signature of client (or person acting for client)

Date

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date

___ Copy accepted by client ___ Copy kept by therapist

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Client Bill of Rights

You have the right to:

- Get respectful treatment that will be helpful to you.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Receive nondiscriminatory treatment with sensitivity to differences of race, age, gender, ethnic origin, language, disability, sexual orientation, political and religious beliefs.
- Ask for and get information about the therapist's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist thinks will be needed, substitute therapists (in cases of vacation and emergencies), and cancellation policies.
- Refuse to answer any question or give any information you choose not to answer or give.
- To have the right to confidentiality, except in the cases of 1) distinct danger to yourself or others, 2) when children, elderly or disabled adults are abused, neglected or in danger, or 3) by order of the court.
- Know if your therapist will discuss your case with others (for instance, supervisors, consultants, or students).
- Ask that the therapist inform you of your progress and to participate in the development of a treatment plan.
- To decide to not enter into therapy with me. If you wish, I will provide you with names of other good therapists.
- You have the right to end therapy at any time. The only thing you will have to do is to pay for any treatments you have already had. You may, of course, have problems with other people or agencies if you end therapy – for example, if you have been sent for therapy by a court.
- Report immoral and illegal behavior by a therapist.

In the case that you may wish to verify my license or file a complaint you may do so with the Texas Behavioral Health Executive Council at www.bhec.texas.gov and 1-800-821-3205. A copy of my ethical guidelines is always available to you upon your request.

I have reviewed my rights with my therapist and have received a copy of them.

Client Signature

Date

What You Should Know about Private Health Information, Confidentiality in Therapy and My Privacy Practices

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 and the federal Health Insurance Portability & Accountability Act of 1996 (HIPAA) prevent me from telling anyone else what you tell me or that you are even my client, unless you give me written permission.

Your health information is protected by HIPAA. Protected health information is considered to be individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, or transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare, payment for healthcare services, or use in healthcare operations.

Your health information is protected in our HIPAA compliant practice management system and locked offices and filing cabinets. Emails are considered protected health information and are a part of your file. Emails to you are encrypted when sent from your provider but are not encrypted when received by you unless your email is encrypted. Text messages are not encrypted or protected and it is highly recommended that very limited information be communicated by text. Protected Health Information that is in your possession is your responsibility to protect.

HIPAA 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 without your permission.

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. These are very important issues, so please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

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 required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
- 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:
- In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.
 - In cases where your emotional or mental condition is important information for a court’s decision.
 - During a malpractice case or an investigation of me or another therapist by a professional group.
 - In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
 - 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**:

- 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 may be available to help my clients. I must give him or her some information about my clients, like you.
- 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.**

- 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 the 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.
- 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.
- 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.
- 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.
- 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.
- 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. Here is what you need to know about confidentiality **in regard to insurance and money matters**:

- If you use your health insurance to pay a part of my fees, insurance companies require some information about our therapy. Insurers such as Blue Cross/Blue Shield or managed care organizations ask for much information about you and your symptoms, as well as a detailed treatment plan.
- It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information at the insurer’s office. You cannot be required to release more information just to get payments.
- If you have been sent to me by your employer’s Employee Assistance Program, the program’s staffers may require some information. Again, I believe that they will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the

program before we talk further.

- d. If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.

6. Finally, here are **a few other points**:

- a. If you want me to send information about our therapy to someone else, you must sign a “release-of-records” form. I have copies you can see, so you will know what is involved.
- b. Any information that you also 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. 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 and to act in your best interests.

Your signature here shows that you have read, discussed with the therapist, understand, and agree to abide by the points presented above. Your signature also acknowledges that you have received a copy the Privacy Practices of this office which contains a complete description of the uses and disclosures of your health information.

Signature of client (or person acting for client)

Date

Printed name

Signature of client

Date

Printed name

Signature of therapist

Date

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Information and Informed Consent for Telehealth Treatment

Telehealth is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

I understand that Telehealth services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the Telehealth sessions will be recorded or photographed. I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to Telehealth, and that no information obtained in the use of Telehealth that identifies me will be disclosed to other entities without my written consent except as required by law. I further understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to Telehealth services.

I understand that Telehealth is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. If the telehealth internet connection is disrupted, the therapist will call me.

I understand that I or my therapist may discontinue the Telehealth sessions at any time if it is felt that the video technology or physical setting in which I'm in is not adequate for a therapeutic environment. I also understand that I or my therapist may discontinue the Telehealth sessions at any time if it is felt that telehealth is not appropriate for my clinical situation. My therapist will make appropriate referrals as indicated.

I will authenticate my location and identity as requested or required by my therapist for my safety, therapist compliance with state regulations about practice location and insurance authentication requirements.

I understand that if there is an emergency during a Telehealth session, then my therapist may call emergency services and/ or my emergency contact.

I understand that emails and text messages are a part of my medical record and are protected health information. I also understand that email from my therapist is encrypted when sent to me, but encryption and protection when received or sent by me is determined by my technology, email accounts and my actions. I also understand that text messages are never encrypted when sent or received by myself or my therapist.

I understand a “no show” or late cancel fee policy I signed and agreed to in my intake paperwork applies to telehealth sessions.

I understand my telehealth sessions will take place on the Kareo HIPPA compliant platform and that I will be texted and/or emailed links that I can use to connect on my computer and cell phone.

I hereby give my informed consent for the use of Telehealth in my care.

Client Signature (or person acting for client)

Date

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Child Checklist of Characteristics

Name: _____ Date: _____

Age: _____ Person completing this form: _____

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first please mark all of the items that apply to your child on the "Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics." **Where there are multiple choices, please underline or circle those that apply.** You may also add a note or detail in the space next to the concerns checked.

- Affectionate
- Argues, "talks back," smart-alecky, defiant
- Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- Cheats
- Cruel to animals
- Concern for others
- Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- Complains
- Cries easily, feelings are easily hurt
- Dawdles, procrastinates, wastes time
- Difficulties with parent's paramour/new marriage/new family
- Dependent, immature
- Developmental delays
- Disrupts family activities
- Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- Distractible, inattentive, poor concentration, daydreams, slow to respond
- Dropping out of school
- Drug or alcohol use
- Eating – poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- Exercise problems
- Extracurricular activities interfere with academics
- Failure in school
- Fearful
- Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- Fire setting
- Friendly, outgoing, social
- Hypochondriac, always complains of feeling sick
- Immature, "clowns around," has only younger playmates
- Imaginary playmates, fantasy
- Independent
- Interrupts, talks out, yells
- Lacks organization, unprepared
- Lacks respect for authority, insults, dares, provokes, manipulates
- Learning disability
- Legal difficulties – truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales

- Likes to be alone, withdraws, isolates
- Lying
- Low frustration tolerance, irritability
- Mental retardation
- Moody
- Mute, refuses to speak
- Nail biting
- Nervous
- Nightmares
- Need for high degree of supervision at home over play/chores/schedule
- Obedient
- Obesity
- Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- Oppositional, resists, refuses, does not comply, negativism
- Prejudiced, bigoted, insulting, name calling, intolerant
- Pouts
- Recent move, new school, loss of friends
- Relationships with brothers/sisters or friends/peers are poor – competition, fights, teasing/provoking, assaults
- Responsible
- Rocking or other repetitive movements
- Runs away
- Sad, unhappy
- Self-harming behaviors – biting or hitting self, head banging, scratching self
- Speech difficulties
- Sexual – sexual preoccupation, public masturbation, inappropriate sexual behaviors
- Shy, timid
- Stubborn
- Suicide talk or attempt
- Swearing, blasphemes, bathroom language, foul language
- Temper tantrums, rages
- Thumb sucking, finger sucking, hair chewing
- Tics – involuntary rapid movements, noises, or word productions
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Underactive, slow-moving or slow responding lethargic
- Uncoordinated, accident-prone
- Wetting or soiling the bed or clothes
- Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics:

- _____
- _____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with.

Which is it? _____

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Checklist of Concerns for Children

Name of Child _____ Date: _____

Age: _____ Person completing this form: _____

Please mark all of the items below that apply to your child, and feel free to add any others at the bottom under "Any other concerns or issues." **Where there are multiple choices, please underline or circle those that apply to your child.** You may also add a note or detail in the space next to the concerns checked.

- Abuse to self by others – physical, sexual, emotional abuse
- Abuse to others – physical, sexual, emotional, cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration; distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use – prescription medications over-the-counter medications, street drugs
- Eating problems – overeating, under eating, appetite, vomiting (see also "Weight and diet issues)
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Fertility issues
- Financial or money troubles, debt, impulsive spending, low income
- Flashbacks (pictures, smells, sounds, physical sensations)
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores – quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking

- Legal Matters, charges, suits
- Loneliness
- Marital conflict in family, distance/coldness, infidelity/affairs, remarriage, different expectations,
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Pain, chronic
- Panic or anxiety attacks
- Parenting, child management, single parenthood
- Perfectionism
- Pessimism
- Phobia
- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems (see also "Career concerns ...")
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Self-harming behavior
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse)
- Scary ideas, or pictures in your head
- Shyness, oversensitivity to criticism
- Sleep problems – too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts or attempts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- History of Trauma – to self or as a witness (including accidents)
- Witness of physical, sexual or emotional abuse
- Weight and diet issues
- Withdrawal, isolation
- Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

- _____
- _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

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Child Developmental History Record

A. Identifications

1. Child's name: _____ Birthdate: _____ Age: _____
Person(s) completing this form: _____ Today's date: _____
2. Mother's name: _____ Birthdate: _____ Home phone: _____
Address: _____
Currently employed: No Yes, as: _____ Work phone: _____
3. Father's name: _____ Birthdate: _____ Home phone: _____
Address: _____
Currently employed: No Yes, as: _____ Work phone: _____
4. Parents are currently Married Divorced Remarried Never Married Other _____
Child's custodian/guardian is: _____
5. Step-parent's name: _____ Birthdate: _____ Home phone: _____
Address: _____
Currently employed: No Yes, as: _____ Work phone: _____

B. Development

Please fill in any information you have on the area listed below.

1. Pregnancy and delivery

Prenatal medical illnesses and health care: _____

Was the child premature? _____ Weight and height at birth: _____

Any birth complications or problems? _____

2. The first few months of life

Breast fed? _____ If so, for how long? _____ Why did breast feeding stop?

D. Residences

1. Homes

Dates		Location	With Whom	Reason for moving	Any Problems?
From	To				

2. Residential placements, institutional placement, or foster care

Dates		Program Name or location	Reason for Placement	Problems?
From	To			

E. Schools

School (name, district, address, phone)	Grade	Age	Teacher	Grades

F. Special skills or talents of child

List hobbies, sports; recreational, musical, TV and toy preferences, etc. _____

G. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important? _____

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Center for Epidemiological Studies

Depression Scale for Children (CES-DC)

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me. _____	_____	_____	_____	_____
2. I did not feel like eating, I wasn't very hungry. _____	_____	_____	_____	_____
3. I wasn't able to feel happy, even when my family or _____ friends tried to help me feel better.	_____	_____	_____	_____
4. I felt like I was just as good as other kids. _____	_____	_____	_____	_____
5. I felt like I couldn't pay attention to what I was doing. _____	_____	_____	_____	_____
DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy. _____	_____	_____	_____	_____
7. I felt like I was too tired to do things. _____	_____	_____	_____	_____
8. I felt like something good was going to happen. _____	_____	_____	_____	_____
9. I felt like things I did before didn't work out right. _____	_____	_____	_____	_____
10. I felt scared. _____	_____	_____	_____	_____
DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep. _____	_____	_____	_____	_____
12. I was happy. _____	_____	_____	_____	_____
13. I was more quiet than usual. _____	_____	_____	_____	_____
14. I felt lonely, like I didn't have any friends. _____	_____	_____	_____	_____
15. I felt like kids I know were not friendly or that _____ they didn't want to be with me.	_____	_____	_____	_____
DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time. _____	_____	_____	_____	_____
17. I felt like crying. _____	_____	_____	_____	_____
18. I felt sad. _____	_____	_____	_____	_____
19. I felt people didn't like me. _____	_____	_____	_____	_____
20. It was hard to get started doing things. _____	_____	_____	_____	_____

Caffeine Consumption Questionnaire

			Average number of ounces/doses /tablets per day	Average total per day
Beverages				
Coffee (6 oz.)	125mg	X	_____	_____
Decaf Coffee (6 oz.)	5 mg	X	_____	_____
Espresso (1 oz.)	50 mg	X	_____	_____
Tea (6 oz.) Green	35 mg	X	_____	_____
Tea (6 oz) Black	50 mg	X	_____	_____
Cocoa (6 oz.)	15 mg	X	_____	_____
Energy drinks (12 oz.)	*equivalent 200 mg	X	_____	_____
Caffeinated Soft Drinks (12 oz.)	40-60 mg	X	_____	_____
Chocolate candy bar	20 mg	X	_____	_____
Over-the-Counter Medications				
Anacin	32 mg	X	_____	_____
Appetite-control pills	100-200 mg	X	_____	_____
Dristan	16 mg	X	_____	_____
Excedrine	65 mg	X	_____	_____
Midol	132mg	X	_____	_____
NoDoz	200mg	X	_____	_____
Triaminicin	30 mg	X	_____	_____
Vanquish	33 mg	X	_____	_____
Vivarin	200 mg	X	_____	_____
Prescription Medications				
Cafergot	100 mg	X	_____	_____
Fiorinal	40 mg	X	_____	_____
TOTAL MG. CAFFEINE PER DAY				_____

*Caffeine content of energy drinks vary. They also include a number of stimulating herbs.

> 250 milligrams a day, if taken after noon, *may* interfere with deep sleep

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