



7250 Peak Dr., Suite 214, Las Vegas, NV 89028

Registration Form

CLIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Gender: _____ Clients School & Grade: _____

Mother's Name: _____ Father's name: _____

Parent's marital status: ☐ Married ☐ Divorced ☐ Separated Custodial Parent: _____

Whom may we thank for referring you? _____

In case of emergency who should we notify? _____

INSURANCE INFORMATION

Person Responsible for Account: _____

Relationship to Client: _____ Date of Birth: _____

SSN: _____ Employer: _____

Insurance Company: _____ Subscriber #: _____

Group #: _____ Phone #: _____

Insurance Address: _____

Is the client covered under additional insurance? ☐ Yes ☐ No. If yes, Subscribers Name: _____

Relationship to Client: _____ Date of Birth: _____

SSN: _____ Occupation: _____

Insurance Company: _____ Subscriber #: _____

Group #: _____ Phone #: _____

Insurance Address: _____

Client's Name

Date

Signature of Client/Parent/Legal Guardian

Relationship



TREATMENT SERVICES AGREEMENT AND CONSENT FORM

Welcome to McGuire Psychological Services (MPS). This document contains important information about our professional services and business practices. Please read this document carefully and ask questions for clarification at any time. When you sign this document, it will represent an agreement between you and MPS.

SERVICES OFFERED

MPS is dedicated to creating and maintaining a collaborative treatment approach with the client and their families, focusing on evidence based and scientifically validated assessment and treatment services. MPS understands every client is unique with differing circumstances. Given this, we work with you and your family to identify goals consistent with individual and family needs.

MPS provides a range of services, including neuropsychological and psychological diagnostic evaluations, and mental health services, including intake evaluations and individual, couple, and family therapy for an array of presenting problems and mental health disorders.

Diagnostic Evaluations: Diagnostic evaluations may include some or all the following:

- Assessment of Autism Spectrum Disorders symptoms and behaviors
- Assessment of Intellectual Abilities
- Assessment of Executive Functioning
- Assessment of Language Fundamentals
- Assessment of Adaptive Functioning
- Assessment of Achievement
- Assessment of Behavioral and Emotional Functioning
- During the evaluation, the evaluator will gather information including a developmental history, conduct psychological testing, and observe the individual being tested. At the end of the diagnostic evaluation, a comprehensive report will be developed, including a diagnosis, summary of the strengths and weaknesses identified in the evaluation process, and treatment recommendations.

ASSESSMENT, PREPARATION, AND PARTICIPATION

When a diagnostic evaluation is being conducted, it is important for the individual to perform their best. Please inform the evaluator if there have been any recent changes in behaviors, medications, diet, sleep routine, or if there has been any significant illness that may impact performance on testing. The length of a diagnostic evaluation can vary depending on the assessment instruments used and can exceed 8 hours in some situations. Given this, it is important the individual being assessed has had adequate rest and nutrition prior to the evaluation.

Parent/caregivers participation is an expectation of service. Participation may include data collection, implementation of recommended strategies, and team meetings.

APPOINTMENTS

MPS staff are committed to providing consistent and reliable service as scheduled. Any party may cancel or reschedule sessions previously scheduled at no cost to the client. MPS understands there are circumstances that arise, such as illness or family emergencies, which necessitate the cancellation of appointments. To

avoid any misunderstandings, MPS requests the client/family send an email to the treating provider prior to the scheduled session. Excessive cancellations may result in termination of services, as consistency is critical for treatment success. If you need to cancel, MPS asks you provide as much advanced notice as possible, as will the MPS service providers.

COMMUNICATION

MPS understands the importance of open communication and is committed to responding to your questions and comments in a timely manner. The treatment providers are committed to providing quality services, which include timely and professional communication. Clients will be provided with telephone numbers and email addresses of those individuals who will be directly involved in their care. If you have basic questions about MPS, you are welcome to send an email to mmcguire@mcguirepsych.com.

MPS does not provide on-call coverage 24 hours per day, 7 days per week. In the event of an emergency, please contact your physician or call 911 and/or go to the nearest hospital emergency room.

Clients may contact their treatment providers with questions or comments by telephone or email. Concerns can be directed to MPS's CEO, Dr. Michelle McGuire, at mmcguire@mcguirepsych.com or 725-485-7100.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

MPS is required to adhere to the Federal Health Insurance Portability and Accountability Act (HIPAA), when using and disclosing Protected Health Information (PHI). The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations, and other specified purposes as outlined in MPS's Notice of Privacy Policy. If you request information to be shared with other treatment providers, you will first need to sign a written Authorization to Release Protected Health Information specifying what information can be released and to whom it can be shared.

There are times when state laws may require the disclosure of confidential information without expressed written permission under certain circumstances. These circumstances include: if a person is in danger of hurting themselves or someone else; child abuse, elder abuse, or abuse of a vulnerable adult is suspected; or if court ordered. MPS staff routinely consult with other professionals. In doing so, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them.

As a part of our commitment to providing comprehensive and effective neuropsychological and psychological diagnostic evaluation services, we may utilize artificial intelligence (AI) technologies to assist in the assessment and analysis of psychological data. AI tools can enhance the accuracy and efficiency of evaluations by identifying patterns and insights that support clinical decision-making. The integration of AI aims to augment the evaluation process by enhancing the analysis of psychological assessments, providing additional insights to inform treatment recommendations and improving the overall quality and efficiency of psychological services. While AI technologies offer significant advantages, it is important to acknowledge potential risks, including despite stringent security measures, there is a minimal risk of unauthorized access to personal information; AI systems may have inherent biases or limitations that could affect the interpretation of psychological data; and over-reliance on AI tools may impact the clinician's independent judgment. All data processed by AI tools will be handled in accordance with applicable privacy laws and ethical guidelines. We are committed to maintaining confidentiality and security of your personal information. Your participation in evaluations involving AI assistance is entirely voluntary. You have the right to decline the use of AI in your assessment without any impact on the quality of care you receive. If

you wish to decline the use of AI in your assessment, please check yes and sign: ☐ Yes _____

FEES AND HEALTHCARE INSURANCE INFORMATION

The following fee schedule represents the fee-for-service rates as of April 1, 2025:

Diagnostic Evaluation:	\$2,500.00
Psychological Testing:	\$200.00 per hour
Intake Evaluation:	\$250.00
Individual Therapy:	\$200.00
Couples or Family Therapy:	\$250.00

Payment for all treatment services is due at the time of the service, unless other arrangements have been made. If your insurance carrier provides financial assistance for treatment services, and MPS is a contracted provider for your insurance, MPS will discuss the procedures for billing your insurance carrier. The amount of reimbursement and the amount of any co-payment or deductible depends on the requirements of your specific insurance plan. You should also be aware you are responsible for verifying and understanding the limits of your insurance coverage.

You understand you are financially responsible for all charges whether paid by your insurance. In the event your account becomes past due, your balance will accrue interest at the rate of 1% per month (i.e. 12% per annum). A past due account is an account not paid within 30 days from the first date of billing you. If you fail to pay in full or make any kind of satisfactory arrangement for payment or otherwise within 60 days of your first bill, (or we are unable to locate/notify you of your account status despite reasonable effort) your balance will be turned over to an outside office Collection Agency. A \$50 charge will be assessed to all collection accounts, in addition to any accrued interest. If your account is referred to an Collection Agency, interest will continue to accrue at the rate noted herein. In addition, you will be responsible for all added percentage-based Collection fees/costs per our prevailing collection company contract, Attorney fees, Court Costs, Administrative/Service Fees & associated Miscellaneous Fees and Costs. You authorize said assignee to release all necessary information to secure the payment of said benefits.

INFORMED CONSENT FOR SERVICES

Your signature below indicates you have received and read the information in this document. Consent by all parents/legal guardians is required prior to evaluations, assessments, or treatment services being provided to minor children.

These policies have been explained, and I fully and freely give my consent for services to be provided.

Client's Name/Attestation Signature

Date

Client/Parent/Legal Guardian Signature

Date

MPS Representative

Date



CLIENT RIGHTS AND RESPONSIBILITIES

You have the right to:

- Considerate and respectful care and to be comfortable in the environment in which your care is provided.
- Receive care in a safe setting, free from verbal or physical abuse or harassment.
- Receive information about you or your child's evaluation and/or treatment status, course of treatment, and outcomes of treatment in terms you can understand.
- Participate actively in decisions regarding you or your child's evaluation and/or treatment and to receive as much information about your proposed evaluation and/or treatment as you may need to give informed consent or to refuse a course of treatment.
- Be advised if the provider proposes to engage in or perform research affecting you or your child's treatment. You have the right to refuse to participate in such research projects and your decisions will not affect your right to receive care.
- An estimated cost of you or your child's evaluation and/or treatment.
- Reasonable responses to any reasonable requests made for evaluation and/or treatment services.
- Have personal privacy respected. Case discussions, consultations, and other evaluation and/or treatment services are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. Written authorization shall be obtained before medical records are made available to anyone not directly concerned with you or your child's care, except as otherwise required by law. You have the right to access information contained in you or your child's records within a reasonable time frame, except in certain circumstances specified by law.
- Receive a written "Notice of Privacy Practices" explaining how your Protected Health Information (PHI) will be used and disclosed.
- Receive reasonable continuity of care and know in advance the time of your appointments as well as the identity of the person providing the care.
- Exercise these rights without regard to age, disability, gender, gender identity or expression, sexual orientation, economic status, educational background, race, color, religion, ancestry, national origin, marital status, or source of payment.

You have the responsibility to:

- Follow McGuire Psychological Services (MPS) rules and regulations affecting care and conduct. This includes the following:
 - Show respect for the rights and privacy of other clients and their families while in the waiting room and other areas of the clinic. ALL clients are entitled to a private, quiet, therapeutic atmosphere. This includes monitoring the behavior of all children you may bring with you to appointments as well as the individual who is a client of MPS while in the reception area.
 - Complete any intake paperwork provided to you prior to your first scheduled appointment or the appointment may be rescheduled.
 - Report, to the best of your knowledge, accurate and complete information regarding any matters pertaining to your child's condition or payment information and insurance information.
 - Unless actively participating in a session or meeting with your child's provider, please remain in the waiting room area. You should not leave the clinic while your child is receiving an evaluation and/or treatment unless arrangements have been made prior and approved by the CEO.
 - Use of cell phones is prohibited in the clinical area of the clinic. Please turn off your cell

phone prior to entering the clinical area. Should you choose to use your cell phone during a session, you will be asked to return to the reception area for the remainder of your child's session.

- Comply with all posted rules and regulations while in the clinic.
- Be considerate of all MPS facilities and equipment and use them in a manner as to not abuse or destroy.
- Arrive on time for all appointments. If you are up to 15 minutes late, you will be seen, but the appointment will end at the scheduled time. If you are more than 15 minutes late, the appointment will be rescheduled.
- Be respectful of your provider's time. Please provide the most advanced notice of a cancellation as possible. Failure to provide notice may result in the assessment of fees.
- Continuity of care is critical to success. If you cancel more than five appointments in a two-month period, MPS staff will meet with you to discuss your child's attendance and make appropriate adjustments to the schedule, which may include a reduction in the number of scheduled appointments.
- If you fail to call to cancel an appointment more than two times, a written notice will be sent, and your child may be removed from the schedule.
- Payment is expected at the time services are rendered unless prior arrangements have been made.
- Follow the treatment plan recommended by your child's providers. It is your responsibility to tell your service providers whether or not you can and want to follow the treatment plan recommended for your child. The most effective plan is the one which all participants agree is the best and which is carried out exactly.

ACKNOWLEDGEMENT

By signing this form, you acknowledge you have read, understood, and agree to comply with the above Client Rights and Responsibilities. You may request a copy of this document for your records.

Printed Name of Client

Signature of Client (or Client's Parent/Legal Guardian)

Date:

MPS Representative

Date:



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NOTICE OF PRIVACY PRACTICE

This notice describes how your Protected Health Information (PHI) may be used and disclosed by McGuire Psychological Services (MPS) and how you can obtain access to this information. Please review this information carefully.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where, and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep records of your symptoms, examinations, test results, diagnosis, treatment plans, progress notes, and other medical information. We also may obtain health records from other providers. In using and disclosing this PHI we will follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA), 45CFR, Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations, and other specific purposes explained in this notice. This includes contacting you for appointment reminders and follow-up care.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:

- Request a restriction of the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the Privacy Officer at MPS. We will notify you within 30 days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of \$.60 per page and the actual cost of postage per **NRS 629.061**, except you are not entitled to access to, or to obtain a copy of psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the request amendment.
- Obtain an accounting of disclosures of your PHI, except we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorizations, among other exceptions.
- Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, email, fax, and/or telephone.
- Revoke authorization to use or disclose PHI at any time except when action has already taken place.

OUR RESPONSIBILITIES

The law requires us to:

- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our Notice of Privacy Practices and will apply the change to all your PHI, including information obtained prior to the change.

- Post notice of any changes in our Privacy Policy in the lobby and make a copy available to you upon your request.
- Use or disclose your PHI only with your authorization except as described in this notice.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your PHI.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

You may contact the designated Privacy Officer, Michelle McGuire, Owner/CEO, 7250 Peak Dr., Suite 200A, Las Vegas, NV 89028, 725-485-7100. If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

DISCLOSURES OF PHI

We may use or disclose your PHI for treatment, payment, and operation, and for purposes described below:

- **Treatment:** We will use and exchange information obtained by a physician, nurse practitioner, psychologist, or other health professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become a part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as determined necessary for your care. For example, we may disclose your PHI to an outside doctor for referral. We may also provide your health care providers with copies of various reports to assist them in your treatment.
- **Payment:** We will send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as the portion of your PHI necessary to obtain payment.
- **Health Care Operations:** Members of the staff, trainees, students, a Risk or Quality Improvement team, or similar internal personnel may use your information to assess the care and outcomes of your care to improve the quality of the care and services we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors, or attorneys may be required to review your health information to meet their responsibilities.
- **Other uses and disclosures not requiring authorization:**
 - **Business Associates:** There are some services provided to our organization through contracts with business associates. We may disclose your PHI to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
 - **Notifications:** We may disclose limited PHI information to friends and family identified by you as being involved in your care or assisting you with payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
 - **Legally Required Disclosures, Public Health, & Law Enforcement:** We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, though in such circumstance you will not be personally identified), to an employer to evaluate whether an employee has a work related injury, and to public officials to report

births and deaths. We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.

- **Information Regarding Decedents:** We may disclose PHI regarding a deceased person to: 1) Coroners and Medical Examiners to identify cause of death or other duties; 2) Funeral Directors for their required duties; and 3) to procurement organizations for purposes of organ and tissue donation.
- **Research:** We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure that privacy of your PHI. In all other situations, we may only disclose PHI for research purposes with your authorization.
- **Disclosures Requiring Authorization:** All other disclosures of PHI will only be made pursuant to your written authorization; which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.

ACKNOWLEDGEMENT

Client's Name- Please Print

By signing this form, you acknowledge receipt of this Notice of Privacy Practice. Our Notice of Privacy Practice provides information about how we may use and disclose your PHI. We encourage you to read this information in full.

If you have any questions about our Privacy Practices, please contact our front office at 725-485-7100.

Client, Parent/Legal Guardian Signature

Date

Print Name

Relationship to Client



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LEGAL CUSTODY

Client Name: _____ Date of Birth: _____

I, the undersigned, indicate by my signature below, I have legal custody of the child (named above), and, therefore, have the right to seek evaluation and/or treatment for this child. I have been advised by McGuire Psychological Services it is their recommendation my child's other parent, if any, be informed of my decision to seek evaluation and/or treatment.

SIGNATURES

Printed Name - Parent or Legal Guardian

Signature

Date

MPS Representative

Date



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CONSENT TO USE ELECTRONIC COMMUNICATION

Risks to confidentiality and privacy: The treatment providers cannot ensure the confidentiality of any form of communication through electronic media or guarantee absolute protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically. Email, e-faxes, and texts may be sent erroneously to the wrong address. Backup copies of emails and texts may exist even after the sender and/or recipient has deleted the correspondence. Employers and online services have a right to inspect emails sent through their company systems. E-mails and text messages can be used as evidence in court.

CONSENT

I have been advised of the risks of using electronic communication and I consent to the use of the following (please initial):

_____ Email: Address: _____

_____ Texting: Number(s): _____

_____ Fax: Number: _____

Additionally, MPS treatment providers can use the following means by which to contact me, and or leave a message:

_____ Home Phone: _____ Work Phone: _____

Client's Name Date

Signature of Client or Legal Guardian Date

MPS Representative Date



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Neuropsychological and Developmental History

CLIENT INFORMATION

Name: _____ Today's Date: _____
Date of Birth (Age): _____ () Handedness: ☐ Right ☐ Left ☐ Ambidextrous
Primary Language: _____ Sexual Orientation: _____
Sex assigned at birth: ☐ Male ☐ Female Pronouns: ☐ he/him ☐ she/her ☐ they/them
Current Grade: _____ School: _____
Race/Ethnicity: _____ Spirituality: _____
Are there any disability needs? ☐ No ☐ Yes: _____
Who referred you? _____
Name of person completing this questionnaire/ relationship: _____

REFERRAL INFORMATION

Please describe the symptoms or problems that are of most concern to client: _____

When did these problems start? _____

Have they gotten worse over time? Please describe: _____

In your opinion, what are the major causes of the difficulties? _____

Describe client's strengths: _____

Describe some of client's weaker areas: _____

Has the client had a psychological evaluation before? ☐ No ☐ Yes, Dates: _____
Psychologist: _____
Tests given: _____

Outcomes/Diagnosis: _____
Are you willing to sign a release? ☐ No ☐ Yes
Is this evaluation subject to litigation of any kind? ☐ No ☐ Yes: _____

FAMILY INFORMATION

Parents:

Mother's name: _____ Age: _____

Highest Education: _____ Occupation: _____

Father's name: _____ Age: _____

Highest Education: _____ Occupation: _____

Parents are: ☐ married ☐ separated ☐ remarried ☐ deceased

☐ divorced (custody arrangements: _____)

Child is: ☐ biological ☐ adopted (at age: _____) ☐ foster (since age: _____)

Siblings: (names/age): _____

How does the client get along with them? _____

Others living in the home (names, ages, relationship): _____

Childcare arrangements (if needed: what type? Hours/days?) _____

Has the client experienced death or separation from a loved one? Describe: _____

Are there any significant family or marital conflicts? Explain: _____

Are there any current or previous legal issues in the family? ☐ No ☐ Yes: _____

PREGNANCY AND BIRTH HISTORY

Age of Mother _____ and father _____ at client's delivery.

How many prior pregnancies? _____ How many prior miscarriages? _____ Fertility Specialist consulted?

☐ No ☐ Yes, which procedure: _____

Known health problems of mother during pregnancy: ☐ Vaginal Bleeding ☐ Toxemia ☐ Trauma

☐ Hypertension ☐ Gestational Diabetes ☐ Fever/Rash ☐ Blood incompatibility ☐ Injury

☐ Other: _____

Did mother use tobacco during pregnancy? ☐ No ☐ Yes, how often? _____

Was there tobacco use in the home? ☐ No ☐ Yes, how often? _____

Did mother drink alcohol during pregnancy? ☐ No ☐ Yes, how often? _____

Did mother use illegal substances during pregnancy? ☐ No ☐ Yes, (what, how much, how often)? _____

List any medications used during pregnancy and frequency: _____

Delivery was: ☐ Vaginal ☐ Cesarean (reason _____)

Labor was: ☐ Spontaneous ☐ Induced ☐ Easy ☐ Moderate ☐ Hard

Baby was: ☐ Full term ☐ Premature (_____ weeks gestation)

Birth weight: _____ pounds _____ ounces

Was labor prolonged? ☐ No ☐ Yes, how long? _____

Were forceps used during delivery? ☐ No ☐ Yes:

Any birth complications: ☐ cord around neck ☐ meconium staining ☐ lack of oxygen/blue ☐ feet first

☐ jaundice/yellow Describe: _____

Did baby breath spontaneously? ☐ No ☐ Yes Oxygen required? ☐ No ☐ Yes: _____

Other interventions required? ☐ No ☐ Yes, explain: _____

In intensive care nursery? ☐ No ☐ Yes, length of stay? _____

How old was the baby at discharge from the hospital? _____

Medical problems at discharge? _____

List any problems in the first few months of life: _____

Did mother experience any postpartum depression? ☐ No ☐ Yes, interventions? _____

DEVELOPMENTAL HISTORY

Motor

Age sat alone: _____ crawled: _____ stood alone: _____ walked alone: _____

Was child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, riding a bike, playing ball)? ☐ No ☐ Yes, explain? _____

How is the child's handwriting? _____

Was physical or occupational therapy ever recommended? ☐ No ☐ Yes, length: _____

Any current motor or coordination issues: _____

Speech/Language

Age child spoke first word: _____ put 2-3 words together: _____

Speech delays or problems (e.g., stuttering or articulation problems)? ☐ No ☐ Yes, describe: _____

Was speech therapy ever recommended/pursued? ☐ No ☐ Yes, length: _____

Was the child slow to learn the alphabet? ☐ Yes ☐ No

Was the child slow to learn the names of colors? ☐ Yes ☐ No

Was the child slow to learn to count? ☐ Yes ☐ No

Other languages spoken in the home, besides English: _____

Language child speaks with parents: _____ siblings: _____ friends: _____

Toileting

Age when toilet trained: _____ Did the child ever have: ☐ problems with bedwetting

☐ urine accidents ☐ soiling/fecal accidents If yes, at what age: _____

Any current problems with toileting? _____

Adaptive

As an infant, to a significant degree, were any of the following present during the first two years of life?

☐ Did not enjoy cuddling ☐ Was not calmed by being held or stroked ☐ Difficult to comfort

☐ Colic ☐ Excessive restlessness ☐ Poor sleep ☐ Head banging ☐ Difficulty nursing

COGNITIVE, EMOTIONAL AND BEHAVIORAL FUNCTIONING

Has the client ever showed the following?

Describe:

☐ Problem solving difficulties

☐ Concentration difficulties

☐ Memory impairment

☐ Sensory issues

☐ Frequent crying

☐ Irritability

☐ Distractibility

☐ Apathy/Lack of interest

☐ Temper tantrums

☐ Mood swings

☐ Aggression

☐ Self-injurious behaviors

☐ Destructive behaviors

☐ Anxiety/tension

☐ Fearfulness

☐ Repetitive behaviors

☐ Repetitive thoughts

☐ Fatigue

☐ Changes in eating or sleeping

☐ Nightmares

☐ Increased suspiciousness

☐ Unusual thoughts

☐ Hallucinations

☐ Daydreaming

☐ Impulsivity

- ☐ Restlessness/Hyperactivity _____
- ☐ Low frustration tolerance _____
- ☐ Forgetting _____
- ☐ Suicidal thoughts _____
- ☐ Personality changes _____
- ☐ Legal difficulties _____
- ☐ Tobacco/alcohol use _____
- ☐ Other substance use _____

How does the client get along well with: Peers: _____

Adults: _____

Does the client have friends? _____ Keep friends? _____ Understand gestures? _____

Understand jokes? _____ Have a good sense of humor? _____ Understand social cues? _____

Have problems with peer pressure? _____ Get taken advantage of by others? _____

How many friends does the client have? How old are their friends? _____

What does the client like to do for fun? _____

What extracurricular activities is the child involved in? _____

MEDICAL HISTORY

Has the client's vision been checked? ☐ Yes ☐ No Problems? _____

Has the client's hearing been checked? ☐ Yes ☐ No Problems? _____

Does the child have allergies to food/medications? ☐ No ☐ Yes: _____

Adverse reactions: _____

Primary Care Physician: _____ Sign a release? ☐ Yes ☐ No

Previous and Current health conditions/ medical issues:

Dates	Providers	Treatment/Outcomes

Please list all surgeries/hospitalizations (use additional paper if necessary):

Dates	Reasons	Treatment/ Outcomes

Has the client ever had a head injury with loss of consciousness or feeling of being “dazed”? ☐ Yes ☐ No

Type of head injury	Date	Loss of consciousness	Outcome

Please list all current medications:

Medication	Amount	Reason

Family history:

Is there a history of learning disabilities? ☐ No ☐ Yes, describe: _____

Is there a history of social problems? ☐ No ☐ Yes, describe: _____

Is there a history of neurological illness? ☐ No ☐ Yes, describe: _____

Is there a history of psychiatric disorders? ☐ No ☐ Yes, describe: _____

Is there a history of addiction/gambling? ☐ No ☐ Yes, describe: _____

Does anyone in the family have a problem similar to the client? _____

EDUCATIONAL HISTORY

Does the client have an IEP or 504 Plan: ☐ No ☐ Yes, category: _____

Are you willing to provide a copy of the IEP? ☐ Yes ☐ No, reason: _____

Placement: ☐ regular classroom ☐ resource support ☐ self-contained classroom ☐ speech/OT/PT
☐ alternative school setting

Any grades repeated: ☐ No ☐ Yes, which grades/reason: _____

Any grades skipped: ☐ No ☐ Yes, which grades/reason: _____

Teachers report problems in: ☐ reading ☐ spelling ☐ math ☐ writing ☐ attention/concentration
☐ socialization ☐ behaviors: _____

Any other academic or school problems? Please explain: _____

Current letter grades: _____

Have teachers reported problems that are not evident at home? If so, what are they? _____

INTERVENTION HISTORY

Has the client been seen by another ABA agency, psychologist, psychiatrist, or clinic? ☐ No ☐ Yes:

Dates	Providers	Treatment/ Outcomes

Would you be willing to sign a release? ☐ Yes ☐ No, reason: _____

Are you engaged with any community supports (Support groups, social services?) ☐ No ☐ Yes: _____

Please add any other comments that you feel are important for us to know: _____

Parent's Signature

Date