Lesley Stabinsky Compton, PhD

Information, Policies, and Consent
(Revised January 1, 2020)

We are honored that you have selected Woodlands Family Institute, P.C. to provide counseling or psychological services. All of us do our best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my practice policies and to ensure that you understand our professional relationship.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more satisfying.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. You are best served by experiencing me in my professional role. If at any time you are dissatisfied with my services, please let me know.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you.

Office Policies

Psychotherapy
This document provides important information about my professional services and business policies. Your signature in reference to this form will indicate that you have received this information, have read it, understand it, and agree to it.
If you have concerns or questions, please feel free to ask me about them.

Sessions
Therapy sessions are scheduled for 50 minutes, unless otherwise planned in advance. I make every effort to start appointments on time. The session time that we have scheduled is reserved for you. If you are not able to keep an appointment, I ask you to give me at least 24 hour notice. Sessions not cancelled with 24 hour notice will be charged my standard rate.

Standard Rate
$175.00 per 50 minute session.
Charges for other professional services, such as phone calls, insurance reports, third-party consultations, and correspondence will be prorated on the basis of $175.00 per hour. Off-site consultation is charged at the rate of $175.00 per hour, portal to portal.

Forensic Rates
$600.00 per hour (portal to portal) for court testimony or deposition. Payment is due 24 hours prior to services provided.

Payment Policy
Payment is due at the time of service. The office accepts checks, cash, Visa and Master Card. It is not our policy to carry balances forward. We expect balances to be made up promptly or by the next regularly scheduled appointment. If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a $10.00 rebilling fee for every statement sent out after the first billing. There is also a $25.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and will impact your credit rating.

Your health insurance policy is a contract between you and your insurance company. I am not a party to that contract. Although I am not listed as a provider on any insurance network panels, benefits are sometimes available for services rendered by "out-of-network" providers. I advise that you contact your insurance company to determine how your insurance company will reimburse you. If you elect to seek reimbursement by an insurance carrier for services rendered, the office will provide you with a receipt to assist you in completing your insurance claim. We will consult your third-party payer only at your direction with such consultations billed to your account. The client remains responsible for payment in full.

Cancellations
Since the scheduling of an appointment involves the reservation of time specifically for you, 24 hour advance notice for any cancelled appointments will not be charged. If you do not meet this time schedule, please expect to be charged the regular session fee for that appointment.

Office Hours
My normal office hours are 8 a.m. to 6 p.m. on Tuesdays and Wednesdays.

Emergencies
If you are experiencing a life threatening emergency please call 911. In the event of an emergency that is not life threatening, leave a message with the answering service, making sure to state that your call is an emergency. I will respond to your call as promptly as possible. The office phone is 281-363-4220 or 713-866-4494.

Contacting Me
Due to my work schedule, I am often not immediately available by telephone. I will make every effort to return your call on the same day that you make it, with the exceptions of weekends and holidays.

I use email, cell phone, and texting for scheduling and occasional between-session contact. I do not use these means of communications to discuss therapeutic topics or issues. I will respond to emails within 1-5 days. Do not use email or text messaging to contact me about urgent matters. My email account is secure and encrypted. However, while my email is secure, yours may not be.

I do not have a professional Facebook page, but I do have a personal Facebook profile. I do not accept friend requests from current clients. If you request to be added as a "friend" to my personal Facebook page, please note that this request will not be confirmed. The American Psychological Association has very strict guidelines with regard to contact between a psychologist and a client outside of a professional relationship.

Confidentiality

You should be aware that I practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professional consulted is also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions unless it seems important to our work together. All administrative staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
We also have contacts with some business services, such as the answering service, electronic claims processing services, and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available on request.

I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else; b) I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose abuse or neglect of children, the elderly, or disabled persons; e) the need to release information to other professionals involved in your treatment; f) in proceedings in which a claim is made about ones physical, emotional, or mental condition; g) when disclosure is relevant in any law suit affecting the parent-child relationship; h) where otherwise legally required. If you are under 18, your parents or legal guardians(s) may have access to your records and may authorize their release to other parties.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be not absolute guarantee of cure in the practice of psychotherapy.

_____ _____

CLIENT'S SIGNATURE DATE

Client Information Statement

The Texas Boards of Examiners of Licensed Psychologists, Marriage and Family Therapists, Licensed Social Workers and Licensed Professional Counselors were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of psychology, family therapy, and counseling. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

After reading the agreements, please ask about any part of the agreement that you do not understand.

PERSONAL DATA RECORD

Client Name _____ Date of Birth _____

Address _____

City/State/Zip _____

SSN _____ TXDL _____

Employer/School/Address _____

May we leave a message at any of the following?

Cell phone (circle one) _____ Yes No

Work phone (circle one) _____ Yes No

Unencrypted email address _____ Yes No

*** Please do not cancel appointments via email. You must contact the office directly.**

If you would like to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other _____

CONSENT FOR TREATMENT

Client Name _____Date of Birth _____

I give full consent for ***myself, my child/adolescent or dependent*** due to legal guardianship to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

_____ _____

Authorized Signature Date

REQUIRED: We require that a credit card be provided for after-hours appointments, missed sessions, and late cancellations. You may also designate the use of this card for regularly scheduled sessions.

Cardholder's Name_____Relationship_____

MC/VISA/DISC No._____ Exp. Date _____

Signature of Authorized User _____

☐ **Use for <u>regular</u> sessions, after hours, missed or late cancel sessions**

Financial Responsibility

Name of person(s) financially responsible for this account _____

Address/phone if different from client _____

_____

_____

Signature(s) _____

Relationship to client _____

Emergency Contact

Name _____ Phone _____

Alternate phone _____ Address_____

_____

Relationship to client _____

Referred to our office by _____

May we send a **thank you** to the person who referred you? (circle one) Yes No

May we mention your **name** in that thank you? (circle one) Yes No

Appointment Reminders

As a courtesy, you will receive an appointment reminder to your email address or your cell phone (via text message or computer generated voice mail message), the day before your scheduled appointments.

Your name: (Please print): _____

Your email address: _____

Your cell number: _____

Where would you like to receive appointment reminders? (Check one)

_____ Via text message on my cell phone (normal text message rates will apply)

_____ Via email message to the address listed above

_____Via automated voice mail message on my cell phone

****Missed appointment fees will still apply. 24 hour cancellation policy still applies. Please call the office if you need to cancel an appointment.****

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____

Signature Date

{Please refer to pages 8-9 of this document}

I acknowledge that I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies.** I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

_____ _____

Client or Authorized Representative Signature Date

_____Refuse to Sign _____Unable to Sign (specify reason) _____

_____ _____

Signature of Person Documenting Refusal or Inability to Sign Date

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute, P.C. may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *general consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.
  Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within WFI such as utilizing information that identifies you.
- "*Disclosure*" applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY

Identifying Information/Presenting Problem:

Child's Name_____DOB:_____ Age: _____

Education (grade):_____Present School:_____

Guardian(s): _____

Who referred your child for services:_____

Primary Reason for Services:_____

How long have these problems occurred? (weeks, months, years)

_____

What happened that makes you seek help at this time? _____

_____

Problems perceived to be:_____ very serious_____ serious_____ not serious

What changes would you like to see in your child? _____

_____

What changes would you like to see in yourself? _____

_____

What changes would you like to see in your family? _____

_____

Developmental History:

Prenatal:

Normal pregnancy?____Yes____No Was prenatal care received:____Yes_____No

Medications, smoking, drugs, or alcohol taken during pregnancy (amount and frequency):

_____

Complications during pregnancy:_____

If mother ill or upset during pregnancy, please explain: _____

Family/Partner reaction to pregnancy: (explain) _____

Father's age at birth_____Mother's age at birth_____

Length of active labor:_____hrs._____Easy_____Difficult

Full term:_____Yes ____ No; Number of weeks _____

Birth weight:_____lbs._____oz. Birth length: _____

Any complications for mother or infant during or after birth? Please explain_____

_____

Number of days in hospital: _____ Postpartum blues or depression? _____

Newborn: Breast or bottle fed? Breast feeding difficulties? _____

Any difficulties connecting to baby? _____

Please check any of these that occurred during the first 12 months:

_____ Difficult to put on a schedule	_____ Sociable
_____ Alert	_____ Easy to comfort
_____ Difficult to feed	_____ Difficult to keep busy
_____ Difficult to get to sleep	_____ Overactive, in constant motion
_____ Colicky	_____ Very stubborn, challenging
_____ Cheerful	_____ Affectionate

At approximately what age did your child first accomplish the following:

Rolled over: _____	Sat Up: _____
Crawled:_____	First steps:_____
First word:_____	Put 2 words together:_____
Toilet trained:_____	Began daycare/preschool:_____

Where there any delays in development?_____

Does your child have any speech difficulties?:_____

Motor difficulties (e.g. clumsiness) ?:_____

Does your child have difficulties with hygiene?_____

Please describe any other developmental concerns:_____

Medical History:

Has your child ever been hospitalized, had a seizure, head injury, surgery, or major illnesses?:

___Yes (Explain below) ____No

Age	How Long	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has child ever been seen by a medical specialist?____Yes____No

Age	How Long	Reason
_____	_____	_____

Child Health Information: Note all health problems the child has had or has now.

___High fevers	___Dental problems	___Pneumonia	___Weight problems
___Flu	__Allergies	___Encephalitis	___Skin problems
___Meningitis	___Asthma	__Seizures	___Headaches
__Unconsciousness	___Stomach	___Concussions	___Accident-prone
___Head injury	___Anemia	___Fainting	___Dizziness
___Sinus	___Tonsils out	___Heart	___Vision

___Hearing ___Earaches ___Infectious diseases
___Other illnesses (explain) _____

What medications does your child currently take? (include over-the-counter and supplements)

Name	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____

_____Name and Phone number of Pediatrician: _____
Date and results of last vision screen: _____
Date and results of last hearing screen: _____
Describe child's appetite_____Any weight concerns? _____
Circle and describe any Feeding Challenges: Pickiness/ Overeating/Stuffing/Gagging/ Choking/Vomiting _____
Describe the child's sleeping patterns:_____
(include problems falling asleep, staying asleep, not enough sleep, oversleeping and sleepwalking) Bedtime: _____

Approximate Number of Hours of Sleep Per Night: _____

Is there a history of nightmares or night terrors? _____ Describe):

_____

Is there a history of bedwetting? (Describe): _____

Mental Health History:

Has the child received therapy services or counseling in the past? ___ Yes ___No

Current Services:_____

Past Services:

Name of provider:_____Dates:_____Type of Service_____

Name of provider:_____Dates:_____Type of Service_____

Is your child seeing a psychiatrist for medication? Or in the past? ___ Yes ___No

Name of Psychiatrist:_____Dates of treatment:_____

Medication the Psychiatrist Prescribed:_____

Has your child ever received psychological testing in the past? ___ Yes ___ No

Date/s:_____Who conducted the testing?_____

Do you have a copy of the report?_____

Results of testing:_____

List any previous mental health diagnoses:_____

Is there a history of self-harm or suicidal thoughts, threats, or attempts? _____

Explain:_____

List any mental health medications that family members are taking or have taken in the past (who):_____Has anyone in the family received mental health services?

(Describe):_____

Family

Mother: Relationship to child___natural parent___relative___stepparent ___adopted

Occupation:_____Education:_____

Religion:_____Birthplace:_____Age: _____

Father: Relationship to child-___natural parent___relative___stepparent___adopted

Occupation:_____Education:_____Religion:

_____Birthplace:_____Age: _____

Are parents: Married ___Yes ___ No
Separated ___ Yes ___ No
Divorces ___ Yes ___ No

Current Members of the Household:

Name	Age	Relationship	How do they get along
1			
2			
3			
4			
5			
6			

Siblings or other immediate family members NOT in the home:

Name	Age	Relationship	How do they get along
1			
2			

If father is not actively involved, have there been other father figures? (e.g. stepfather, boyfriend, relatives) Explain:_____

Describe how everyone typically gets along in your home:

___Calm, No Conflict___Distant, not much interaction___Parent Conflicts___A lot of Arguing/Conflict___Very Close___Conflict Only Regarding Child

Explain:_____

Has the child or the family been involved with the Child Protective Services? _____

Dates:_____Reason for Involvement:_____

_____

If child is adopted:
Adoption source: _____

Reason and circumstances: _____

Age when child first in home:_____Date of legal adoption: _____

What has the child been told? _____

Living Arrangements:	Places	Dates
Number of moves in child's life	_____	_____
	_____	_____
	_____	_____
Present Home:___renting___own	_____	_____
___house___apartment	_____	_____

Does the child share a room with anyone else?___Yes___No

If yes, with whom?_____Was

the child ever placed, boarded, or lived away from the family?_____Yes___No

Explain: _____

What are the major family stresses at the present time, if any? _____

_____

What are the sources of family income? _____

Has the child been exposed to any of the following:

(Please put an X next to all that apply and explain below):

( ) Physical Abuse:_____

( ) Emotional or Verbal Abuse:_____

( ) Sexual Abuse: _____

( ) Domestic or Family Violence: _____

( ) Substance Use or Abuse: _____

( ) Neglect or Abandonment: _____

( ) Separation from Parent:_____

Child's reaction to divorce/separation:_____

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

____Allergies	____Deafness	____Muscular Dystrophy
____Anemia	____Diabetes	____Anxiety

____Asthma ____Glandular problems ____Autism

____Bleeding tendency ____Heart diseases ____Mental Retardation
____Depression ____High blood pressure ____Seizures
____Cancer ____Kidney disease ____Cerebral Palsy

____Mental illness ____Alcohol/Drug Problem ____Migraines
____Suicide ____Learning Problems ____Other (specify):

Comments re: Family Health: _____

_____

Education History:

Does/did your child receive early intervention? Behavioral/Speech/OT/PT

Other_____Did your child attend daycare/preschool?_____

How old was child when began school?_____Where did they attend?_____

Name of Current School:_____District:_____

Grades/classes repeated or failed:_____Reason: _____

Typical Grades:_____

Circle Classroom Type: Mainstream Class Special Education Class

Resource Assistance Other: _____

ARD/IEP Primary Eligibility: MD Mild MD Mod MD Sev MD Prof Autism OHI

ARD/IEP Secondary Eligibility: _____

Has your child had educational/developmental testing? (If yes, Where, When, Results?) _

_____

Number of schools the child has attended & reason for changes?

_____

Describe any history of learning problems the child has:_____

_____

Any History of Attendance Problems (truancy)? Describe:_____

Describe any behavior problems reported by the school:_____

_____

Has the child ever been suspended or expelled?_____Number of suspensions in last two years?_____Reason for suspensions/expulsions?_____

Favorite class or classes:_____Least favorite:_____

Social/Emotional Functioning:

Describe the child's personality:_____

_____

What behaviors are concerning to you?_____

_____

How does he/she deal with frustration or anger ? (Mark those that apply and explain):

( ) No Issues ( ) Physical Aggressiveness ( ) Destruction of Property ( ) Self-Harm

( ) Crying/Sadness ( ) Withdrawal ( ) Verbal Aggressiveness

Explain:_____

What are your child's strengths?_____

What are your child's weaknesses?_____

What is the child afraid of (fears)?_____

Are there any concerns about: ( ) Low Self-Esteem ( ) Sadness/Depression ( ) Worry or Nervousness ( ) Crying _____

Describe your child's relationships with other children or peers:

_____

Does your child have a Boyfriend/Girlfriend? _____

Is your child sexually active?_____

How does the child spend his/her free time?_____

How do you discipline the child? ( ) Physical:_____( ) Time Out ( ) Take Away Privileges ( ) No Discipline

What event/changes(s) have impacted the child?_____

_____

At what age did you first notice any behavioral or emotional issues? _____

What did you do about it at that time?_____

_____

Legal & Substance Abuse History:

Has the child been involved with the court currently or in the past? _____

(Date/s):_____

(Describe)_____

_____

Current Probation? ( ) yes ( ) no

Probation Officer:_____Phone #:_____

Has the child ever used or abused drugs or alcohol? (Circle): Yes No Not Sure

What Substance(s)?_____

(include nicotine and excessive caffeine use)

Age of First Use?_____Frequency of Use?_____

Any Consequences of Substance Use?_____

Symptom Checklist

Please check all that apply: (Please write any symptoms not listed at the bottom)

_____Low Intelligence
_____Learning Problems
_____Motor Delays
_____Language Delays
_____Stuttering
_____Refusing to Speak
_____Bedwetting
_____Urinating in Pants
_____Soiling Pants
_____Smearing Feces
_____Increased Self Esteem
_____Repetitive Movements
_____Poor Social Skills
_____Lack of Eye Contact

_____Depressed Mood
_____Lack of Pleasure in Activities
_____Weight Loss or Gain
_____Insomnia or Oversleeping
_____Feeling Restless or Slowed Down
_____Loss of Energy
_____Feeling Worthless or Guilty
_____Poor Concentration
_____Thoughts of Death
_____Eating Non-Edible Things
_____Less Need for Sleep
_____More Talkative than Usual
_____Racing Thoughts
_____Increased Pleasurable Activities

_____Obsessed with Specific Objects/Topics (e.g. sex, shopping, etc.)
_____Inattention
_____Does Not Listen
_____Problems with Organization
_____Loses Things Easily
_____Damages Property
_____Forgetful
_____Excessive Energy

_____Repetitive Behaviors
_____History of Trauma
_____Shaking or Trembling
_____Avoids Situations
_____Problems Separating from Parents
_____Nausea and/or Stomachaches
_____Sleep Problems

_____Blurts Out/ Talks without Thinking

_____Feeling Like Going Crazy

____Impulsiveness
____Excessive Talking
____Interrupts Others
____Fear of Social Situations
____Gets into Physical Fights
____Fear of Dying
____Chills or Hot Flashes
____Fear of Leaving the House
____Bullies/Threatens Others
____Recurrent Thoughts or Images

{Your clinician will discuss the following items with you upon your initial session, and periodically thereafter as needed.}

Treatment Plan

Diagnostic Impression:

Axis I _____
Axis II_____
Axis III_____
Axis IV_____
Axis V_____

Treatment Goals:

1. Reduce frequency and intensity of:

2. Increase frequency and intensity of:

3. Eliminate:

Treatment Methods and Duration:

____Individual sessions □weekly □bi-weekly □monthly

____Couple/family sessions □weekly □bi-weekly □monthly

Recommendations for Adjunctive Treatment/Assessment:

Plan Review/Revision:

_____ _____
Lesley Stabinsky Compton, PhD Date

_____ _____
Client Signature Date