Responsive Centers for Psychology & Learning

7501 College Boulevard, Suite 250 ♦ Overland Park, Kansas 66210
Telephone: (913) 451-8550 ♦ Fax: (913) 469-5266

CLIENT REGISTRATION FORM – SUE NOLAN, M.A./LIZ SWANSON-HYLAND, PH.D.

CLIENT INFORMATION

Last Name: ________________________________ First Name: ______________________________ Middle Initial: _______

Home Address: ____
Street City State Zip

Date of Birth: __________________ Age: _______ Sex: _______ Social Security Number: ___________________________

Home Phone: ___________________ Cell Phone (Mom): ___________________ Cell Phone (Dad): ___________________

School: ___________________________ Grade: ______

Teacher's Name: ____________________________________ Counselor's Name: ___________________________________

Referred by: _____Physician _____Family Member _____School _____Friend _____Other: __________________________

FINANCIALLY RESPONSIBLE PARTY (adult who brings the client to the appointment)

Last Name: ________________________________ First Name: ______________________________ Middle Initial: _______

Home Address: ____
Street City State Zip

Employer: ____

Home Phone: _______________________ Cell Phone: _______________________ Work Phone: ______________________

Date of Birth: _________________________ Sex: _______ Social Security Number: _________________________________

FINANCIAL POLICY (adult who brings the client to the appointment)

Payment in full is due at the time of service. All payments will be collected at check-in during regular business hours. Anytime our receptionist is not available, please pay your provider of service immediately following your visit.

If you fail to notify the office of a cancellation 24 hours prior to your scheduled visit, you may be charged for the visit.

I have read and understand the above stated policies.

_______________________________________ _______________________________________ ____________________
Printed Name Signature Date

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FINANCIAL POLICY FOR EDUCATIONAL TESTING

All services by Dr. Elizabeth Swanson-Hyland, Susan Nolan, and Dr. Mark Kenney are rendered on a private pay basis and Responsive Centers will not be filing an insurance claim on your behalf. These providers are not participating providers with any insurance company.

Achievement testing services (Susan Nolan and Dr. Kenney) are **NOT BILLABLE** to insurance. They cannot be assigned the CPT codes and diagnosis codes required by an insurance company to process a claim.

Some services rendered by Dr. Swanson-Hyland may be billable to insurance by the client if the client wants to file a claim. We cannot guarantee that the service will be covered or processed for payment. At your request, we will provide you with a visit summary that will contain CPT codes and diagnoses, **IF APPLICABLE**. Sometimes a diagnosis code cannot be assigned. If you have any questions, please discuss them with your provider.

You may choose to submit the visit summary to a flexible spending or health care reimbursement account. We cannot guarantee that these types of accounts will cover such expenses. Please contact your plan administrator with questions.

I have read, understand, and agree to this policy.

____

Printed Name Date

____

Signature

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CONSENT TO TREAT FOR TESTING

WELCOME
Welcome to our practice. Please read this document carefully and note any questions you might have so you and your examiner can discuss them. *Once you sign this, it will constitute a binding agreement between you and your examiner*.

NOTICE OF PRIVACY PRACTICES
By signing this agreement you consent to the use of your personal health information for purposes of diagnosis, treatment planning, payment or healthcare according to the Notice of Privacy Practices posted on the Responsive Centers website and provided at the Responsive Centers offices.

TESTING
Psychological and psycho-educational testing vary depending on the referral concerns to be addressed, the referral source, and the age and ability of the patient. There are a number of different approaches that can be used. Psychological and psycho-educational testing are often voluntary. There are some cases in which testing is court ordered and participation is required. All testing requires an active effort on the part of the recipient for the results to be reliable and valid. The general goals of an evaluation include, but are not limited to, the establishment of a diagnosis, collection of data sufficient to permit case formulation, and to develop a treatment plan. Other goals of evaluation may include academic considerations, placement, determination of competency, or custody recommendations. Testing may determine the presence of a disorder that has treatment consequences such as learning disabilities or substance abuse disorders.

The evaluation process may require only one session or multiple sessions. It may be conducted solely by one examiner or several may be involved. There is generally a face-to-face interview with the client and often contact with parents, teachers, spouses, physicians, or other collateral resources. Consent is required to speak with collateral resources. The interview based information and that received from collateral resources are integrated with the data obtained through other components of the evaluation.

CONFIDENTIALITY
In general, the confidentiality of all communications between you and your examiner is protected by law. Examiners can release information only with written permission with some exceptions. In some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require testimony.

There are some situations in which your examiner is legally required to take action to protect others from harm, even though that requires revealing some information about you. If your examiner believes that you, a child, an elderly person, or a disabled person is being abused, your examiner is required to file a report with the appropriate state agency.

If your examiner believes that you are a serious threat to another person, your examiner is required to take protective actions, which may include notifying the potential victim, notifying the police, and seeking appropriate hospitalization. If you threaten to harm yourself, your examiner may be required to seek hospitalization or contact a family member or others who can provide protection.

INDEPENDENT PRACTICE
Responsive Centers for Psychology and Learning is an association of independently practicing professionals, which shares certain expenses and administrative functions. While members share a name and office space, they are completely independent in providing you with clinical services and are fully responsible for those services. Any matters concerning your evaluation should be addressed with your examiner first. If the matter is not resolved to your satisfaction, you may contact our executive director.

I have read the above information and understand its contents. I give my full consent for testing. I have had the opportunity to read and obtain a copy of the Notice of Privacy Practices.

______________________________	______________________________
Print Name	Witness
______________________________	______________________________
Signature	Date

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CLIENT INTAKE AND DEVELOPMENTAL HISTORY

Date: ______________ **Form Completed by:** ____________________________ **Referred by:** _________________________

Client's Name: ______________________________ Date of Birth: _______________ Age: ______ Current Grade: _______

Home Address: ____
Street City State Zip Does client have cell phone?

Home Phone: ____________________ Cell Phone (Mom): ____________________ Cell Phone (Dad): ____________________

Name of Emergency Contact: ____ Phone: ______________________

May we contact you at work? ____Yes ____No Work Phone (Mom): ________________ Work Phone (Dad): ________________

May we contact you by personal e-mail? ____Yes ____No E-Mail Address: ____

Are parents married? ____Yes ____No Separated? ____Yes ____No Divorced? ____Yes ____No

Client resides with: __________________ Is client adopted? ____ If yes, age/conditions when adopted: _____________________

School: ____________________________ Teacher's Name: ____________________ Counselor's Name: _________________

School Address: ____
Street City State Zip

School Phone: _______________________________ School Fax: _______________________________

Mother's Information

Name: _______________________________________

Address: ______________________________________
(If different than above)

____

Age: _____ Education (years): ___________________

Place of Employment: ___________________________

Type of Employment: ___________________________

Father's Information

Name: _______________________________________

Address: ______________________________________
(If different than above)

____

Age: _____ Education (years): ___________________

Place of Employment: ___________________________

Type of Employment: ___________________________

Please list all other children in the family (including step siblings):	Age:	Grade:	List other people living with the family:
______________________________________	_____	_____	______________________________
______________________________________	_____	_____	______________________________
______________________________________	_____	_____	______________________________
______________________________________	_____	_____	______________________________

1. Describe the nature of your current concerns and why you are seeking help:

____

____

____

____

2. Has there been previous testing that resulted in a diagnosis? _____ If yes, what type? ______________________________
(Please provide copies of any previous test reports or assessment results)

____

____

3. When diagnosed? _________________ By whom? ____

4. What type of support has the client qualified for at school and what types of services have been provided?

____

____

<u>Current Physician's Name</u>: ____

Physician's Address: ____
Street City State Zip

Physician's Phone: ___________________________________ Physician's Fax: ________________________________

List other physicians or specialists that treat the client:

____

Past medication and dosage prescribed? Was it effective? (Please list the medication history/dosage and conditions) ___________

____

____

____

Current Medication and Dosage: ____

____

Please describe the dates and nature of any past services and who provided them:

Counseling: ____

Therapy: ____

Other: ____

SCHOOL HISTORY

1. Summary of school progress (e.g., schools attended, academic, social, testing) within each of these grade levels:

   Preschool: ____

   Kindergarten: ____

   Grades 1 through 3: ____

   Grades 4 through 6: ____

   Grades 7 through 12: ____

   College: Degree/Date of Graduation: ____

2. Has the client ever been in any type of special education program, and if so, how long?

   Notes on:
   Which district, agency, or individual provided specialized services?

   Learning disabilities class: ____Yes ____No

   If Yes, dates and duration of placement: _______________

   Behavioral/emotional disorders class: ____Yes ____No

   If Yes, dates and duration of placement: _________________

   Resource room: _____Yes _____No

   If Yes, dates and duration of placement: _________________

   Speech and language therapy: _____Yes _____No

   If Yes, dates and duration of therapy: ___________________

   Occupational or physical therapy: _____Yes _____No

   If Yes, dates and duration of therapy: ___________________

Tutoring: ____

Summer School: ____

3. Is the client right handed or left handed? __________

   Does the client wear glasses? ____Yes ____No Condition: __________________________ Age diagnosed: ______________

4. Current accommodations or individualized support: (Attach a copy of current IEP or accommodation plan, if available)

____

____

____

____

5. Current Academic Information:

Subject	Below Grade Level	At Grade Level	Above Grade Level	Observations and Teacher Comments
Reading				
Math				
Social Studies				
Science				
Writing				
Spelling				
Other				

Please use the space below, if needed, in order to better describe any specific problems or patterns of difficulties the client has experienced academically. Feel free to include any comments teachers have made or attach any examples of testing or work that shows where there are academic difficulties or inconsistencies.

SOCIAL HISTORY

Comments and Notes

1. How does the client get along with his/her brothers/sisters?
    - Doesn't have any ___________
    - Better than average ___________
    - Average ___________
    - Worse than average ___________

2. How easily does the client make friends?
    - Easier than average ___________
    - Average ___________
    - Harder than average ___________
    - Don't know ___________

3. On average, how long does the client keep friendships?
    - Less than 6 months ___________
    - 6 months – 1 year ___________
    - More than 1 year ___________
    - Don't know ___________

4. Describe any additional information on ability to make and maintain social relationships:

   At home: ____

   At school/work: ____

5. Describe involvement in outside activities:

   Sports: _______________ Music: _______________ Clubs: _______________ Scouts: _______________ Church: ______________

   Please describe other special interests or hobbies: ____

6. Have any of the following stress events occurred within the past 12 months?
    - Parents divorced or separated ___________
    - Family accident or illness ___________
    - Death in the family ___________
    - Parent changed jobs ___________
    - Child changed schools ___________
    - Family moved ___________
    - Family financial problems ___________
    - Other (please specify)____

BEHAVIORAL HISTORY

1. Check each of the following as it applies:

	Yes	No	Sometimes	Comments
Truthful				
Daydreams				
Withdrawn				
Sense of humor				
Outgoing				
Shy				
Nervous				

Check each of the following as it applies	Yes	No	Sometimes	Comments
Easily frustrated or upset				
Inability to control temper				
Difficulty adjusting to changes				
Difficult to discipline				
Stealing				
Overactive				
Short attention span				
Difficulty following directions				
Respect for authority figures				
Good self concept				
Follows through with responsibilities				
Self help skills adequate				

2. Describe any behavioral concerns: Other (Related) Concerns:

   Has the client ever talked about dying or attempted suicide?

Has the client ever been:

3. Suspended from school: ___Yes ____No Expelled from school: ____Yes ____No Retained in grade: ____Yes ____No
   Explain circumstances:

4. Have there been difficulties related to substance use? ____Yes ____No Involvement in sexual abuse? ____Yes ____No
   Explain circumstances:

5. Had legal difficulties or been arrested? ____Yes ____No
   Explain circumstances:

6. Have any behavior modifications been attempted? ____Yes ____No
   Behavior modification program: ____Yes ____No Daily/weekly/report card: ____Yes ____No
   Other (please specify): ____

____

7. What other strategies have been implemented to address behavior? (Check all which have been successful)
   - Verbal reprimands: __________ Physical punishment: __________
   - Acquiescence to client: __________ Time out (isolation): __________
   - Removal of privileges: __________ Rewards: __________
   - Avoidance of client : __________ Professional intervention: __________
   - Other: ____________________________

8. On average, what percentage of the time does the client eventually comply with commands?
   0-20%: ________ 20-40%: ________ 40-60%: ________ 60-80%: ________ 80-100%: ________

9. To what extent are you and your spouse consistent with respect to disciplinary strategies?
   Most of the time: __________ Some of the time: __________ None of the time: __________

DEVELOPMENTAL AND MEDICAL HISTORY

HEALTH HISTORY

A. Date of the client's last physical exam: ________________________________ Explain/Note Circumstances

B. At any time has the client had any of the following?

1. Asthma: ____Never ____Past ____Present _________________________
2. Allergies: ____Never ____Past ____Present _________________________
3. Diabetes, arthritis, or other chronic illnesses: ____Never ____Past ____Present _________________________
4. Epilepsy or seizure disorder: ____Never ____Past ____Present _________________________
5. Febrile seizures: ____Never ____Past ____Present _________________________
6. Chicken pox or other common childhood illnesses: ____Never ____Past ____Present _________________________
7. Heart or blood pressure problems: ____Never ____Past ____Present _________________________
8. Broken bones: ____Never ____Past ____Present _________________________
9. Severe cuts requiring stitches: ____Never ____Past ____Present _________________________
10. Head injury with loss of consciousness: ____Never ____Past ____Present _________________________
11. Lead poisoning: ____Never ____Past ____Present _________________________
12. Surgery: ____Never ____Past ____Present _________________________
13. Lengthy hospitalization: ____Never ____Past ____Present _________________________
14. Speech or language problems: ____Never ____Past ____Present _________________________
15. Chronic ear infections: ____Never ____Past ____Present _________________________
16. Hearing difficulties: ____Never ____Past ____Present _________________________
17. Eye or vision problems: ____Never ____Past ____Present _________________________
18. Eye glasses/contact lenses: ____Never ____Past ____Present _________________________
19. Appetite problems (over eating or under eating): ____Never ____Past ____Present _________________________
20. Sleep problems (falling asleep, staying asleep): ____Never ____Past ____Present _________________________
21. Soiling problems: ____Never ____Past ____Present _________________________
22. Wetting problems: ____Never ____Past ____Present _________________________
23. Sensory Integration problems: ____Never ____Past ____Present _________________________
24. Other developmental delays, health difficulties, or concerns:

 Please describe: ____

 ____

 ____

PREGNANCY AND DELIVERY

A. Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.): ______________________________

B. Length of delivery (number of hours from initial labor pains to birth): ______________________________

C. Mother's age when client was born: ______________________________

D. Client's birth weight: ______________________________

E. Did any of the following conditions occur during pregnancy/delivery?

1. Bleeding: _____No _____Yes
2. Excessive weight gain (more than 30 lbs): _____No _____Yes
3. Toxemia/preeclampsia: _____No _____Yes
4. Rh factor incompatibility: _____No _____Yes
5. Frequent nausea or vomiting: _____No _____Yes
6. Serious illness or injury: _____No _____Yes
7. Took prescription medication(s): _____No _____Yes
 If yes, name of medication(s): ____
8. Took illegal drugs: _____No _____Yes
9. Used alcoholic beverages: _____No _____Yes
 If yes, approximate # of drinks per week: ______

E. Did any of the following conditions occur during pregnancy/delivery? (cont.)

10. Smoked cigarettes: _____No _____Yes
    If yes, approximate # of cigarettes per day (e.g., ½ pack): ____________
11. Was medication given to ease labor pains? _____No _____Yes
    If yes, name of medication: ____
12. Delivery was induced: _____No _____Yes
13. Forceps used during delivery: _____No _____Yes
14. Had a breech delivery: _____No _____Yes
15. Had a caesarean delivery: _____No _____Yes
16. Other problems: _____No _____Yes
    If yes, please describe: ____

____

F. Did any of the following conditions affect the client during delivery, or within the first few days after birth?

1. Injured during delivery: _____No _____Yes
2. Cardiopulmonary distress during delivery: _____No _____Yes
3. Delivered with cord around the neck: _____No _____Yes
4. Had trouble breathing following the delivery: _____No _____Yes
5. Needed oxygen: _____No _____Yes
6. Was cyanotic, turned blue: _____No _____Yes
7. Was jaundiced, turned yellow: _____No _____Yes
8. Had an infection: _____No _____Yes
9. Had seizures: _____No _____Yes
10. Was given medications: _____No _____Yes
11. Born with congenital defect: _____No _____Yes
12. Was in hospital more than 7 days: _____No _____Yes

INFANT HEALTH AND DEVELOPMENT

Comments and Notes

During the first 12 months, was the client:

1. Difficult to feed: _____No _____Yes
2. Difficult to get to sleep: _____No _____Yes
3. Colicky: _____No _____Yes
4. Difficult to put on a schedule: _____No _____Yes
5. Alert: _____No _____Yes
6. Cheerful: _____No _____Yes
7. Affectionate: _____No _____Yes
8. Sociable: _____No _____Yes
9. Easy to comfort: _____No _____Yes
10. Difficult to keep busy: _____No _____Yes
11. Overactive, in constant motion: _____No _____Yes
12. Very stubborn, challenging: _____No _____Yes

Other observations: ____

____

EARLY DEVELOPMENTAL MILESTONES

At what age did the client first accomplish the following?

1. Sitting up without help: ___________
2. Crawling: ___________
3. Walking alone, without assistance: ___________
4. Using single words (e.g., “mama,” “dada,” “ball,” etc.): ___________
5. Putting two or more words together (e.g., “mama up”): ___________
6. Bowel training, day and night: ___________
7. Bladder training, day and night: ___________

Family History

Please provide information regarding relatives (siblings, parents, grandparents, aunts, uncles, cousins, etc.) who have ever been identified with or suspected to have difficulty in these areas.

	List Relatives with History of Difficulty	**As a Child/as a Teen/ as an Adult**
1. Oppositional behavioral or problems with aggressiveness and defiance now, or as a child		
2. Problems with attention, level of activity, or impulse control now, or as a child		
3. Learning disabilities		
4. Developmental delays/mental retardation		
5. Failed to graduate from high school		
6. Depression for greater than 2 weeks		
7. Anxiety disorder that impaired adjustment		
8. Autism or Asperger's		
9. Alcohol abuse		
10. Substance Abuse		
11. Tics or Tourette's		
12. Antisocial behavior (assaults, thefts, arrests)		
13. Psychosis or schizophrenia		
14. Physical abuse		
15. Sexual abuse		
16. Other		

Please answer these questions

1. Which of the following are considered to be a significant problem at the present time? **Comments and Notes**

- Fidgets _____No _____Yes
- Difficulty remaining seated _____No _____Yes
- Easily distracted _____No _____Yes
- Difficulty awaiting turn _____No _____Yes
- Often blurts out answers to questions before they have been completed _____No _____Yes
- Difficulty following instructions _____No _____Yes
- Difficulty sustaining attention _____No _____Yes
- Shifts from one activity to another _____No _____Yes
- Difficulty playing quietly _____No _____Yes
- Often talks excessively _____No _____Yes
- Often interrupts/intrudes on others _____No _____Yes
- Often does not listen _____No _____Yes
- Often loses things _____No _____Yes
- Often engages in physically dangerous activities _____No _____Yes

2. When did these problems begin? Specify age: __________

3. Which of the following are considered to be a significant problem at the present time?

- Often loses temper _____No _____Yes
- Often argues with adults _____No _____Yes
- Often actively defies or refuses adult requests or rules _____No _____Yes
- Often deliberately does things that annoy other people _____No _____Yes
- Often blames others for own mistakes _____No _____Yes
- Is often touchy or easily annoyed by others _____No _____Yes
- Is often angry or resentful _____No _____Yes

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