

**Jeff M. Bauman, Psy.D., P.A., and Associates**  
**Application for Services and Financial Policies –C/A**

PLEASE answer as complete as possible.

Date \_\_\_\_\_ Please tell us who referred you \_\_\_\_\_

Child/Adolescent Complete Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone \_\_\_\_\_ Wk. Phone Mom \_\_\_\_\_ Wk. Phone Dad \_\_\_\_\_

Are there any restrictions as to where we may phone parent/guardian? \_\_\_\_\_

May we contact parent/guardian by E-Mail? \_\_\_\_\_ If so, E-Mail address \_\_\_\_\_

Father's name \_\_\_\_\_ Age \_\_\_\_\_ Education \_\_\_\_\_

Father's place of employment \_\_\_\_\_

Father's type of employment \_\_\_\_\_

Mother's name \_\_\_\_\_ Age \_\_\_\_\_ Education \_\_\_\_\_

Mother's place of employment \_\_\_\_\_

Mother's type of employment \_\_\_\_\_

Is child/adolescent adopted? \_\_\_\_\_ If yes, age when adopted \_\_\_\_\_

Are parents married? \_\_\_\_\_ Separated? \_\_\_\_\_ Divorced? \_\_\_\_\_

If parents are divorced has either parent remarried? \_\_\_\_\_

Please explain as needed: \_\_\_\_\_

Do both parents agree to this evaluation/treatment? Please

explain. \_\_\_\_\_

Previous mental health professional/provider \_\_\_\_\_

Primary physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Child/Adolescent's Complete Name \_\_\_\_\_

What brings you/your child in for treatment at this time?

\_\_\_\_\_

How long have the difficulties been present?

\_\_\_\_\_

What are your goals for treatment?

\_\_\_\_\_

I hereby apply and consent to psychological services/consultation with Dr. Bauman and Associates. I certify that I am the legal parent or guardian of the identified patient and that I have the right to independently seek medical/psychological treatment for this child. If there is another party who needs to agree. I certify that I have notified that party and they agree to this treatment. I understand that it is my responsibility to cooperate with treatment.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Charges for services are due and payable at the time services are rendered. If you have health insurance, it should be understood that this is an agreement between you and your carrier. You remain directly responsible to the doctor for your account. If you fail to meet your financial responsibilities, we reserve the right to turn your account over to a collection agency or appropriate court.

I hereby give my consent to release necessary information for taking such action. I understand that I will be responsible for any expenses incurred due to collection or judicial actions in this regard.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE BE SURE TO READ YOUR COPY OF PATIENT'S RIGHTS AND RESPONSIBILITIES and HIPAA PRIVACY NOTICE!** These are always available on our website. ([www.WestonChildPsychologist.com](http://www.WestonChildPsychologist.com))

I have read and understand the Patient's Rights and Responsibilities and HIPAA.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Child's/Adolescent's Name \_\_\_\_\_

Please complete the following information as best you can. This allows for more efficient and effective use of your first session.

**Child/Adolescent's SYMPTOMS INCLUDE**

Depression Anxiety Insomnia Sadness Crying Spells Impulsive

Suicidal Thoughts No pleasure No Energy Alcohol abuse Pain

Can't sit still Can't concentrate Can't Work Can't eat Eating too much

Sleeping too much Worrying too much Weight loss Weight gain Drug abuse

Headaches Troubling thoughts Feeling paranoid Feeling out of control

Thoughts to harm others Distrustful Fearful Oppositional Behavior Explosive outbursts

Educational difficulties Homework battles

Others that we have not mentioned.

\_\_\_\_\_  
\_\_\_\_\_

**MENTAL HEALTH HISTORY** (Include dates/providers of any hospitalizations and outpatient treatment) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY** (Please list all blood relatives who have a documented or suspected psychiatric problem, including addictive disorders.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Child/Adolescent Name** \_\_\_\_\_

**Developmental and Medical History**

**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 child was born \_\_\_\_\_

D. Child's birth weight \_\_\_\_\_

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

1. Bleeding \_\_\_\_\_

2. Excessive weight gain (more than 30 lbs.) \_\_\_\_\_

3. Serious illness or injury \_\_\_\_\_

4. Took prescription medication (which? ) \_\_\_\_\_ 5. Used alcoholic beverages (how many drinks per week \_\_\_\_\_) **NO YES**

6. Used recreational drugs \_\_\_\_\_

7. Smoked Cigarettes (how many packs per day?(\_\_\_\_\_)

8. Forceps used during delivery \_\_\_\_\_

9. Breech delivery \_\_\_\_\_

10. Other problems-please describe \_\_\_\_\_

Did your child have any difficulties during delivery or within the first few days after birth? \_\_\_\_\_

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**INFANT HEALTH AND TEMPERAMENT**

During the first 12 months, was your child:

1. Difficult to feed? \_\_\_\_\_

2. Difficult to get to sleep \_\_\_\_\_

3. Colicky \_\_\_\_\_

4. Difficult to put on a schedule \_\_\_\_\_

5. Alert \_\_\_\_\_

6. Cheerful \_\_\_\_\_

7. Affectionate \_\_\_\_\_

8. Sociable \_\_\_\_\_

9. Easy to comfort \_\_\_\_\_

10. Difficult to keep busy \_\_\_\_\_

11. Overactive, in constant motion \_\_\_\_\_

Child's/Adolescent's name \_\_\_\_\_

## **EARLY DEVELOPMENTAL MILESTONES (AS MUCH AS YOU CAN REMEMBER)**

At what age did your child first accomplish the following?

1. Sitting without help
2. Crawling
3. Walking without assistance
4. Using single words
5. Putting two or more words together
6. Bowel training, day and night
7. Bladder training, day and night

## **HEALTH HISTORY**

Date of child's last physical exam: \_\_\_\_\_

At any time has your child had the following?

1. Asthma \_\_\_\_\_
2. Allergies (to what? ) \_\_\_\_\_
3. Diabetes \_\_\_\_\_
4. Epilepsy or seizure disorder \_\_\_\_\_
5. Heart or blood pressure problems \_\_\_\_\_
6. Broken bones \_\_\_\_\_
7. Surgery \_\_\_\_\_
8. Head injury with loss of consciousness \_\_\_\_\_
9. Lengthy hospitalization \_\_\_\_\_
10. Speech or language problems \_\_\_\_\_
11. Chronic ear infections \_\_\_\_\_
12. Hearing difficulties \_\_\_\_\_
13. Vision problems \_\_\_\_\_
14. Fine motor/handwriting problems \_\_\_\_\_
15. Gross motor difficulties/clumsiness \_\_\_\_\_
16. Appetite disturbance \_\_\_\_\_
17. Sleep problems \_\_\_\_\_
18. Soiling problems \_\_\_\_\_
19. Wetting problems \_\_\_\_\_
20. Other health difficulties-please describe \_\_\_\_\_

Current Medications: \_\_\_\_\_ Prescribed by: \_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

**Jeff M. Bauman, Psy.D., P.A. and Associates**

**HIPAA CONSENT**

**This form is an agreement between you and this practice. When we use the word “you” below, it can mean you, your, child, a relative, or other person if you have written his/her name here Patient Name)\_\_\_\_\_.**

**Your signature here certifies your consent that we may use/share your Protected Health Information as described in the HIPAA PRIVACY NOTICE you have received. Please make sure to read that document and ask us any questions.**

**After you have signed this consent, you have the right to revoke it (by writing a letter to Dr. Bauman). We will then comply with your wishes from that time forward. Of course we cannot do anything about information shared previous to your revocation.**

\_\_\_\_\_  
**Signature of patient or his/her personal representative    Date**

\_\_\_\_\_  
**Printed name of patient or personal representative    Date**

\_\_\_\_\_  
**Relationship to patient**