# Jeff M. Bauman, Psy.D., P.A.

**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: _______________
Please list all addresses where this child/adolescent lives.

Address: __________________________ City: _____________ Zip: ______________ (Which parent?)___________
Address: __________________________ City: _____________ Zip: ______________ (Which parent?)___________

Are there any restrictions as to where we may phone or leave message for parent/guardian? ____________

May we contact parent/guardian by E-Mail? ______ If so, E-Mail address ___________________________

Parent #1 Name____________________________ Age_____ Education_____________________________

Parent #1 Place of employment______________________________________________________________

Parent #1 Type of employment_______________________________________________________________
Parent #1 Phone____________________________________

Parent #2 Name ____________________________ Age_____Education ____________________________

Parent #2 Place of Employment_______________________________________________________________

Parent #2 Type of employment________________________________________________________________
Parent #2 Phone____________________________________
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(especially if divorced) 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. This practice does not bill nor interact directly with insurance companies. You remain directly responsible to the practice 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.

In the unlikely event that I do not meet my financial obligation, I hereby give my consent to release necessary information for taking collection action. I understand that I will be responsible for any expenses incurred due to collection or judicial actions in this regard.
Signature _________________________________________Date _____________________

*I understand that it is my responsibility to provide at least* ***48 hours notice*** *during business hours in order to cancel or reschedule an appointment. The practice will charge full fee for appointments cancelled or missed without this notice.*
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 websites. WestonChildPsychologist.com or FloridaADHD.com

I have read and understand the Patient's Rights and Responsibilities-2018 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   Worry   Sadness   Crying Spells   Impulsive   Oppositional Behavior

Suicidal Thoughts   No pleasure   No Energy   Tearfulness   Difficulty making/keeping friends

Can't sit still   Can't concentrate   Can't eat   Eating too much   Headaches   Stomach Issues

Sleep issues   Weight loss   Weight gain   Drug use   Alcohol use

Toilet(elimination) issues   Troubling thoughts   Feeling paranoid   Feeling out of control

Thoughts to harm others   Distrustful   Fearful   Explosive outbursts

Educational difficulties   Homework battles   Lack of Motivation   Decreased school grades

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? ______________________
______________________________________________________________________________________________

**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. Additionally I am asking your consent to communicate with the treatment team. This team consists of other healthcare professionals such as your pediatrician or psychiatrist during the treatment episode.**

**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**