



# NeuroBehavioral Associates, LLC

Assessment & Intervention for Neurological & Psychiatric Conditions

## NeuroBehavioral Associates -- New Patient Information

### Information, Authorization and Consent to Treatment

Welcome to Neurobehavioral Associates. We are pleased that you selected our facility for your therapy and we are sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from your therapist, policies regarding confidentiality and emergencies and several other details regarding your treatment here at Neurobehavioral Associates. Although providing this document is part of your ethical obligation to our profession, more importantly, it is part of our commitment to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.

### Background information, theoretical views, and Client Participation

Information regarding your therapist's educational background and experience may be found on our website under their name. It is our belief that as people become more aware accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control and you may end your relationship with your therapist at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and your therapist talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or nonprescription drugs at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest the greater the return.

Furthermore, it is our policy to only see clients who we believe have the capacity to resolve their own problem without assistance. It is our intention to empower you to your growth process to the degree that you are capable of facing life's challenges in the future without your therapist. We also do not believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, your therapist will direct you to other resources that will be of assistance to you. Your personal development is our number one priority. We encourage you to let us know if you feel that transferring to another facility or another therapist is necessary at any time. Our goal is to facilitate healing and growth and we are very committed to helping you in whatever way seems to produce maximum benefit.

### Confidentiality and records

Your communications with your therapist will become part of a clinical record of treatment and it is referred to as Protected Health information (PHI). Your PHI will be kept in a file stored in a locked cabinet in our locked business office. It is filed under your first name and last initial to protect your confidentiality to the fullest extent. Additionally, your therapist will always keep everything you say to her or her completely confidential with the following exceptions: (1) You direct your therapist to tell someone else and you sign a 'Release of information form. (2) Your therapist determines that you are a danger to yourself or to others. (3) You report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) Your therapist is ordered by a judge to disclose information. In the latter case, your therapist's license does not provide him or her with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a counselor. This state has a very good track record of respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. We cannot guarantee the appeal will be sustained, but we will do everything in our power to keep what you say confidential. Please note that in couples' counseling, your therapist does not agree to keep secrets. Information revealed in any context may be discussed with either partner.

### Financial responsibility, Structure, and Cost of Sessions

You hereby agree and accept financial responsibility for the filing of your insurance and are solely responsible for any and/or all unpaid portions of your claim filed under Neurobehavioral Associates. You agree to allow Neurobehavioral



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Associates to file and accept assignment of benefits of your insurance claims on your behalf. Should your insurance deny any or part of your insurance claims, you agree to pay for your services rendered to you by Neurobehavioral Associates. Your doctor/therapist agrees to provide psychotherapy for the fee of \$250 per 20-30minute session, \$275 per 45-50-minute session, \$331 per 60-minute session and up to \$331 per 60 minute (and group) therapy session, unless otherwise negotiated by you or your insurance carrier. Telephone calls that do not exceed 10 minutes in duration will be billed up to \$100 per 10-minute increments. The fee for each session will be due at the conclusion of the session. Cash, personal checks, Visa, MasterCard, Discover, or American Express are acceptable for payment and we will provide you with a receipt of payment.

The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a \$35 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. We will be glad to provide you with a statement for your insurance company and to assist you with any questions you have in this area.

## **Cancellation policy**

If you are unable to keep an appointment, you may notify your therapist at least 24 hours in advance. There is a \$45.00 no show fee for all new patients and missed therapy appointments. If such advance notice is not received, you will be financially responsible for the evaluation, interview session or testing you missed. A "No Show" fee if therapy is missed will be applied for all forensic, IUME and/or Workman Compensation in the amount of \$1980 for the missed evaluation and testing. Please note that insurance companies do not reimburse for missed interviews, evaluations, sessions or testing.

## **In the Case of an Emergency**

Neurobehavioral Associates is considered to be an outpatient facility and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beeper nor are we available at all times. If at any time this does not feel like sufficient support, please inform your therapist and he or she can discuss additional resources or transfer your case to a therapist with a 24-hour availability. Generally, your therapist will return phone calls within 24-48 hour. If you have a mental health emergency, we encourage you not to wait for a call back, but do one or more of the following

Call Behavioral Health Link/GCAL: 800-715-4225 or other crisis hotline

Call Augusta University at 706-721-0211 or call local hospital

Call Georgia Regional Hospital 706-792-7006 or call local hospital

CALL 911

Go to your nearest emergency room

## **Professional Relationship**

Psychotherapy is a professional service we will provide to you. Because of the nature of therapy your relationship with your therapist has been different from most relationships. It may differ in how long it lasts, the objectives or the topics discussed. It must also be limited to only the relationship of the therapist and the client. If you and your therapist were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapists' interest and the clients interest and then the client's interests might not be put first. In order to offer all of our clients the best care your therapist judgements needs to be unselfish and purely focused in your needs. This is why your relationship with your therapist must remain professional in nature.

Additionally, there are important differences between therapist and friendship. Friends may see your problem only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems =so that they can feel helpful. These short- term solutions may not be in your long-term best interest. Friends do not usually follow your advice to see whether it was useful. They may need to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist response to your situation are based on tests theories and methods of change.



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You should also know that therapists are required to keep the identity of their clients confidential. As much as your therapist would like to, for your confidentiality, he or she will not address you in public unless you speak to him or her first. Your therapist also must decline any invitations to attend gatherings with your family or friends. Lastly when your therapy is completed, your therapist will not be able to be a friend to you like other friends. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

## **Statement regarding Ethics, Client Welfare and Safety**

Neurobehavioral Associates you that our services will be rendered in a professional manner consistent with the ethical standards of the American Psychological Association and/or the American Counseling Association and/or the National Association of Social Workers and/or the American Association for Marriage and Family Therapy. If at any time you feel that your therapist is not performing in an ethical or professional manner, we ask that you please let him or know immediately. If the two of you are unable to resolve your concerns, contact Jeremy, Hertz, Psy.D at 706-823-5250. Due to the very nature of psychotherapy, as much as we would like to guarantee specific results, regarding your therapeutic goals, we are unable to do so. However, your therapy with your participation will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless. Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better, this may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work best for you, help is generally on the way.

## **Technology statement**

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is our utmost importance to us that we maintain your confidentiality, respect your boundaries, and certain that your relationship with your therapist remains therapeutic and professional. Therefore we've developed the following policies

Cell phone- is important for you to know that cell phones may be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem feel free to discuss with your therapist.

Text messaging and email- both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a way to convey information. If you choose to utilize text or email, please discuss this with your therapist.

However please know that it is our policy to utilize these means of communication strictly to confirm appointment confirmations. Please do not bring up any therapeutic content via text or email to prevent compromising confidentiality. You also need to know that we are required to keep a copy of all emails and texts as part of your clinical records

Facebook, LinkedIn, Instagram, Pinterest, etc. It is our policy not to accept requests from any current or former clients on social networking sites because it may compromise your confidentiality.

Google- It is our policy not to search for clients on google or any other search engine. We respect your privacy and make it a policy to allow you to share information about yourself to your therapist as you feel appropriate. If there is content on the Internet that you would like to share with your therapist for therapeutic reasons, please print this material and bring it to your session.

**Twitter and Blogs-** We may post psychology news on twitter or write an entry on a blog. If you have an interest in following either of these, please let your therapist know so that he/she may discuss any potential implications to your therapeutic relationship. Once again, managing your confidentiality is a priority. We would recommend using an RSS feed or locked Twitter list which would eliminate you having a public link to our content.



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In summary, technology is constantly changing and there are implications to all of the avocet hart we may not realize at the time. Please feel free to ask questions and know that we are open to any feelings or though you have about these or other modalities of communication.

Our Agreement to Enter into a Therapeutic Relationship and HIPAA compliance form

We are sincerely looking forward to facilitating you on your journey towards healing and growth. If you have any questions about any part of this document, please ask your therapist.

Please print and sign you name below indicating that you have read and understand the terms of this form. You agree to the policies of your relationships with your therapist and you are authorizing your therapist to begin treatment with you.

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Client Name (Please Print)

---

Date

---

Client Signature

---

Date

If applicable

---

Parents or legal guardian's name (Please Print)

---

Date

---

Parents of Legal Guardian's Signature

---

Date

The signature of the Therapist below indicates that she or she has discussed this form with you and has answered any questions you have regarding this information

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Therapists Signature

---

Date



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## Financial Agreement

Mental health benefits are similar to insurance benefits. Each insurance company makes its own decisions related to diagnosis covered, amount of reimbursement, for specific services and what it seems necessary in terms of diagnostic procedures and testing. In fact, you made your own decisions about the type of coverage when you made choices about deductibles and copay amounts. Neurobehavioral Associates works diligently to work with you and your insurance company to maximize the use of your available funds. We will always provide detailed information about which recommended services are covered by your insurance and which services are not, to the best of our ability.

It is important for you to understand that we are required to provide diagnostic codes and clinical information to insurance companies in order for you to be eligible for coverage of services related to that diagnosis. This diagnosis then becomes part of your permeate medical record. Some patients choose not to use insurance to cover our services in order to avoid the necessity of filing documentation of any psychological diagnosis. These are your decisions and we will do everything we can to make our services affordable no matter what you decide.

Full payment is due at the time services are rendered. As a courtesy, we may file your insurance, but you will be responsible for the full fee. If the session is longer than 45-60 minutes you may be billed for the additional time in 10-15-minute increments. If neuropsychological or psychological testing takes longer than the time allotted by insurance due to the complexity of your case, you will be responsible for any balance owed. If your case required an affidavit, report, or if we need to consult with an attorney and/or guardian ad litem, we will charge for the time required to complete the task. A charge will be made based on the amount if time required for this service. Insurance will not cover services other than office visits between the client and the therapist. We will bill for all the time involved for phone calls to the client, family, or other testing or consulting individuals or written information to all individual involved., Time in court is also billed at a higher rate than therapy sessions as it require preparation and is a different service.

Payment is expect at each session. There will be a fee charged for missed appointment and a late cancellation. We reserve the right to turn over any uncollected debt (over 60 days) to a collection agency and/or magistrate court. Insurance does not cover these types of services. If you have an outstanding balance greater than \$45.00, we reserve the right to refuse scheduling another appointment until payment is received. If a collections agency becomes involved, you will be responsible for all associated fees. Additionally, workman's compensation and forensics no shows will incur the full fee of \$331/hour. If workman's compensation or attorney does not pay on the claim, you will be held personally responsible. We will charge a credit card on file for all missed appointment balances greater than \$45.00. Our patients will be notified 24 hours prior to any charges via phone call. Payment plans will be available upon request.

Appointment Cancellation Policy: You will be charged a fee of (\$45 for therapy, \$100 for intake evaluation, \$300 for psychological or neuropsychological testing) if you do not provide 24-hour notice of a cancelation. Insurance companies do not cover appointments that are not kept.

By signing this agreement, you are agreeing to pay for any services which are not covered by your insurance at the time the services are rendered. You are authorizing Neurobehavioral Associates to c charge the card provided below for any account balances which include, but are not limited to, co pays, co-insurance, and written telephone correspondence. Neurobehavioral Associates reserves the right to discontinue services I f any unpaid balance are not paid within 60 days.

Please note that the card provided must be a credit card to avoid problems related to nonsufficient fund transactions.

Name as it appears on card \_\_\_\_\_ Visa    Mastercard    Amex    Discover

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_



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Staff signature \_\_\_\_\_ Date \_\_\_\_\_

## Background Questionnaire-Child

*The following is a detailed questionnaire on your child's development, medical history, and current functioning at home and at school. This information will be integrated with the testing results to provide a better picture of your child's abilities as well as any problems areas. Please fill out this questionnaire as completely as you can.*

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Name of School \_\_\_\_\_  
Person filling out this form \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Stepmother \_\_\_\_\_ Stepfather \_\_\_\_\_ Other \_\_\_\_\_

Biological Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
Number of years of education \_\_\_\_\_ Degree/Diploma (if applicable) \_\_\_\_\_

Biological Father's Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
Number of years of education \_\_\_\_\_ Degree/Diploma (if applicable) \_\_\_\_\_

Marital status of biological parents \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Other \_\_\_\_\_

If biological parents are separated or divorced

How old was child when the separation occurred? \_\_\_\_\_  
Who has legal custody of the child? \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Joint/Both \_\_\_\_\_ Other \_\_\_\_\_  
Stepparent's Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

If this child is not living with either biological parent

Reason \_\_\_\_\_  
\_\_\_\_\_ Adoptive parents \_\_\_\_\_ Foster Parents \_\_\_\_\_ Other Family Member \_\_\_\_\_ Other: \_\_\_\_\_  
Names/Legal guardian(s) \_\_\_\_\_

List all people currently living with your child's household

Name	Relationship to Child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any brothers or sisters are living outside the home, their names and their ages \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary language spoken in the home \_\_\_\_\_  
Other languages spoken in the home \_\_\_\_\_  
If your child's first language is not English, please complete the following  
Child's first language \_\_\_\_\_ Age child learned English \_\_\_\_\_



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## Current Medications

Medication	Reason taken	Dosage	Start date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Presenting Concerns \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### *Behavior*

- \_\_\_ Stubborn
- \_\_\_ Irritable, angry, or resentful
- \_\_\_ Frequent tantrums
- \_\_\_ Strikes out at others/hitting others
- \_\_\_ Throws or destroys things
- \_\_\_ Lying
- \_\_\_ Stealing
- \_\_\_ Argues with adults
- \_\_\_ Low frustration threshold
- \_\_\_ Daredevil Behavior
- \_\_\_ Runs away
- \_\_\_ Needs a lot of supervision
- \_\_\_ Impulsive
- \_\_\_ Poor sense of danger
- \_\_\_ Skips school
- \_\_\_ Dangerous to self or to others
- \_\_\_ Purposely harms or injures self
- \_\_\_ Talks about killing themselves
- \_\_\_ Unusual fears, habits, or mannerisms
- \_\_\_ Seems depressed
- \_\_\_ Cries frequently
- \_\_\_ Excessively worried or anxious
- \_\_\_ Overly preoccupied with details
- \_\_\_ Overly attach to certain objects
- \_\_\_ Not affect by negative consequences
- \_\_\_ Drug abuse
- \_\_\_ Alcohol abuse
- \_\_\_ Sexually active
- \_\_\_ Sees things no one else can
- \_\_\_ Hears things no one else can

### *Motor Skills*

- \_\_\_ Poor Fine motor coordination
- \_\_\_ Poor gross motor coordination

### *Sleeping and Eating*

- \_\_\_ Nightmares
- \_\_\_ Trouble
- \_\_\_ Eats poorly
- \_\_\_ Eats excessively

### *Social Development*

- \_\_\_ Prefers to be alone
- \_\_\_ Excessively shy or timid
- \_\_\_ More interested in objects rather than people
- \_\_\_ Difficulty making friends
- \_\_\_ Teased by other people
- \_\_\_ Bullies other children
- \_\_\_ Not sought after by peers for friendships
- \_\_\_ Difficulty seeing another person's point of view
- \_\_\_ Overly trusting of others
- \_\_\_ Doesn't emphasize with others
- \_\_\_ Doesn't appreciate humor
- \_\_\_ Separation anxiety/worries about parents

### *Other problems*

- \_\_\_ Bladder problems (not seizure related)
- \_\_\_ Poor bowel movements
- \_\_\_ Headaches
- \_\_\_ Motor/vocal tics
- \_\_\_ Stomachaches
- \_\_\_ Pain
- \_\_\_ Overreacts to noises
- \_\_\_ Overreacts to touch
- \_\_\_ Excessive daydreaming and fantasy life

Other problems \_\_\_\_\_  
\_\_\_\_\_



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## Education Program

Does your child have a modified learning program?

Yes  No

Are you satisfied with current learning program?

Yes  If not, explain \_\_\_\_\_

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

Is your child receiving learning assistance at school?

No  If yes, explain \_\_\_\_\_

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

Has your child been receiving tutoring?

No  If yes, explain \_\_\_\_\_

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

Briefly describe classroom or school problems \_\_\_\_\_

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

Is there an individual Education Plan?

Yes  No

Is your child in special education classes

No  If yes, explain \_\_\_\_\_

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

Has your child been suspended or expelled from school?

No  If yes, explain \_\_\_\_\_

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

What are your child's favorite subjects

No  If yes, explain \_\_\_\_\_

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

## Cognitive Skills-rate your child's cognitive skills relative to other children's of the same age

Speech	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Severe Problem
Comprehension of speech	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Severe Problem
Problem Solving	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Severe Problem
Organizational skills	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Severe Problem
Remembering events	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Severe Problem
Remembering facts	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Severe Problem
Learning from experience	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Severe Problem
Understanding concepts	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Severe Problem
Overall intelligence	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Severe Problem

## Check specific problems

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Poor understanding of time               | <input type="checkbox"/> Frequently Loses belongings                  | <input type="checkbox"/> Slow learner      |
| <input type="checkbox"/> Difficulty finding words to express self | <input type="checkbox"/> Difficulty planning ahead                    | <input type="checkbox"/> Slow thinking     |
| <input type="checkbox"/> Disorganized speech                      | <input type="checkbox"/> Doesn't foresee consequences of actions      | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> Forgets to do things                     | <input type="checkbox"/> Ungrammatical speech                         | <input type="checkbox"/> Poor articulation |
| <input type="checkbox"/> Talks like a younger child               | <input type="checkbox"/> Difficulty with math and understanding money |  |

## Developmental History

If your child was adopted, please fill in as much of the following information as you can

During your pregnancy, did the mother of this child-

Take medications

No  If yes, explain \_\_\_\_\_

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

Drink alcoholic beverages

No  If yes, explain \_\_\_\_\_

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

Use Drugs?

No  If yes, explain \_\_\_\_\_

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



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List any complications during pregnancy (excessive vomiting, excessive staining/blood loss, threatened miscarriage, infections, toxemia, fainting, dizziness, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Duration of pregnancy (weeks) \_\_\_\_\_ Duration of labor(hours) \_\_\_\_\_ Apgars \_\_\_\_\_

Was there any indication of fetal disease? \_\_\_\_\_ What was the birth weight?  
\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check all that apply following birth: \_\_\_\_\_ Labor induced \_\_\_\_\_ Forceps \_\_\_\_\_ Breech \_\_\_\_\_ Cesarean  
If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Check all that apply following birth: \_\_\_\_\_ Jaundice \_\_\_\_\_ Breathing problems \_\_\_\_\_ Incubator \_\_\_\_\_ Birth defect  
If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Where there any other complications? \_\_\_\_\_ No \_\_\_\_\_ Yes  
If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Were there any feeding problems? \_\_\_\_\_ Were there any sleeping problems?  
\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any growth or development problems during the first few years of life  
Were any of the following present (to a significant degree) during infancy or the first few years of life  
\_\_\_\_ Unusually quit \_\_\_\_\_ Colic \_\_\_\_\_ Head banging  
\_\_\_\_ Did not like to be held or cuddled \_\_\_\_\_ Excessive restlessness \_\_\_\_\_ Constantly into everything  
\_\_\_\_ Not alert \_\_\_\_\_ Excessive sleep \_\_\_\_\_ Excessive number of accidents  
\_\_\_\_ Difficult to sooth \_\_\_\_\_ Diminished sleep

*Please indicate the appropriate age at which your child first showed the following behaviors. Please state "never" if your child has never shown the listed behavior.*

Smiled _____	Tied shoes _____
Rolled over _____	Dressed self _____
Sat alone _____	Fed self _____
Crawled _____	Bladder trained _____
Walked _____	Daytime _____
Ran _____	Nighttime _____
Babbled _____	Bowel training _____
First word _____	Rode tricycle _____
Sentences _____	Rode bicycle _____

## Medical History

Vision problems  
\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Date of last vision exam \_\_\_\_\_

Hearing problems  
\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Date of last hearing exam \_\_\_\_\_



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<i>Illness or condition</i>	<i>Dates(s) or Age(s)</i>	<i>Illness or condition</i>	<i>Dates(s) or Age(s)</i>
Measles	_____	Loss of consciousness	_____
German measles	_____	Poisoning	_____
Severe Headaches	_____	Mumps	_____
Rheumatic Fever	_____	Chicken pox	_____
Bone/ joint disease	_____	Diphtheria	_____
Jaundice/hepatitis	_____	Scarlet fever	_____
Meningitis	_____	Tuberculosis	_____
Pneumonia	_____	Anemia	_____
Encephalitis	_____	Diabetes	_____
High fever	_____	Cancer	_____
Seizures	_____	High blood pressure	_____
Injuries to head	_____	Heart disease	_____
Hospitalizations	_____	Asthma	_____
Operations	_____	Bleeding problems	_____
Ear infections	_____	Eczema or hives	_____
Paralysis	_____	Sexual abuse	_____
Allergy	_____	Other _____	_____

## Family Medical History

<i>Condition</i>	<i>Relationship to Child</i>	<i>Condition</i>	<i>Relationship to Child</i>
Seizures or epilepsy	_____	Suicide attempt	_____
Attention deficient	_____	Physical abuse	_____
Hyperactivity	_____	Sexual abuse	_____
Learning disability	_____	Mental Illness	_____
Mental Retardation	_____	Depression or Anxiety	_____
Alcohol abuse	_____	Neurological illness	_____
Childhood behavior problems	_____	Tic/Tourette's syndrome	_____
Other _____	_____		

List any previous assessments that you have had

Neurological	Date _____	Name of Examiner _____
Psychiatric	Date _____	Name of Examiner _____
Psychological	Date _____	Name of Examiner _____
Neuropsychological	Date _____	Name of Examiner _____
Educational	Date _____	Name of Examiner _____
Speech Pathology	Date _____	Name of Examiner _____

List any psychological/psychiatric treatment you child has had (psychotherapy, family therapy, inpatient or residential)

<i>Type of Treatment</i>	<i>Date</i>	<i>Name of Therapists</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



# NeuroBehavioral Associates, LLC

Assessment & Intervention for Neurological & Psychiatric Conditions

Have there been any recent stressors that you think may be contributing to your child's difficulties? (Illness, deaths, operations, accidents, separations, divorce of parents, parent change job, changed schools, family moved, family financial, remarriage, sexual trauma, other losses?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Other information

What are your child's favorite activities? \_\_\_\_\_

Has your child ever been in trouble with the law? If yes, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

On average, what percentage of the time does your child comply with requests or commands? \_\_\_\_\_

What have you found to be the most satisfactory ways of helping your child? \_\_\_\_\_

What are your child's assets or strengths? \_\_\_\_\_

Does your child have spiritual beliefs? \_\_\_\_\_

Is there any other information you think may help us in assisting your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_