Costa Clinical Psychology,LLC
625 Spruce St. #7666
Brookings, OR 97415
(541) 412-0700

Patient Registration

Date:_____

Patient Full Name_____ SS#_____

Mailing Address:_____ Zip_____

Phone Numbers: Home_____ Cell_____

Gender:_____ DOB:_____ Email:_____

Patient Employer:_____ Work Number:_____

If Student, School:_____ Grade:_____

Family Physician:_____ Referred By:_____

Other Current Mental Health Providers:_____

Insured/Responsible Party Information

Please complete regardless of insurance coverage

Full Name of Insured:_____ Relationship to Patient:_____

Home Address:_____ Phone:_____

Employer Address:_____

Work Phone:_____ Insured's SS#_____ DOB:_____

Primary Insurance:_____ I.D.#:_____ Group#:_____

Secondary Insurance:_____ I.D.#:_____ Group#:_____

Workman's Compensation:_____ yes _____ No; Company_____

Office Billing and Insurance Policy

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company.
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of the original.
6. I understand and accept use of Therapy Notes for my electronic health record and as a billing vendor.

Printed Name:_____

Signature:_____ Date:_____

Costa Clinical Psychology, LLC
625 Spruce St.
P.O. Box 7666
Brookings, OR 97415
Phone: (541) 412-0700 email: CostaClinicalPsychology@gmail.com

Consent for Treatment of Minor Child

We/I, the undersigned parent(s) and/or guardian of minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. If health care of said minor is ruled by a legally binding custody agreement, then the most recent copy shall be provided to Costa Clinical Psychology prior to the start of services. We/I also understand that Costa Clinical Psychology prefers to include both parents in the treatment of said minor if it is in the best interest of the child and does not violate any court orders to do so.

Signed this_____ day of _____, 2021.

_____

Mother or Guardian

_____

Father or Guardian

The above was explained to: (circle all that apply) Mother / Father / Legal Guardian

By_____ on the ____day of _____, 2020.

Costa Clinical Psychology, LLC
625 Spruce St.
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Educational Release of Information

I, the parent/legal guardian of _____ minor child do give my consent to _____ for the release of educational information to COSTA CLINICAL PSYCHOLOGY, LLC for the purpose of coordination of care in discussing, planning and implementing mental health treatment and/or consultation regarding identified educational needs deemed beneficial to the child listed above. This consent is authorized during the duration of treatment with COSTA CLINICAL PSYCHOLOGY, LLC.

_____

Printed Name of Parent/Legal Guardian

_____

Signature of Parent/Legal Guardian

_____

Date

Costa Clinical Psychology, LLC
625 Spruce St. #7666
Brookings, OR 97415

Name:_____

Medication List

Medication	Dosage:	How taken and in what form:	When Taken:	What for:

INFORMED CONSENT TO TREATMENT

Welcome
Welcome to Costa Clinical Psychology, LLC. This document provides information about Teresa I. Costa, PsyD and Jeanne Bisson, LMFT and our practice. This will explain the services we provide, our business policies, and your rights as a client. Please read it carefully and ask any questions you may have about the information presented to you. When you sign this document, it will constitute an agreement between us and mark the beginning of our therapeutic relationship.

About Costa Clinical Psychology, LLC
We are located at 625 Spruce St. in Brookings, Oregon between Wharf and Fern Streets. When you arrive, we ask that you park on the right side of the parking area in front of the purple sign. If there is not enough parking, then please park along the street. The left side of the parking area is for the owner of the building. There is a handicapped parking space on the west side of the building. We currently employ two clinicians and their information is below. We have a certified therapy dog by the name of Maddie that belongs to Dr. Costa. She is a mixed breed 8-10-pound dog. If you are allergic to pet fur or would rather not be around her please let us know in advance so we can make arrangements to put her in another room while you are being seen.

Teresa I. Costa, PsyD;
I am a clinical psychologist residing and practicing in the state of Oregon and licensed by the Oregon Board of Psychologist Examiners. I earned my doctorate in clinical psychology from the California School of Professional Psychology at Alliant International University. My first career was in the area of special education after earning my Master's in Early Childhood Special Education from the University of Oregon and my Child Development Bachelor's Degree from Humboldt State University. For many years I have specialized with children and their families helping them to negotiate difficulties with school and home due to Autism, ADHD, mood disorders, Oppositional Defiant Disorder or other issues causing school to be more difficult that it needs to be. Since opening my private practice, I have also supported local veterans and adults with disabilities or the elderly on Medicare.

Jeanne Bisson, LMFT
I received my Master's Degree in Counseling from John F. Kennedy University in Campbell, California in 2003. I am a Licensed Marriage & Family Therapist in Oregon and Hawaii. I have over 17 years of experience using a client-centered and strength-based approach when working with children and families struggling with Autism, ADHD, Anxiety, Anger, Grief, Loss, Divorce, Step-family issues, Mental Illness, Physical and Emotional Abuse, Healthy relationships & Social

Skills. I utilize Play Therapy and Cognitive Behavioral Therapy. On a personal note, I love the beach, hiking and other outdoor activities.

Understanding Psychotherapy

Psychotherapy is an unusual health care relationship, and more than most health care you may receive, the relationship is likely to be an important part of the treatment. Treatment itself may vary depending on characteristics of the client, therapist, and issues worked on. Additionally, Psychotherapy requires you to engage with the process, including working actively and fully on the things we talk about both in-session and in your everyday life.

Like most health care treatments, psychotherapy can have benefits as well as risks. Since our work will likely involve talking about unpleasant aspects of your past and current life, you may experience unpleasant emotions like loneliness, sadness, regret, guilt, grief, anger, and frustration. However, research has demonstrated that engaging in therapy is usually more effective than doing nothing and that most people benefit from therapy. Benefits may include greater happiness or contentment; increased self-knowledge and self-awareness; more satisfying relationships; and solutions to specific problems. Please keep in mind that there are no guarantees of what you will experience; each person's therapy experience and outcome is unique.

Philosophy & Approach

We seek to build collaborative relationships with our clients to understand the issues more effectively they may be dealing with and to help find ways to resolve them. We use our clinical expertise to integrate various psychological theories and techniques, tailoring the therapy experience to each client's needs and personality. As part of this process, we consider our client's culture to be central to understanding their lives and issues, as well as learning how culture and community may support and/or hinder our efforts. The techniques we use are grounded in classic and contemporary psychological theory and supported by current psychological research. We value and encourage continual feedback from clients about how the therapy experience and relationship is working for them.

Scheduling & Cancellation Policy

Sessions are made by appointment only and typically last 45-50 minutes. We work with most clients weekly, but we will collaboratively agree on how often we meet based on factors particular to your situation. Once you have scheduled an appointment, you are expected to be on time for that appointment.

Missed or Cancelled Sessions:

We truly understand that life happens and can disrupt the best laid plans. We ask that if you cannot make a scheduled appointment that you contact us as soon as possible so that we might use your time slot for someone that may need an extra session or be in crisis. If you miss your sessions frequently, we will work with you to try and find a better time to reduce your absences. However, if the cancelations or no shows persist we will cancel your recurring appointment so that someone else can make use of the time.

Appointment Reminders

We do not call clients to remind them of upcoming appointments. As a courtesy, We can enroll you in our reminder system, which is a service of our HIPAA compliant electronic health records provider. The System will send you a message (2 days prior) via email, text message, or voice message (your choice) reminding you of upcoming appointments. If you wish to be enrolled in this system, please authorize us to leave messages via the appropriate method on your Registration Form. You may request that we remove you from the reminder system at any time. Please note: failure to receive an automated reminder does not relieve you of the responsibility of attending the session.

Contacting Us

We are typically in the office from 10:00 AM to 5:00 PM on Monday through Friday, except for major holidays. However, it is our policy, to not answer the phone when we are with a client, so we are often not immediately available. When we are unavailable, our phone will be answered by our Medical Administrative Assistant. If in the event that he/she is not available, please leave a message and we will return your call as soon as possible. You may also contact us via e-mail at costaclinicalpsychology@gmail.com and we will respond in kind and in the same timeframe as a phone message. **Please do not include confidential information in your voice message, or e-mail.** In the digital era, it is safest to consider only face-to-face contact as confidential.

Emergencies:

If you need support immediately and cannot wait for us to return your message, please call the **Curry County Crisis Line at 877-519-9322**. If you believe you may be a risk to the safety of yourself or others, please call 911 or go to the nearest emergency room or hospital.

Professional Records

The laws and standards of my profession require that we keep treatment records, including diagnoses, treatment plans, and progress notes. Your mental health records are maintained as an electronic record in a secure, HIPAA compliant, medical records system called TherapyNotes. You have a right to receive a copy of your records, or we can create a summary if you prefer. We recommend that you review them in my presence so that we can discuss the contents, as this will help avoid misinterpretation, confusion, and unnecessary distress. Please note, we charge an appropriate fee for any professional time spent in responding to information requests.

You have the right to fully understand your treatment plan and to ongoing review of your treatment plan. We will collaboratively generate initial goals for therapy, and we will periodically review the plan both independently and with you.

If you are under thirteen years of age, please be aware that the law may provide your parents the

right to examine your treatment records.

Confidentiality - Rights & Limitations
Information that you share in treatment is held in the strictest confidence possible under law, However, there are some limitations to address at the time of consent. As noted in my Notice of Privacy Practices, the following exceptions to confidentiality apply:

Abuse of Children, Elderly Persons, Mentally Ill Adults, Developmentally Disabled Adults, or Animals:
If we have reasonable cause to believe that a child or elderly person has been abused (by you or another party), we may be required to report the abuse.

Domestic Violence:
If we have reasonable cause to believe you are the victim or perpetrator of domestic/partner violence that is impacting children, we may have an ethical obligation to disclose your PHI to prevent harm to you or others.

Serious Threat to Health or Safety:
We may disclose confidential information when we judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. We must limit disclosure of the otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.

Judicial or Administrative Proceedings:
If (a) You become involved in a lawsuit, and your mental or emotional condition is an element of your claim; or (b) A court orders your confidential information to be released or orders your mental evaluation.

Health Oversight:
The Oregon State Board of Psychologist Examiners may subpoena relevant records from me should we be the subject of a complaint.

Worker's Compensation:
If you file a worker's compensation claim, this constitutes authorization form to release your relevant mental health records to involved parties and officials. This would include a past history of complaints or treatment of a condition similar to that involved in the worker's compensation claim.

Even in these cases we will preserve your privacy to the best of our ability. Any third-party requests to release your information will need to be reviewed and approved by you. You have the right to

request and understand information shared, with whom it is shared, and for what reason it is shared. Please see your notice of privacy rights for more information.

If you are using health insurance to pay for therapy, your insurance company may ask for information about your symptoms, your diagnosis, and our treatment methods. If they do, we will inform you of the information they have requested. We will provide only as much information as the insurance company requires to grant your benefits. Please note that we have no control over how these records are handled at the insurance company.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have as soon as they arise.

Scope of Practice

Our role in your therapy relationship is strictly to provide mental health services. Any and all medical questions, including those pertaining to medications, must be directed to a medical professional. We will provide referrals to appropriate providers if you wish. It is our policy to collaborate with your other providers to help ensure you receive comprehensive, informed, integrated care. Doing so requires your written consent on a separate release of information. You are free to decline or revoke such consent at any time within the provisions noted in our Notice of Privacy Practices.

Outside of Office Contacts

Being a small town there is a high possibility of seeing each other outside of the office. Rest assured you being a patient will never be disclosed to anyone outside of the office/practice. If you are comfortable saying hello feel free to interact with us in the same manor you would any other person in the community or conduct any associations or business relationship that has to do with living in the same community. However, therapeutic discussions shall never take place outside the office or other predetermined therapeutic venues. Nor will we ever disclose that you are in therapy through this practice.

Client Rights

If at any time you feel that this psychotherapy relationship is not beneficial, you have the right to seek other services to best help with your needs. We will provide resources should you need them. You have the right to be fully informed before you begin a psychotherapy relationship. Any questions or concerns are welcome and encouraged.

Consent to Treatment

Your signature below indicates that you have read and understood this document. Your signature also indicates that you have received and reviewed a copy of the Notice of Privacy Practices, and that any questions you may have were answered to your satisfaction. Further, your signature indicates your agreement with the terms of this document and your desire to enter into therapy with me. Thank you for inviting me to embark on this journey of exploration and growth with you.

_____ _____

Client's Signature Date

_____

Client's Printed Name

_____ _____

Costa Clinical Psychology Representative Date

FEE POLICY

Fees (Costa Clinical Psychology)

The fees for our services are as follows:

- Initial consultation (30 minutes): No charge
- Intake session (60 minutes): $300
- Individual session (60 minutes): $225
- Couples/Family session (60 minutes): $225
- Crisis session (50 minutes): $175
- Group session (120 minutes): $45/participant
- Phone calls longer than 5 minutes: Hourly rate (prorated)

All other services requested by you or performed for your benefit will be charged the appropriate hourly fee, prorated to reflect the actual time spent. This includes, but is not limited to copying, faxing, or phone calls after treatment is established that last 5 minutes or longer. (I.E. Conversations between sessions, attending school meetings or conducting observations of your child within the school setting on behalf of your child, consultations with other health providers, or preparing written treatment summaries.

On a limited basis, we may agree on a reduced fee if your financial status warrants it. The reduced fee will be within an established "sliding scale" of payment and is only available to a very limited number of clients at a time. If you are encountering a financial hardship, please talk to our office and see if we can accommodate a new fee agreement. We will want to know the nature of the hardship (lost your job, medical bills, etc.) and the expected duration of the hardship. Typically, we will only allow sliding fees for 6 months. Payment agreements outside of our normal fees will be documented, kept on file, and reviewed quarterly to determine continuing eligibility.

If you become engaged in legal proceedings and request or require our participation, please understand that this detracts from our regular work and other clients. Thus, our legal fee of $150 per hour applies to any time spent on the entire court process, including but not limited to consultation with attorneys, travel time, waiting to testify, preparing written briefs, and actual testimony. Also, be advised that your insurance may not cover these fees and you may be solely responsible for payment.

Insurance, & Billing

Costa Clinical Psychology participates in Medicare, Blue Cross/Blue Shield, ODS, Magellan, TriWest Healthcare Alliance, ChampVA, Tricare, Aetna, Providence, Cigna, Allcare Health and

OHP provider networks, all other networks could be considered "Out-Of-Network" and may not cover your sessions. Costa Clinical Psychology, LLC is happy to bill insurance companies for whom we are in network with, and we will provide a receipt that you may submit to out-of-network insurance plans for reimbursement. It is important that you contact your insurance company to inquire about mental health benefits before we begin working together; as well as understanding how much of our fee your insurance will reimburse to you. Please remember that your insurance policy is an agreement between you and your insurance company, and that you are ultimately responsible for paying the fees we have agreed upon.

Non-Covered Services

Any or all portions of a bill may be denied for payment by the insurance carrier because services are not covered under a patient's health plan, have been applied to the patient's deductible or co-insurance portion, or because the patient is not eligible or has exhausted their benefits. Any or all non-covered portion of the bill are expected to be paid in full by the patient within 30 days of the date of service.

In the event that your account becomes past-due by more than 30 days and we have not agreed on a payment plan, we have the option to use legal means to secure payment, including hiring a Collection's agency or using small claims court; the costs of pursuing such options will be included in the claim. Generally, the only health information that we will release is your name, the nature of the services provided, and the amount due.

Payment

Payment of our agreed upon fee or copay is due at the time of service. We prefer payments made via credit card (MasterCard, Visa, Discover) or cash; however, we will also accept checks.

Please be advised that this office bills you as a courtesy. *If at any time your balance exceeds $300.00 we reserve the right to withdraw from treatment.* Please contact our office to arrange for a new fee agreement/payment plan. We are willing to work with your situation, but we will need to sign a new fee agreement. If payment is note made at the time of service, we reserve the right to reschedule the appointment. Any past due balances that are not subject to a new fee agreement within 30 days of initial bill or are not paid pursuant to the terms of the fee agreement may be *sent to collections.* By signing below, you agree to these terms.

_____ _____

Client's Signature Date

_____

Client's Printed Name

Costa Clinical Psychology, LLC
Notice of Privacy Practices

625 Spruce St. #7666
Brookings Or. 97415
541-412-0700

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 02/24/2020

This Notice of Privacy Practices applies to the following organizations.

Costa Clinical Psychology, LLC

_____ _____

(Patient Signature) **(Date)**

_____

(Printed Name)

Costa Clinical Psychology, LLC. 625 Spruce St., PO Box 7666, Brookings, OR. 97415
T: (541) 412-0700 F: (541) 412-0711 *Costaclinicalpsychology@gmail.com*

Costa Clinical Psychology, LLC
P.O. Box 7666
625 Spruce St.
Brookings, OR. 97415

CHILD/ADOLESCENT PSYCHOSOCIAL

IDENTIFYING INFORMATION Date: _____

Name of child_____ Gender: _____

Birth date_____ Place of Birth_____ Age _____

Address_____ City _____ State _____

Zip Code _____ Telephone ( ) _____ County _____

Education (grade) _____ Present School _____

Referred by _____

CHIEF COMPLAINT:

Presenting Problems: (Check all that apply)

____ Very unhappy	____ Impulsive	____ Fire setting
____ Irritable	____ Stubborn	____ Stealing
____ Temper outbursts	____ Disobedient	____ Lying
____ Withdrawn	____ Infantile	____ Sexual trouble
____ Daydreaming	____ Mean to others	____ School performance
____ Fearful	____ Destructive	____ Truancy
____ Clumsy	____ Trouble with the law	____ Bed wetting
____ Overactive	____ Running away	____ Soiled pants
____ Slow	____ Self-mutilation	____ Eating problems
____ Short attention span	____ Head banging	____ Sleeping problems
____ Distractible	____ Rocking	____ Sickly
____ Lacks initiative	____ Shy	____ Drug use
____ Undependable	____ Strange behavior	____ Alcohol use
____ Peer conflict	____ Strange thoughts	____ Suicide talk
____ Phobic	____ Self Harm	____ Thoughts of Dying

Explain:

Costa Clinical Psychology, LLC
P.O. Box 7666
625 Spruce St.
Brookings, OR. 97415

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

_____

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

_____

Problems perceived to be: ____ Very Serious ____ Serious ____Not Serious

What are your expectations of your child? _____

_____

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? _____

_____

PSYCHOSOCIAL HISTORY:

CURRENT FAMILY SITUATION

Mother-Relationship to child ___ Natural parent ___ Relative

___ Step-parent ___ Adoptive parent

Occupation _____

Education _____ Religion_____

Birthplace _____ Birth date _____

Age _____ Involved in Child's life ____Yes ____No

Father-Relationship to child ___ Natural parent ___ Relative

___ Step-parent ___ Adoptive parent

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Occupation _____

Education _____ Religion_____

Birthplace _____ Birth date _____

Age _____ Involved in child's life ____Yes ____No

Marital History of Parents:

Natural Parents: ___ married when_____ Ages _____ _____

___ Separated when _____

___ divorced when _____

___ deceased when _____

Step-Parents: ___ married when _____

If child is adopted:

Adoption Source: _____

Reason and Circumstances of adoption:_____

_____

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 ___ buying _____ _____

___ house ___ Apt. _____ _____

Does the child share a room with anyone else? ____ yes ____ No

If yes, with whom? _____

If no, how long has he/she had own room? _____

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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? _____

_____

BROTHERS and SISTERS: (include if step-brothers or step-sisters)

Name	Age	Gender	School or Occupation	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug abuse (yes or no)

List all other extended family members & their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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Others living in the home (and their relationship):

1. _____

2. _____

HEALTH OF FAMILY MEMBERS: (Excluding patient)

Name	Relationship to child	Type of Illness	When occurred	Length of Illness
1				
2				
3				
4				

Does or did any member of the child's family have any problems with:

____ Reading ____ Spelling ____ math ____ speech

(if yes, please explain.) _____

_____

Is there any history in the child's family of:

____ mental Illness ____epilepsy ____ birth defects ___schizophrenia

(if yes, please explain:) _____

_____

CHILD HEALTH INFORMATION:

Note all health problems the child <u>has had</u> or <u>has now</u>.

	AGE		AGE
____ High Fevers	____	____ Dental Problems	____
____ Pneumonia	____	____ Weight Problems	____
____ Flu	____	____ Allergies	____
____ Encephalitis	____	____ Skin Problems	____

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CHILD HEALTH INFORMATION: (Continued)

	AGE		AGE
____ Meningitis	____	____ Asthma	____
____ Convulsions	____	____ Headaches	____
____ Unconsciousness	____	____ Stomach Problems	____
____ Concussions	____	____ Accident Prone	____
____ Head Injury	____	____ Anemia	____
____ Fainting	____	____ High or Low Blood Pressure	____
____ Dizziness	____	____ Sinus Problems	____
____ Tonsils Out	____	____ Heart Problems	____
____ Vision Problems	____	____ Hyperactivity	____
____ Hearing Problems	____	____Earaches	____

Other Illness:(Explain) _____

_____

Has the child ever been hospitalized? ____ yes ____ No if yes, please explain:

Age How Long Reason

____ _____ _____

____ _____ _____

____ _____ _____

Has the child ever been seen by a medical specialist? ____ Yes ____ No

AGE How Long Reason

_____

_____ _____ _____

Has child ever taken, or is he/she presently taking any prescribed medications? ____ Yes____No

AGE How Long Reason

_____

_____ _____ _____

_____ _____ _____

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Name of Primary Physician: _____

DEVELOPMENTAL HISTORY

Prenatal—Child wanted? ____ Yes ____ No Planned for? ____ Yes ____No
Normal pregnancy? ____ Yes ____ No
If mother ill or upset during pregnancy, explain:_____

_____

Length of pregnancy: _____

Paternal support and acceptance: (explain) _____

BIRTH

Length of active labor: ____ hrs. ____ Easy ____ Difficult
Full Term ____ Yes ____ No
If premature, how early:? _____

If overdue, how late:? _____

Birth weight: ____ Lbs. ____ Oz.
Type of delivery ____ spontaneous ____ cesarean ____ with instruments
____ head first ____ breach
Was it necessary to give the infant oxygen? ____ Yes ____ No If yes, how long: _____
Did infant require blood transfusions? ____ Yes ____ No
Did infant require X-ray? ____ Yes ____ No
Physical condition of infant at birth:
Anorexia ____ Yes ____ No
Trauma ____ Yes ____ No
Other complications ____ Yes ____ No
Did mother abuse alcohol/drugs during pregnancy? ____ Yes ____ No

(if yes to any of the above, please explain) _____ _____

_____

NEWBORN PERIOD

		How Long
Irritability	____ Yes ____ No	_____
Vomiting	____ Yes ____ No	_____
Difficulty breathing	____ Yes ____ No	_____
Difficulty sleeping	____ Yes ____ No	_____
Convulsions/twitching	____ Yes ____ No	_____
Colic	____ Yes ____ No	_____
Normal weight gain	____ Yes ____ NO	_____

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Was child breast fed? ____ Yes ____ NO _____

DEVELOPMENTAL MILESTONES:

Age at which child:

Sat up: _____

Crawled: _____

Walked: _____

Spoke single words: _____

Sentences: _____

Bladder trained: _____

Bowel trained: _____

Weaned: _____

Describe the manner in which toilet training was accomplished: _____

_____

EARLY SOCIAL DEVELOPMENT:

Relationship to siblings and peers:

____ individual play ____ group play
____ competitive ____ cooperative
____ leadership role ____ a leader

Describe special habits, fears, or idiosyncrasies of the child: _____

_____

_____

_____

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EDUCATIONAL HISTORY:

Name of school	City/State	from:	to:
preschool			
elementary			
junior high			
high school			

Types of classes: ____ regular ____ learning disability ____ continuation
____ emotionaly handicapped ____ opportunity ____ other

Did child skip a grade?	Yes _____	No _____
Repeat a grade?	Yes _____	No _____
Did the child have any specific learning difficulties:	Yes _____	No _____
Has child ever had a tutor or other special help with school work?	Yes _____	No _____
Does child attend school on a regular basis?	Yes _____	No _____
Does child appear motivated for school?	Yes _____	No _____
Has child ever been expelled?	Yes _____	No _____

ACADEMIC PERFORMANCE:

Highest grade on the last report card? _____

Lowest grade on the last report card? _____

Favorite subject? _____

Least favorite subject? _____

Does child participate in extracurricular activities? ____ Yes ____ No (explain) _____

_____

In school, how many friends does child have? ____ a lot ____ a few ____ none

What are child's educational aspirations? ____ quit school ____ graduate from high school ____ go to college

Has child had any special testing in school? (if yes, what were the results?) _____

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Psychological ____ Yes ____ No Vocational ____ Yes ____ No

List the child's special interests, hobbies, skills:

_____

_____

_____

Has the child ever had difficulty with the police? ____ Yes ____ No (if yes, explain) _____

_____

Has the child ever appeared in juvenile court? ____ Yes ____ No (if yes, explain) _____

_____

Has child ever been on probation? ____ Yes ____ No

From	To	Reason	Probation Officer
_____	_____	_____	_____

Has child ever been employed? ____ Yes ____ No

Job	Employee	How long?
_____	_____	_____
_____	_____	_____

ADDITIONAL COMMENTS OR CONCERNS:

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

_____ _____

Parent/step parent/legal guardian Date:

_____ _____

Reviewing Therapist Date: