

## **The Sullivan Center for Children**

3443 W. Shaw Avenue, Fresno, CA 93711

559-271-1186

559-271-8041 (fax)

# **CHILD/ADOLESCENT INTAKE PACKET** **INSTRUCTIONS**

1. You have opened up this PDF version of our child/adolescent intake packet. It contains consent for treatment and HIPPA Notice of Privacy Practices as well as several pages gathering personal, medical and educational history and a map to our location.
2. Print out this PDF by hitting the print button or going to "file" and then scrolling down to the print button.
3. Read and fill out the forms. It is absolutely necessary to complete each item thoroughly and accurately. Please take your time and give thoughtful consideration to each question, and do not leave any items blank.
4. When done, bring this completed packet in when you come in for your initial evaluation. Give this packet to our Front Desk Staff when you check in.

## Child & Adolescent Intake Packet

Please complete each item thoroughly and currently. Take your time and give your thoughtful consideration to each question. When done, return this packet to our Front Desk staff.

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name of Person Filling Out This Form:		Name of Legal Custodians:			
Relationship to Child:		Relationship to Child:			
Patient's Last Name	First	Middle	Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City		State	Zip Code
Patient's Social Security No.	Home Phone No. ( )	School:		Grade:	
<b>Best phone number to reach responsible party if session has to be cancelled or rescheduled:</b>					
Party:		Number: ( )		Confidential Voice Mail <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Biological Parents Status:**

Married  
  Living Together Not Married  
  Divorced  
  Separated  
  Parental Rights Terminated  
  Widow  
 Joint Legal Custody  
  Sole Legal Custody  
 Specify Custodian: \_\_\_\_\_

*Attach a copy, if applicable of the court order which determines custody arrangements and legal custodianship. This is necessary for our records.*

Biological Mother's Last Name	First	Middle	Birth Date / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Email address:	
Street Address		City		State	Zip Code	
Mother's Social Security No.		Home Phone No. ( )		Cell Phone No. ( )		
Occupation	Employer			Employer Phone No. ( )		

Biological Father's Last Name	First	Middle	Birth Date / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Email address:	
Street Address		City		State	Zip Code	
Father's Social Security No.		Home Phone No. ( )		Cell Phone No. ( )		
Occupation	Employer			Employer Phone No. ( )		

Nearest Relative Not Living with You \_\_\_\_\_ Address \_\_\_\_\_

Phone#: \_\_\_\_\_ Cell# \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Address \_\_\_\_\_

Phone# \_\_\_\_\_ Cell# \_\_\_\_\_

**Consent for Treatment**

As this child's legal custodian, I authorize Sullivan Center for Children to provide these services:

Psychological Services     Yes     No    Psychiatric/Medication Services     Yes     No

\_\_\_\_\_  
Signature of Patient or Financial Guarantor

\_\_\_\_\_  
Date

\_\_\_\_ Parent/Intact Marriage

Divorced/Legally Separated/Estranged, Never-Married Parents: \_\_\_\_ Joint Legal Custody    \_\_\_\_ Sole Legal Custody (Please provide legal documentation regarding custodial status)

Other Legal Relationships – be specific: \_\_\_\_\_

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**Consent for Verification and Billing of Insurance**

If intending to use insurance coverage for payment of services, you must provide this information and sign below.  
Please give your insurance card to the receptionist to have a copy made for your file.

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
If another family member is client here, list name(s)			

Subscriber's Name	Subscriber's ID	Birth Date / /	Group#	Policy#	Co-Payment \$
Insurance Company Name, Phone Number & Address (on card):					
Occupation	Employer	Employer Address		Employer Phone No. ( )	
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Drivers Lic.# _____					

Name of Secondary Insurance (if applicable)	Secondary Subscriber's Name	Group #	Policy#
Subscriber's ID	Subscriber's Birth Date	Co-Pay Amount	
Insurance Company Name, Phone Number & Address (on card):			
Occupation	Employer	Employer Address	Employer Phone No. ( )
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

I realize that it is **solely** my responsibility to pay for services as well as to determine what my insurance coverage, benefits and limits are. I request that the Sullivan Center for Children provide clinical services and I agree to be financially responsible for these costs. The Sullivan Center will bill my insurance, but regardless of any insurance billing assistance provided to me by the Center, I will be responsible for my account. I authorize insurance payments be paid directly to the Sullivan Center. By signing this Financial Agreement I consent to the release of information to my insurance company as required for validation, billing, reimbursement, and related services. I understand that this account may be subject to finance charges of 1.5% per month (18% per annum) of the unpaid balance after 90 days. If the account becomes delinquent and referred to an attorney or collection agency, I will be held responsible for actual attorney fees and collection expenses. If you have health insurance it may cover a part of the cost of your treatment here, and to determine whether it will, we need the above information. Please advise office if you have secondary insurance coverage. **Please provide office with copies of insurance card and driver's license.**

\_\_\_\_\_  
Signature of Patient or Financial Guarantor

\_\_\_\_\_  
Date

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**ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES**

**I HEREBY ACKNOWLEDGE RECEIPT OF THE ABOVE Notice of Privacy Practices**

Patient Signature: \_\_\_\_\_ or

Signature of Legal Guardian: \_\_\_\_\_

Printed Name of Legal Guardian: \_\_\_\_\_

\_\_\_\_\_ Parent \_\_\_\_\_ Other: Specify Legal Relationship \_\_\_\_\_

Date: \_\_\_\_\_

# The Sullivan Center for Children

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## Office Policies / Consent to Treatment / Financial Agreement

Welcome to the Sullivan Center for Children. This document outlines our office policies and procedures; authorizes us to begin evaluation and treatment; and establishes the financial/clinical agreement between you, your clinician and The Sullivan Center for Children. This document also provides information regarding how your medical and/or mental health information may be used and how you may access those records. Please read this information carefully. If you have any questions, please discuss them with your therapist.

**MEDICAL/MENTAL HEALTH RECORD KEEPING:** The privacy of your medical and mental health information is extremely important to us and we are committed to protecting your privacy. We create a record of care which includes dates of service and type of treatment provided. The Sullivan Center for Children maintains paper records and also makes use of electronic record keeping and electronic billing. All records, whether paper or digital, are maintained by the Sullivan Center for Children in full compliance with state, federal, and professional regulations.

**LEGAL CONSENT TO TREATMENT:** Any individual over the age of eighteen, who is not legally prohibited from doing so, consents to their own treatment. For minors under the age of eighteen, it is Sullivan Center policy that legal guardians provide written consent. In situations of joint legal custody, it is Sullivan Center policy that both legal guardians must consent to treatment. A parent having sole legal custody may consent to treatment. It is our policy to request proof of legal custody or guardianship. Exceptions to the above policy are rare and can be made only with the approval of the Clinical Director.

**CONFIDENTIALITY:** To maximize the benefit of evaluation and treatment trust must be developed between patient and therapist; you must be open and honest. Information disclosed within therapy is confidential and may not be revealed to anyone without your written consent except where disclosure is required by law. Your therapist will discuss issues of confidentiality and will ask for your consent to communicate with anyone considered essential for appropriate evaluation and treatment. Children and adolescents also have the right to confidentiality with their therapist. Sharing helpful information between parents and children is necessary in the treatment of adolescents and children. Your therapist will discuss what is needed and appropriate with you and your child and request your consent.

**LIMITS OF CONFIDENTIALITY:** All Sullivan Center Clinicians are mandated reporters in accordance with California State Law. Disclosure may be made or is mandated in the following circumstances: 1.) Where there is a reasonable suspicion of a child neglect/abuse, abuse of disabled persons, or elder adult physical abuse/severe neglect. 2.) Where the patient is likely to inflict serious self-harm. 3.) Where there is a reasonable suspicion that the patient presents a danger of violence to others. Sullivan Center Clinicians have a duty to warn persons in a life-threatening situations and must make a report to authorities and the intended victim(s) to prevent serious imminent harm to another or the public. 3.) The clinicians of the Sullivan Center are mandated reporters to the Food and Drug Administration regarding the adverse effects of prescribed medications. 4.) Disclosure may also be required pursuant to some legal proceedings, such as custody disputes. The Sullivan Center will release confidential information in the course of judicial/administrative proceedings as required by law, law enforcement purposes as required by law, a valid court order, or as

provided by your specific written consent. 5.) In the event of an emergency, confidential information may be disclosed to notify a person responsible for your care regarding your location, general condition, or medical information. 6.) If you are seeking Worker's Compensation, or you are receiving services through Victims of Crime, Tulare County Mental Health, Golden State Agency, or any other third-party which is covering payment, it is necessary for the Sullivan Center to disclose confidential information to those agencies either as required by law or contract.

Since agencies vary, if your services are financially supported by a third-party agency, or mandated by court order, you and your clinician will discuss specific limits of confidentiality.

I understand and Agree. Please Initial Here \_\_\_\_\_

**USE CONFIDENTIAL INFORMATION:** The Sullivan Center for Children will use your mental health records for these purposes. 1.) Treatment: Clinicians will maintain treatment information and records. This information is used by clinicians involved in treatment to document progress, and record other information relevant to services rendered. 2.) Financial Arrangements/Payment: If you so desire, we will submit requests for payment to your insurance company in either electronic or hardcopy format, or both. We will provide Insurance companies with the information required in order for you to receive your mental/medical health insurance benefits. Since the policies of insurance companies will vary, please contact your clinician and insurance provider to obtain further specifics. The Sullivan Center will attempt to resolve billing concerns including financial difficulties, yet be aware that in the event that your account is in default, limited and specific information may be released to a Credit Collection Agency in order to settle your account. 3.) We may also obtain services from our business associates such as accounting/legal service providers or our insurers as necessary. Quality assurance consultants, transcriptionists, billing services, practice reviewers, auditors, certification/accreditation agencies, and other professionals may use confidential information. These business associates are required to appropriately safeguard your information and any statistical analyses or data exchanges made are conducted without inclusion of identifying information wherever possible. 4.) As a training institution, clinical records are reviewed by supervisors and their trainees.

I understand and Agree. Please Initial Here \_\_\_\_\_

**TRAINING AND RESEARCH:** The Sullivan Center for Children is a training and research institution. We are committed to ongoing training and research in the areas of childhood, adolescent, and family psychopathology, psychological assessment, psychological and psychiatric treatment, treatment outcomes, and mental health service delivery. Case material and mental health records of patients at the Sullivan Center may be used for such purposes. In addition patients may be asked directly to participate in a research study or provide information for research purposes.

Sullivan Center for Children, 3443 W. Shaw Fresno, 93711, (559) 271-1186. [www.sullivancenterforchildren.com](http://www.sullivancenterforchildren.com)

PRIVILEGED & CONFIDENTIAL – DO NOT DISCLOSE OR RELEASE WITHOUT AUTHORIZATION

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All personal data is thoroughly disguised for such purposes to assure maintenance of patient confidentiality. The Sullivan Center adheres to all ethical and legal standards for research and research participants outlined by the American Psychological Association and the California Board of Psychology.

I understand and Agree. Please Initial Here \_\_\_\_\_

**PATIENT RIGHTS:** Billing and patient care information is maintained in electronic and hardcopy records. If you wish to exercise any of these rights, please contact JoAnn Pflughoft, Officer Manager at 271-1186, or Linda Rios, 3443 W. Shaw Ave., Fresno, CA 93711, fax: (559) 271-8041, during normal business hours. Either can assist you in the proper exercise of your rights. The information maintained is available to you in accordance with the following rights.

1. If you would like to limit or restrict the use or disclosure of your health information, you have a right to make such a request in writing. The Sullivan Center may not unconditionally approve the request, but each request is carefully reviewed.
2. You will receive a hardcopy of the Sullivan Center "Notice of Privacy Practices for Protected Health Information." You may also access this information on our website, [www.sullivancenterforchildren.com](http://www.sullivancenterforchildren.com)
3. By written request, you may request a copy of your health and billing records, although we are not required to approve all such requests. For copies, pre-payment of two-dollars (\$2.00) per page, with a thirty-dollar (\$30) minimum fee (in order to cover staff and equipment costs to reproduce your record) is requested. Records are available for in-person pickup within 30-days of receipt of pre-payment (delivery alternatives are available and must be requested in writing). In the event a clinician determines your access to information may be harmful, additional steps are necessary, and you may wish to contact your clinician to discuss questions you may have concerning request for records.
4. You may request, in writing, that your health record be amended to address incomplete or incorrect information. Not all requests are accepted although you may appear a denial by providing an appeal request in writing. If your appeal is denied you may file a statement of disagreement and request that this statement be attached to any required future disclosures.
5. By written request, you may obtain an accounting of disclosures of confidential information made without your permission or request.
6. You may revoke, in writing, any previous authorization to disclose confidential information at any time and the revocation will be effective upon receipt for all future disclosures.

The Sullivan Center for Children reserves the right to refuse services to anyone, including the discontinuation of services as established by legal and professional regulations. The Sullivan Center also reserves all rights to modify or amend these policies. You may file written complaints with our Clinical Director, Kathy Sullivan, Ph.D. You may also file a complaint with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. The Sullivan Center for Children does not require you to

waive your right to file a complaint in order to receive services here.

**EMERGENCY PROCEDURES:** The Center's telephone lines are staffed at all times, either by office personnel or by an answering service. If a need arises to contact your therapist between sessions, please call the Center at (559) 271-1178 and your call will be returned as soon as possible. If you have an emergency, be sure to inform the office staff or the answering services of the emergent nature of your call so that your call will be handed at once. The Sullivan Center has 24-hour telephone coverage via an exchange services and every attempt will be made to locate your clinician in an emergency; if they are unable to be located, a covering Sullivan Center clinician will return your call. Of course, if an emergency is life-threatening, please dial 911.

**APPOINTMENTS:** Initial evaluations may take anywhere from thirty minutes to three hours depending on the nature of the assessment. Individual therapy sessions are usually 40 to 50 minutes though longer or shorter sessions may be prearranged with the provider. Medication management sessions may take from 10 to 30 minutes unless otherwise arranged with the physician. You are expected to arrive to each appointment on-time and the therapist will not extend sessions to make up for lost time when you are late. Your therapist or physician will, likewise, make every effort to attend each appointment on-time. Appointments with our psychiatrist run differently than therapy sessions with our clinicians, and there is frequently some waiting time involved. Please be patient. There are also situations, where therapy sessions must be delayed, such as in emergency session-extensions. In such situations your therapist or physician will attempt to extend your appointment or provide other arrangements to make up for the lost appointment time.

**CANCELLATIONS:** Scheduling an appointment involves reservation of time specifically for you. A **minimum of twenty-four (24) hours notice is required** for rescheduling or cancellation of an appointment. The full session fee (typically \$150.00) will be charged for missed sessions without such notification. Your therapist may waive this fee in the case of emergencies or acute medical illness. Your insurance company or other third party payer will not pay for uncanceled sessions; you will be solely responsible for this expense. This is a busy practice; your cooperation is essential so that we can provide maximum service to all clients. Even if you fail to provide advanced notice, contact the office or your therapist as soon as possible and explain the mishap. If you fail to communicate with our office about uncanceled missed sessions for two consecutive sessions or for three-missed sessions within any six (6) month period of time, your clinician **may initiate termination of your services here** and would then refer you to another agency for continued care. For safety purposes ongoing monitoring for children on medication is necessary. **Medication refills for patients being prescribed medication will not be approved without diligent scheduling of, and attendance at medication follow-up appointments.**

I understand and Agree. Please Initial Here \_\_\_\_\_

**BILLING AND INSURANCE REIMBURSEMENT:** Clinical services are rendered and charged to the patient and not to the insurance company. You are expected to keep your account

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current, not waiting to see what the insurance will pay before making payment to the Center. Once you have provided our office with a copy of your insurance card and necessary information, the Sullivan Center will bill your insurance company weekly. A statement that reflects all charges and payments will be sent to you each month. For families with more than one family member in treatment, it will be *absolutely necessary* for you to indicate on your check the account number and the patient for whom you are making a payment.

I understand and Agree. Please Initial Here \_\_\_\_\_

**PAYMENT FOR SERVICES:** Payment is expected at the time of service unless insurance coverage requires another arrangement or there is a prior agreement with the provider or administration staff. **There may also be fees associated with report preparation, letter writing, and extended telephone consults, that will not be covered by your insurance. Please discuss specific fees or other details with your individual physician or therapist prior to having these services performed.** Due to the ever-changing insurance environment and wide variety of plans, we cannot be responsible for knowing the filing requirements of each insurance company. In order for us to continue to file some insurance, we must enforce that *it is your responsibility to know or find out the filing requirements and limitations of your own plan.* We are familiar with many insurance plans and managed care companies and are happy to assist in any way we can to help you find that information. *We are required by law to collect all co-pays at the time of service. There will be a \$25.00 service charge for any checks returned by your banking institution.* Discuss fees and payment with your therapist and please notify your therapist if any problems arise during the course of treatment regarding your ability to make timely payments. A Finance Charge of 1.5% per month (18% per annum) of the unpaid balance may be assessed after 90 days. The Center has a limited program that provides for reduced fees for some services for patients in clinical and financial need. If you are in such need, discuss the situation with our intake staff or your therapist to determine if you meet criteria for inclusion in this program.

I understand and Agree. Please Initial Here \_\_\_\_\_

**ABOUT OUR PRACTICE:** This is a multidisciplinary healthcare practice. We provide a variety of services including individual, couples, group, psychotherapy, psycho-education, consultation, school counseling, psychological assessment, forensic assessment, medication evaluation, and treatment. Our clinicians are all registered and supervised or licensed/board certified in their respective fields. Our clinicians are actively engaged in ongoing continuing education and follow the highest professional and ethical standards. Sullivan Center clinicians come from a variety of professional backgrounds. Psychologists have a doctorate degree in psychology, have completed both pre- and post-doctoral internships, and have completed strict state competency standards for licensure. Psychologist may conduct personality or neurocognitive assessments, forensic assessment, provide psychotherapy, or supervise psychological trainees and interns. Psychiatrists have a medical doctorate and have completed medical school with additional training including residency in Psychiatry. Psychiatrists may prescribe medications, assess medical conditions,

supervise trainees and interns, and provide psychotherapy. Licensed professional counselors, licensed clinical social workers, and licensed marital-family therapists have completed a Bachelors and/or Master's Degree in social work or a related field and can provide psychotherapy, and case management/care coordination. Psychology Post-Docs at the Sullivan Center have completed their doctoral degree and are practicing under the supervision of a Licensed Psychologist. Psychology Interns are in their final year of doctoral training, and Practicum Students are Master's level trainees. Psychological Interns, Psychological Assistants, and Practicum Level Psychological Trainees at the Center provide services similar to a psychologist. They are registered by the Board of Psychology as Psychological Assistants or by the Board of Behavioral Science as trainees, and are supervised by a Licensed Psychologist or Board Certified Psychiatrist.

Psychotherapy and counseling have earned a reputation for enhancing the quality of life of others. Although the vast majority benefit from these services, there are no certainties and each person will experience these services differently. All psychotherapy involves a substantial commitment, and as with most endeavors, the amount of effort you put forth into your treatment will effect the outcome greatly. Psychotherapy often involves an unsteady rate of progress and many people experience periods of depression, anger, resentment, guilt, fear, tension, anxiety, and other feelings during treatment. Services are provided without warranty or guarantee, but it is important to notify your clinician if you feel you or your child are experiencing any negative effects as a result of treatment. You can expect your clinician to share with you:

- a. their understanding of the problems you have brought to their attention
- b. their approaches to those problems
- c. other approaches they are aware of
- d. what research says about the advantages and disadvantages of approaches
- e. their assessment of progress or lack thereof and resultant options they are aware of
- f. their best opinion about what may happen without treatment

Our therapists make every effort to inform patients of all options for treatment. If you feel that your treatment is not progressing in the way that it should, please discuss this with your therapist, your therapist's supervisor, or both. Sometimes treatment advances most rapidly during moments where you and your therapist directly address such obstacles. In any event, please note that you are also welcome to contact our Clinical Director, Kathy Sullivan, Ph.D., (559) 271-1186, if you would like to do so.

*I have read and understand each of the above policies. I agree to follow and abide by them. I understand that I may revoke my consent, by submitting revocation in writing to the Sullivan Center, which will be made effective upon receipt. Your signature below also acknowledges that you have received a copy of these policies and the HIPAA Notice of Privacy Practices.*

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Today's Date

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Other Family Relations

Check Relationship:					
Stepfather	<input type="checkbox"/> Foster Father	<input type="checkbox"/> Adoptive Father	<input type="checkbox"/> Legal Custodian		
Stepmother	<input type="checkbox"/> Foster Mother	<input type="checkbox"/> Adoptive Mother	<input type="checkbox"/> Other		
Last Name	First	Middle	Birth Date / /	Sex M F	E-mail Address
Street Address	City	State	Zip Code	Cell Phone No. ( )	Home Phone No. ( )
Occupation	Employer				Employer Phone No. ( )

Check Relationship:					
<input type="checkbox"/> Stepfather	<input type="checkbox"/> Foster Father	<input type="checkbox"/> Adoptive Father	<input type="checkbox"/> Legal Custodian		
<input type="checkbox"/> Stepmother	<input type="checkbox"/> Foster Mother	<input type="checkbox"/> Adoptive Mother	<input type="checkbox"/> Other		
Last Name	First	Middle	Birth Date / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	E-mail Address
Street Address	City	State	Zip Code	Cell Phone No. ( )	Home Phone No. ( )
Occupation	Employer				Employer Phone No. ( )

Siblings	Age	Relationship
		<input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib
		<input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib
		<input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib
		<input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib
		<input type="checkbox"/> full <input type="checkbox"/> half sib paternal <input type="checkbox"/> step sib paternal <input type="checkbox"/> step sib maternal <input type="checkbox"/> half sib maternal <input type="checkbox"/> adoptive sib

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## Physical Health Questionnaire

<b>Check if client has or had, any symptoms in the following areas to a significant degree and briefly explain.</b>		
<input type="checkbox"/> Seizures <input type="checkbox"/> Head/Neck Injury <input type="checkbox"/> Ear/Nose/Throat <input type="checkbox"/> Headaches <input type="checkbox"/> Skin <input type="checkbox"/> Lungs	<input type="checkbox"/> Chest/Heart <input type="checkbox"/> Back <input type="checkbox"/> Intestinal <input type="checkbox"/> Bladder <input type="checkbox"/> Bowel <input type="checkbox"/> Circulation	<b>Any Recent Changes In:</b> <input type="checkbox"/> Weight <input type="checkbox"/> Energy Level <input type="checkbox"/> Ability to Sleep <input type="checkbox"/> Mood  Other Pain/Discomfort:
Childhood Illnesses: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations: <input type="checkbox"/> Tetanus <input type="checkbox"/> Pneumonia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Chickenpox <input type="checkbox"/> Influenza <input type="checkbox"/> MMR		
<b>List Any Medical Problems or Conditions (Include Diagnosis and Diagnosing Doctor's Name if Known):</b>		
<b>Surgeries/Hospitalizations</b>		
Year	Reason	Hospital
<b>Exercise</b> <input type="checkbox"/> Sedentary <input type="checkbox"/> Mild Exercise <input type="checkbox"/> Occasional Vigorous Exercise <input type="checkbox"/> Regular Vigorous Exercise		
<b>Diet:</b>	Is client dieting? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, is this a physician prescribed diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Estimate Salt Intake: <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low    Estimate Fat Intake: <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Estimate Sugar Intake: <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low    Estimate Caffeine Intake: <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	

**List All Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:**

Medication	Dosage	Reason/Purpose	Age when first Prescribed	Age when Discontinued	Prescribed Doctor

Allergies to Medications (provide the name of drug and the reaction that occurred):
Please describe any family history of medical conditions:
Please describe any family history of mental illness, including drug/alcohol abuse and domestic violence:

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Briefly describe what services you are seeking and your expectations for treatment.

Please Circle All That Describe the Client:

Very unhappy	Irritable	Temper outbursts	Withdrawn	Sleeping problems	Hallucinates	Day-wetting	Overeating
Fearful	Clumsy	Overactive	Slow	Short attention	Nightmares	Daydreaming	Worrisome
Distractible	Phobic	Lacks initiative	Impulsive	Undependable	Stomachaches	Suicide talk	Pessimistic
Peer conflict	Stubborn	Disobedient	Infantile	Mean to others	School anxiety	Sickly	Agitated
Destructive	Rocking	Trouble with law	Shy	Running away	Poor hygiene	Soiling	Forgetful
Fire setting	Stealing	Sexual trouble	Lying	Self-mutilation	Anorexic	Bedwetting	Abusive
Head-banging	Truancy	Strange behavior	Drug use	Strange thoughts	Hyperactive	Alcohol use	Cruel

- Yes                      Plays with matches, set fires, use firecrackers, bombs, or explosives?
- Yes                      Ever made a serious threat or attempt to cause serious injury/harm/killing of self?
- Yes                      Or, made a serious threat or attempt to cause serious injury/harm/killing another
- Yes                      Threaten attempt, or engaged in serious destruction of property, including fire setting.
- Yes                      Preoccupied with death, dying or morbid thoughts? Draws vivid morbid or angry pictures?
- Yes                      Inappropriate sexual conversations, behaviors, or sexual activity?
- Yes                      Complaint/reports of inappropriate sexual activity with another?
- Yes                      Any access to guns, rifles, weapons in home or friend/relatives home (whether locked up or not)?

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Check yes if any of these symptoms are apparent to you even if you do not believe that these are important or serious.

- Yes      Recent changes in vision, balance, hearing, or coordination?
- Yes      Require hearing aid, have tubes in ears or frequent ear infections or hearing loss?
- Yes      Wears glasses, contact lenses, hearing aid or a prosthesis?
- Yes      Needs/uses leg braces, crutches, prescription shoes, etc?
- Yes      Excessive shakiness, arm or leg tremors?
- Yes      Difficulty sleeping, falling asleep, or difficulty waking up in morning?
- Yes      Frequent or disturbing nightmares? Night sweats/terror?
- Yes      Difficulty eating, excessive eating, or forced vomiting?
- Yes      Appear to be depressed?
- Yes      Unusually lethargic, tired, bored, or apathetic? Cries frequently?
- Yes      Panics when stressed?
- Yes      Problems with eating or appetite?
- Yes      Ever attempted or threatened to attempt suicide?
- Yes      Ever seriously thought about hurting themselves?
- Yes      Ever have trouble sleeping?
- Yes      Been to a counselor or therapist?
- Yes      Any history of a seizure or epileptic attack?
- Yes      Ever been in a car during a serious car accident?
- Yes      Any history of head injury or black-outs?
- Yes      Recent dizziness spells?
- Yes      Recent surgery or hospitalizations?
- Yes      Loss of simple movement of various body parts (Paralysis).
- Yes      Increased difficulty in concentration or attention
- Yes      Increased moodiness or irritability
- Yes      Negative changes in personality or social behaviors
- Yes      Increased difficulty in distinguishing left from right.
- Yes      Increased difficulty with doing mathematics
- Yes      Increased difficulties with eye and hand coordination
- Yes      Hallucinations: visual, auditory, or olfactory (smell)
- Yes      Decreased school performance?
- Yes      Nursed past the age of three years?
- Yes      Has numerous rituals or specific routines and becomes very agitated when altered?
- Yes      Refuses to sleep in own room or alone in own bed
- Yes      Has begun to wet the bed again yet stopped previously?
- Yes      Suspicions of drug and alcohol abuse? Misuse of over the counter/prescription drugs?

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Prenatal & Early Developmental History

The client is the mother's  1<sup>st</sup> born  2<sup>nd</sup> born  3<sup>rd</sup>  4<sup>th</sup>  5<sup>th</sup>  6<sup>th</sup>  Other: \_\_\_\_\_th

1.) Does mother have history of previous:  Miscarriage  Abortion  Stillbirth

2.) During the pregnancy, were there any complications, unusual symptoms, high emotional stress, or physical injuries? \_\_\_\_\_

Approximate month problems began:

Any hospitalizations during term?

3.) Any use of  Tobacco  Coffee/Soda/Caffeine  Alcohol  Heroin  
exposure to  Marijuana  Methamphetamine/Crank  Crack/Cocaine  Other: \_\_\_\_\_

Also, list any prescription medications used during pregnancy:

4.) Was the pregnancy full-term (40 weeks)?  Yes  No, born premature during \_\_\_\_\_ week.

5.) During delivery were there any complications, unusual symptoms, or problems that occurred?

6.) Delivery was:  C-Section  Vaginal  Head First  Feet First  Breech  Forceps  Vacuum  
Birth weight: \_\_\_\_\_ Pounds \_\_\_\_\_ Ounces Birth length: \_\_\_\_\_ Inches

Developmental Milestones

	Age		Age
Hold Head Up	_____	Stood Independently	_____
Rolled over	_____	Walked Independently	_____
Sat up	_____	First word	_____
		Combined words	_____
		Toilet trained	_____

**Any additional information of significance regarding early development.**

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Legal Issues: (list the attorneys and who they represent)	Address:	Dates Seen:
Current or Assigned Psychotherapist:	Address:	Dates Seen:
Previous Psychotherapists:	Address:	Dates Seen:
Speech Therapist:	Address:	Dates Seen:
Occupational Therapist:	Address:	Dates Seen:
Previous Psychiatrists:	Address:	Dates Seen:
Primary Care Physician:	Address:	Dates Seen:
Previous Psychological Testing/Educational Testing:	Address:	Dates Seen:
Previous Mental Health Agencies Involved:	Facility:	Therapist
Previous Residential Mental Health or Hospital Mental Health Services:	Facility:	Therapist

If there is anything else that you would like to comment upon, please make a notation below and continue on the back of this paper.

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## Educational History

List all schools attended with the district, academic years and grades attended schools. Beginning with current year and grade back to preschool.

School	District	Grades Attended	Academic Years Attended

Has the child ever been diagnosed with a Learning Disability?  Yes  No

Has the child ever received Special Education services  Yes  No  
Be specific as to when and what type

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Academic Performance Currently:                      Excellent                      Adequate                      Poor

---

Any history of CPS Involvement:

Describe any current litigation involving the patient:

Describe any involvement with the Juvenile Justice System:

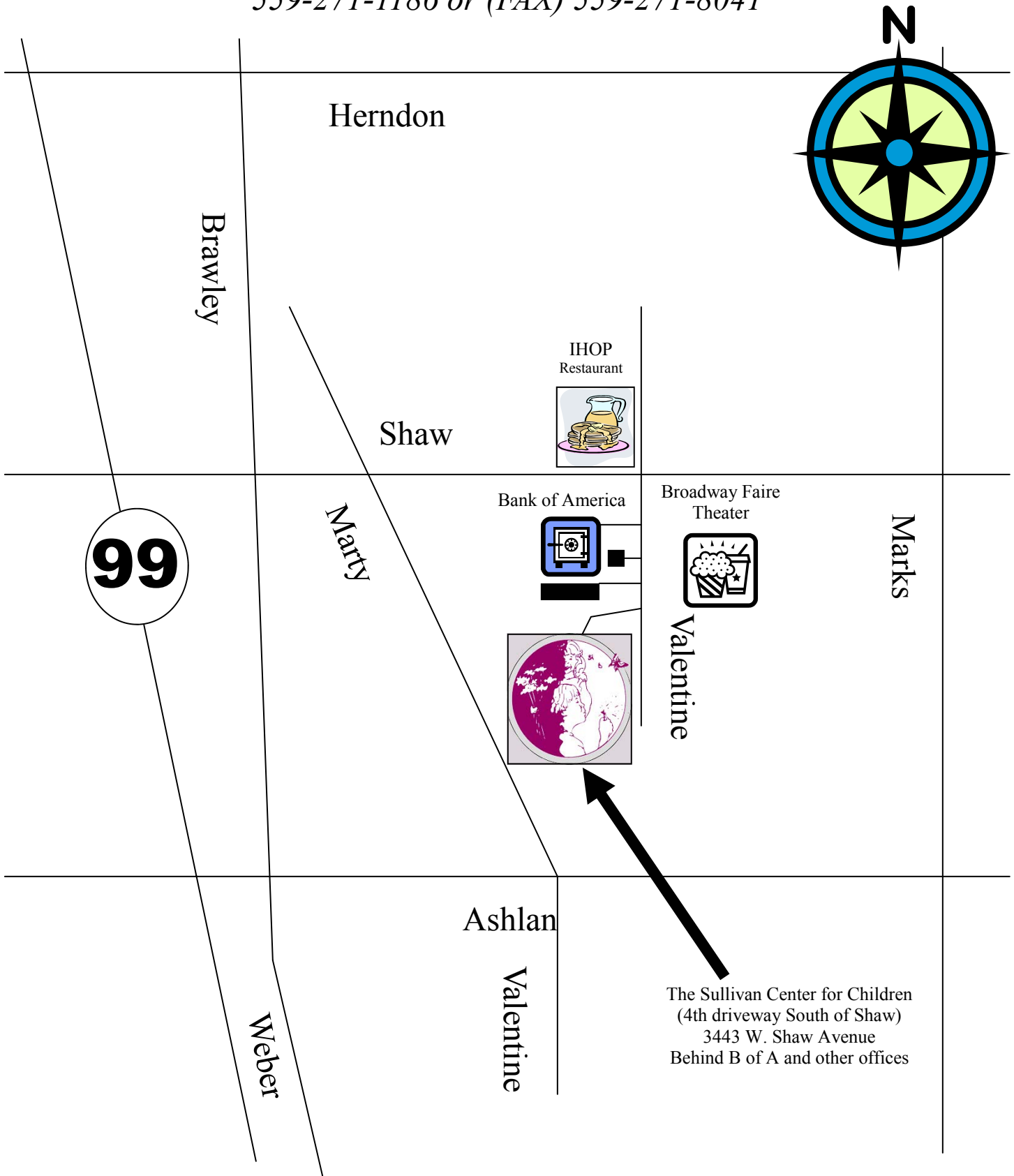
History of Drug/Alcohol Abuse:      Please list types of drugs, how much and how often:

Revised: 07/22/11

# The Sullivan Center for Children

3443 W. Shaw Avenue, Fresno, CA 93711

559-271-1186 or (FAX) 559-271-8041



Herndon

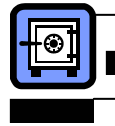
Brawley

Shaw

IHOP  
Restaurant



Bank of America



Broadway Faire  
Theater



Marks

Marty

Valentine



Ashlan

Valentine

Weber

The Sullivan Center for Children  
(4th driveway South of Shaw)  
3443 W. Shaw Avenue  
Behind B of A and other offices