Columbia Counseling Center
COMPREHENSIVE PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

NEW PATIENT TESTING FORM

Please Print Clearly

PATIENT DEMOGRAPHICS

Last Name: ______________ First Name: ______________ Middle: ______________

Alias/ Nickname: ______________________________

Social Security #: ______________ Gender: __________ Date of Birth: ______________ Age: ____

Correspondence sent via email: opt in ☐ opt out ☐ Email: ______________

Appointment Reminders by text: opt in ☐ opt out ☐ Cell #: ______________

Permanent / Physical Address (Required)

Street Address: ______________________________

City: ______________ State: ________ Zip Code: __________ County: ______________

Additional Contact Phone Numbers: Home: ______________ Work: ______________

EMERGENCY CONTACT

Contact Name: ______________________ Relationship: ______________________

Home: ______________ Work: ______________ Cell / Mobile: ______________

GENERAL INFORMATION

Interpreter Needed? **Yes** ☐ **No** ☐ Preferred Language: ______________

Marital Status: ______________ Spouse's Name: ______________

Hispanic / Latino Ethnicity? Yes ☐ No ☐ How did you hear about this center: ______________

Check all Race Categories the patient self-identifies as:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or another Pacific Islander
- ☐ White / Caucasian
- ☐ Declined to Answer

EMPLOYMENT / SCHOOL STATUS (Please Check One)

Employed: Full Time ☐ Part Time ☐ Self Employed ☐ Active Military ☐ Retired ☐ Disabled ☐

Occupation: ______________________ Employer: ______________________

Address: ______________________________

Student: Full Time ☐ Part Time ☐ Grade: ____ School Name: ______________

Is the school requiring this testing for IEP? ☐ YES* ☐ NO

*If yes, when is the Meeting? ______________

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** GUARANTOR OF ACCOUNT (required if patient is a minor) **

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other ______________________

Last Name: ________________ First Name: ______________ Middle: ______________

Date of Birth: ______________ Social Security #: ________________ Gender: __________

Billing Address: ____

City: ______________ State: _____ Zip Code: __________ Contact #: ______________

PRIMARY CARE PHYSICIAN

Name: ___________________________ Phone Number: ______________________ ☐

Fax #: ______________________ Location: ___________________________________

REFERRING PHYSICIAN

Physician Name: _______________________ Phone Number: ______________________

Fax #: ______________________ Location: ___________________________________

Reason for Testing: ____

Should this provider receive a copy of your testing report? ☐ YES ☐ NO

Is this provider a **NEUROLOGIST**? ☐ YES* ☐ NO

*If yes, please have them send records over immediately, these will be required to complete your report.

INSURANCE INFORMATION

Primary Insurance: ____

Subscriber's Name: ______________________ Relationship to Patient: ________________

Date of Birth: ____________ SS#______________ Employer: ______________________

Policy #: ______________________ Group # (if applicable) _________________________

Secondary Insurance (if applicable): _____________________________________

Subscriber's Name: ______________________ Relationship to Patient: ________________

Date of Birth: ____________ SS# ______________ Employer: ______________________

Policy #: ______________________ Group # (if applicable) _________________________

SELF PAY / NO INSRUANCE (Only patients without insurance)

☐ I do not have health Insurance / Do not wish to have my health insurance billed. – See self-pay waiver

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OFFICE POLICY AND SIGNED CONSENT OF PRIVACY PRACTICES

I, as the patient, have read and understand of all office policies. I understand that all copays, deductibles and coinsurance payments that are not covered by my insurance are due in full at the time of service. The accepted payment methods are Visa, Mastercard, Discover, Personal Checks and Money Orders. The office will charge a **$28.00 fee** for any **returned check/s.** Past due accounts are subject to a **3% late interest fee** as well as a no reschedule policy until the balance is paid in full. The office requires **24HOUR notice** to break any Testing Sessions, this policy is strictly enforced and will be subject to a **$75.00 late cancelation fee or no-show fee PER HOUR OF TESTING Scheduled** if the patient does not notify the office at all; this fee is not covered by the insurance. The office does provide 24hour phone coverage which will allow you to leave a message to cancel any appointment. **I agree to allow Dr. Sholtis to discuss treatment with my current physician/s listed above to better asses the needs of my Psychological / Neurological Testing.** I understand that my entire testing process may take up to 3-5 months (from start to finish) to complete. **I acknowledge that there is a $150.00 Testing Material/Supply fee that is not covered by my insurance. This fee is due IN FULL at the first testing session. Failure to pay this fee will result in a reschedule of your appointment/s.**

I declare I have listed all medical health insurance plans from which I may allow Columbia Counseling Center to bill on my behalf. I agree that the information supplied on the form is accurate and up to date to the best of my knowledge. Any future changes in the above information, especially those that may affect the processing of my insurance claims, shall be updated with Columbia Counseling Center in a timely manner before any service has been rendered. Any claim/s that comes back from my insurance company that is not covered for any reason/s will be made the patients responsibility. By signing below, I agree to the above office policies and agree to be responsible for 100% of all fees associated with my personal patient account.

I acknowledge that I have received a copy of the Notice of Privacy Practices and I consent to the policies and disclosure of my PHI.

Patient (guarantor) Name: ______________________ Signature: ______________________

Date of Patient Consent: ______________ Witness (Office Staff) Name: ____________ Date : ________

CHILD INTAKE FORM

Please Print Clearly

CHILD CLINICAL INTAKE

PATIENT IDENTIFICATION:

Childs Name (first & Last): ______________________ Date of Birth: _____/_____/_____

Gender: ❑ Male ❑ Female * If applicable, The Child Identifies themselves differently as ❑ Male ❑ Female

Childs Current Age: ____ Current Educational (Grade): __________ Current School: ______________________

Name of Primary Care Physician: ______________________ Phone # ______________________

PRIMARY CONCERNS: (Please 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-mutilating
- ❑ 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

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:

Mother's relationship to the child is: ❑ Natural Parent ❑ Step-Parent ❑ Relative ❑ Adoptive Parent

Occupation: ______________________ Education: ______________________

Birthdate: _____/_____/_____ Age: _____

Father's relationship to the child is: ❑ Natural Parent ❑ Step-Parent ❑ Relative ❑ Adoptive Parent

Occupation: ______________________ Education: ______________________

Birthdate: _____/_____/_____ Age: _____

CHILD INTAKE FORM

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What are the sources of family income? ____________________

MARTIAL HISTORY OF PARENTS:

Natural Parents:

☐ married ________ ☐ separated / Divorced ____ ☐ deceased ________

Step-parents:

☐ married ________ ☐ separated / Divorced ____ ☐ deceased _______

If child is adopted:

Adoption Source: ____________________ Adoption Age: _______ Date of legal adoption: ___/____/____

Reason and circumstances: ____________________

Has the child bee told? ☐ Yes ☐ No *If yes, to what extent? ____________________

Living Arrangements:

Number of moves in child's life __________ Places Dates

Present home: ☐ house/duplex ☐ condo/apartment ____________ ____________

Are you Currently: ☐ renting ☐ own/buying ____________ ____________

Does the child share a room with anyone? ☐ Yes ☐ No *If yes, with whom? ____________________

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

Was the child ever placed, boarded, or lived away from the family? ☐ Yes* ☐ No

*If yes, explain (when, how long, who they were with, etc.): ____________________

What are the major family stresses at the present time, if any? ____________________

Brother and Sisters:

First Name	Age	Gender	Grade	Living at Home?	Drug or Alcohol Use / Abuse / Treatment?
____________	____	☐ M ☐ F	_____	☐Yes ☐No	☐Yes ☐No ☐Unsure ☐Drug ☐Alcohol
____________	____	☐ M ☐ F	_____	☐Yes ☐No	☐Yes ☐No ☐Unsure ☐Drug ☐Alcohol
____________	____	☐ M ☐ F	_____	☐Yes ☐No	☐Yes ☐No ☐Unsure ☐Drug ☐Alcohol

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

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

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______________________ ______________________
______________________ ______________________

Health of family members:

Relationship to Child	Age	Gender	Type of Illness	Year Illness Occurred
____________	____	☐ M ☐ F	____________	____
____________	____	☐ M ☐ F	____________	____
____________	____	☐ M ☐ F	____________	____
____________	____	☐ M ☐ F	____________	____

To the best of your knowledge, does any member of the child's family have any problems with the following:

☐ reading ☐ spelling ☐ math ☐ speech

If any of the above apply, please explain: ______________________

To the best of your knowledge, Is there any history in the child's family of the following:

☐ mental retardation ☐ epilepsy ☐ birth defects ☐ schizophrenia

If any of the above apply, please explain: ______________________

CHILD HEALTH INFORMATION: (Please note all health problems the child has had or presently has.)

☐ High Fevers
☐ Dental Problems
☐ Pneumonia
☐ Weight Problems
☐ Flu
☐ Allergies
☐ Encephalitis
☐ Skin Problems
☐ 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 illnesses, etc.

Are any of these health problems current? ☐ Yes ☐ No *if yes, please explain: ______________________

*If other illnesses, please explain: ______________________

Has the child ever been hospitalized? ☐ Yes ☐ No *If yes, please explain: Age_______ How long?____________

Reason for the hospitalization:______________________

Has the child ever seen a medical specialist? ☐ Yes ☐ No *If yes, please explain: Age______ How long?__________

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Reason for the specialist visit: ____________________

Has the child ever taken, or is he/she currently taking any prescribed medications? ❑ Yes ❑ No

*If yes, please explain: Age______ How long?____________ Reason:____________________

DEVELOPMENTAL HISTORY:

Prenatal:

Child wanted? ❑ Yes ❑ No Planned for? ❑ Yes ❑ No Was this a normal pregnancy? ❑ Yes ❑ No

If mother was ill or upset during pregnancy, explain: ____________________

Length of pregnancy: __________ Parental support and acceptance? ____________________

Birth:

Length of active labor: _____hours Was your Labor: ❑ Easy ❑ Moderate ❑ Difficult Birth weight: ___lb. ___oz.

Was the child: ❑ Full Term ❑ Overdue ❑Premature *if other then Full Term, please explain: __________

Type of delivery: ❑ spontaneous ❑ cesarean ❑ with instruments ❑ head first ❑breech

Did the infant require oxygen after birth? ❑ Yes ❑ No *If yes, how long did they receive it? __________

Did infant require a blood transfusion after birth? ❑ Yes ❑ No *If yes, please explain: __________

Did infant require an X-ray after birth? ❑ Yes ❑ No *If yes, please explain: __________

Physical condition of infant at birth:

Anorexia: ❑ Yes ❑ No *If yes, please explain: ____________________

Trauma: ❑ Yes ❑ No *If yes, please explain: ____________________

Other complications: ❑ Yes ❑ No *If yes, please explain: ____________________

Were alcohol/drugs abused during pregnancy? ❑ Yes ❑ No *If yes, please explain:__________

New born period:

Irritability	❑ Yes ❑ No	Convulsions/ twitching	❑ Yes ❑ No
Vomiting	❑ Yes ❑ No	Colic	❑ Yes ❑ No
Difficulty breathing	❑ Yes ❑ No	Normal weight gain	❑ Yes ❑ No
Difficulty sleeping	❑ Yes ❑ No	Breast fed	❑ Yes ❑ No

DEVELOPMENTAL MILESTONES:

At what age did the Child do the following:

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 ❑ Competitive ❑ Cooperative

❑ Group play ❑ Leadership role ❑ Follower

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

EDUCATIONAL HISTORY:

Name of School: ______________________ Years attended: ______________ Grade Completed: _____

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Name of School: ______________________ Years attended: ______________ Grade Completed: _____

Type of classes:

❑ regular ❑ continuation ❑ gifted/honors

❑ learning disability ❑ emotionally handicapped ❑ other

Did the child ever skip or repeat a grade? ❑ Yes ❑ No *if yes, please explain: ______________________

Did the child have any specific learning difficulties? ❑ Yes ❑ No *if yes, please explain: ______________________

Has child ever had a tutor or other special help with school work? ❑ Yes ❑ No *if yes, please explain: __________

Does child attend school on a regular basis? ❑ Yes ❑ No *if no, please explain: ______________________

Does child appear motivated for school? ❑ Yes ❑ No *if no, please explain: ______________________

Has child ever been suspended or expelled? ❑ Yes ❑ No *if yes, please explain: ______________________

Highest grade on last report card?______________ Lowest grade on last report card?____________________

Favorite subject?____________________ Least favorite subject?______________________________

Does child participate in extracurricular activities? ❑ Yes ❑ No *if yes, please explain: ______________________

In school, how many friends does the child have? ❑ Many ❑ Few ❑ None

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

Has the child had any special testing in school? ❑ Yes ❑ No *If yes - ❑ Psychological ❑ Academic ❑ Other

Please list the child's special interests, hobbies, and skills: ______________________________

____

Has the child ever had difficulty with the police? ❑ Yes ❑ No If yes, please explain:______________________

Has the child ever appeared in juvenile court? ❑ Yes ❑ No If yes, please explain:______________________

Has the child ever been on probation? ❑ Yes ❑ No

If yes: From__________ to __________. Reason: ____

Probation Officer: ____

Has the child ever been employed? ☐ Yes ☐ No

Occupation	Employer	Dates:

ADDITIONAL COMMENTS / CONCERNS:

____
____
____
____
____
____
____
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____
____