Personal Information – General Background Information

IDENTIFIYING INFORMATION

Date:____ /____ /_____

Name:_____ Date of Birth:____ /____ /_____

Address: _____

Phone (Home): _____ (Work):_____ (Cell): _____

The best number to reach you: _____

Your Preferred Email: _____

Do we have your permission to leave a message and identify ourselves?

YES: ❑ Voicemail home ❑ Voicemail Cell ❑ Text ❑ E-mail **NO:** _____

Occupation: _____ ❑ Full- time ❑ Part-time ❑ Not Employed

Employer: _____ Job Title: _____

FINANCIAL

❑ Cash pay ❑ Out of Network Insurance

**For inquiries regarding insurance coverage: *We do take out of network insurance and we are willing to help you with completing forms for authorization and reimbursement. Please contact your insurance company regarding the necessary steps to take for out of network authorization and billing.*

Person responsible for payment: ❑ client ❑ parent/guardian

Insurance Company:_____

OTHER

How did you hear of us: ❑ Website ❑ Family Member ❑Friend ❑ Online Search ❑Physician
❑Other_____

May we thank someone in particular? _____

Sex: ❑M ❑F Height: _____ Weight _____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed _____Number of Children

Race/Culture(*Check all that apply):*
❑ African ❑ Hispanic ❑ African American ❑ Native American ❑ Asian Pacific Islander
❑ Asian American ❑ Caucasian ❑ Other: _____
Religion/Spiritual Orientation: _____
Highest Completed Educational Grade: _____

The Wellness Connection services you are currently engaging in: (please check)
❑ Mental Health Therapy ❑ Psychological Testing ❑ Psychiatry ❑ Occupational Therapy
❑ Speech Therapy ❑ Chiropractic ❑ Acupuncture ❑ Massage Therapy
❑ Dietitian/Nutrition Counseling ❑ Wellness Coach ❑ Professional Organizer
❑ Workshop/Support Group (specify name of class): _____
❑ Yoga ❑ Kid's Yoga ❑ Pilates

Previous Services? ❑Yes ❑No
Dates: _____-_____ With Whom? _____
Dates: _____-_____ With Whom? _____
Dates: _____-_____ With Whom? _____
Dates: _____-_____ With Whom? _____
Dates: _____-_____ With Whom? _____

IN CASE OF EMERGENCY THE WELLNESS CONNECTION MAY CONTACT:
NAME: _____
RELATIONSHIP: _____
ADDRESS: _____
PHONE: Home: _____ Work: _____ Cell:_____

HIPAA PRIVACY NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of this practice such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Virginia Department of Child and Family Services.

- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **Health Oversight:** If a complaint is filed against me with the Virginia Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- **Worker's Compensation:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and The Wellness Connection's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

The Wellness Connection's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide a revised notice in person or through the mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the office administrator to discuss this further.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2013.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that on (date) ___ / ___ / _____, I received the Notice of Privacy Practices from The Wellness Connection, which sets forth the ways in which my personal health information may be used or disclosed by The Wellness Connection, and outlines my rights with respect to such information.

_____ Patient's signature/Date

Consent for Treatment – Children & Youth

It is important that you understand our policy and procedures regarding the treatment of minors at the beginning of services so you can make an informed decision about receiving services. This information is in addition to The Wellness Connection's Services Agreement.

We expect that parent(s) or guardian(s) will be involved in their child's counseling sessions as deemed appropriate by the clinician. All children must be brought to sessions by a parent or guardian and that person must remain at the Center during the time that their child(ren) is being seen.

We ask that a parent or guardian who has the legal authority to do so consent to their child(ren)'s treatment at the Center. We may ask for a copy of a court order to verify that you are the legal parent/ guardian.

Virginia Law allows for either parent to have access to their child's record or information, regardless of whether they have legal custody or not, unless there is a court order limiting access or terminating parental rights. The Center will attempt to notify the parent authorizing treatment if such a request is made, but please understand that we must comply with a legitimate request.

The Center would like you to recognize the importance of the relationship that your child will be developing with their counselor. The trust that is built in the sessions is the foundation for change and growth for your child. Therefore, we ask that by signing this statement you agree not to involve your child's therapist in any type of legal proceeding against a parent or family member. By doing so you would ask the therapist to betray the trust and relationship they have built with your child.

I have read and agree to all the above provisions about seeking services for my child. I certify that I am the legal parent/guardian and have the authority to consent to services.

Parent/Guardian _____ Date: _____

Pediatric Speech Therapy Intake Form

INFORM US AT ANY TIME SHOULD THIS INFORMATION CHANGE.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Name: _____Form Completed by: _____

Relationship to child: _____ Today's Date _____

I. IDENTIFYING INFORMATION

Child's Name_____ Nickname_____

Date of Birth_____ Age_____ Sex____ Blog/Website_____

Reason for referral:

_____

_____

_____

Parent's Marital Status: *(circle one)* never married / married / separated / divorced / widowed

Father's Name_____	**Mother's Name**_____
Date of Birth_____	Date of Birth_____
Address (if different)_____	Address (if different)_____
_____	_____
Telephone:	Telephone:
Home_____	Home_____
Work_____	Work_____
Cell_____	Cell_____
Email_____	Email_____
Employer_____	Employer_____

Position_____ Position_____

Primary Language_____ Primary Language_____

Birth / Adoptive / Foster or Step Parent Birth / Adoptive / Foster or Step Parent

Please List names and ages of all other people living in the home:

Name	Age	Relationship	Primary Language	Secondary

II. REFERRAL BACKGROUND:

Describe your child's speech, language, or swallowing problem:

_____

Has your child been evaluated by a Speech-Language Pathologist or any other specialist? If so, please specify the conclusions, recommendations, and diagnoses:

_____

_____

_____

Is there any family history of speech, language, or hearing problems in your family? Is, please explain._____

_____

Previous Therapy Interventions (*early intervention, school-based, etc.*):

_____

_____

III. BIRTH HISTORY:

Pregnancy: ___normal or ___complicated

by_____

Labor: _____spontaneous___induced ___premature ___complicated by

_____

Delivery: ___Cesarean ___Vaginal ___Breech ___VBAC ___Forceps ___ Vacuum

Apgar Score: (if known) _____

Single Birth: ____ **Multiple Births:** ___twins ___triplets

___other_____

Gestational Age: _____weeks **Birth Weight:** ____ lbs. _____ oz. / _____ grams

NICU: ___No ___Yes _____ days _____ weeks _____ months

Other complications: (e.g. breathing difficulties, tube feeding)

_____

_____

IV. MEDICAL HISTORY

Illnesses / Injuries / Surgeries / Hospitalization since birth:

____ High Fevers _____ Head Injury _____ Bone Fracture _____ Frequent ear infections

____ Pneumonia _____Eczema _____ Cleft Palate/Lip _____ NG/G tube insertion

____Encephalitis _____Dehydration _____Other:

_____

Current Medications:

_____

_____

Supplements:

_____

Allergies:

_____

Immunizations: Regular Schedule / Altered Schedule / Other _____

Pediatrician / Family Physician:

_____

Address:_____ **Phone:** _____

<u>Check and list any other healthcare professionals/surgeons involved in your child's care:</u>

____ Neurologist	____ Orthopedist	____ Ophthalmologist/Optometrist
____ Osteopath	____ Chiropractor	____ Developmental Pediatrician
____ Dietician	____ ENT	____ Psychologist/Psychiatrist
____ Feldenkrais	____ Massage	____ Craniosacral Therapist
____ Audiologist	Other: _____	

Other relevant FAMILY medical history: (i.e. learning disabilities, ADD/ADHD, genetic disorders, vision difficulties, allergies,
etc):_____

_____

Has your child ever had an Ear Infection? ___YES ___NO If YES, how many?

_____

How many times has your child been placed on antibiotics for an EAR or SINUS infection?

_____

Has your child ever had PE (Pressure Equalizing) Tubes? ___YES ___NO

Do you have any concerns re: your child's VISION? ___YES ___NO Explain:

_____

_____

Date of most recent PSYCHOLOGICAL / DEVELOPMENTAL evaluation:

_____

Date of most recent HEARING screening/test: _____

Date of most recent VISION screening/test: _____

V. DEVELOPMENTAL HISTORY (Please specify any areas in which your child was delayed)

Rolled Over: _____stomach to back _____back to stomach

Sitting: _____stayed sitting when placed _____got self into sitting

Crawling: _____on belly _____on hands & knees

Standing: _____with support _____pulled self to stand

Walking: _____with support _____ cruising around furniture

Walking on toes: ___never ___rarely ____occasionally ___frequently

Falls: ___never ___rarely ____occasionally ___frequently

Baby Devices Used: *(age & hours per day)*

_____Sling Swing _____Exersaucer _____ High Chair

_____Jumper _____Pac'n Play _____Bumbo or other sitter

Sensory Tolerance: (Check all that apply)

___ Allows feet to leave ground when swinging ___ Tolerates bare feet on variety of surfaces

___ Tolerates variety of body positions without fear (i.e. on back, off ground, etc.)

___ Tips head back during bathing/diaper changing w/o anxiety

Comments: _____

Toileting: (Check all that apply) ___ urinates/defecates in toilet when placed there

___ Initiating use of toilet ___ Reliably uses toilet ___ Stopped wearing diapers

Communication: (Check all that apply)

____ Looks at caregiver ____ Smiles ____ Coos/babbles

____ Gestures bye-bye ____ Uses 5 words ____ Imitates sounds

____ Responds to name ____ Plays peek-a-boo ____ Puts two words together

____Uses jargon (words that are not understandable but said in "sentences" where child's inflection lets you know he is saying "something") ____ Speaks in sentences

Feeding: (Check all that apply)

____ bottle ____ cup ____ straw ____ NG/G-tube (feeding schedule) _____

____ solids ____ pureed ____ chunky/table food _____has been exposed to nuts

Swallowing: (Check all that apply)

____ Coughing/choking (before/during/after eating or drinking) ____ Gagging ____ Difficulty chewing food

____Wet, gurgly vocal quality while eating ____ Food left in mouth after eating

____ Slow Eater

Comments _____

Fine Motor Skills: Fill out appropriate age category and check all that apply

Babies/Preschoolers:

____ Holds objects ____ Brings hands to mouth

____ Holds objects in both hands simultaneously ____ Feeds self with fingers

____ Bangs two objects together ____ Feeds self with utensils

____ Manipulating toys like pop beads or shape sorters ____ Scribbling

Comments: _____

<u>Preschoolers/Elementary</u>: Preferred hand: ____ right ____ left

____ Dresses self independently ____ Uses fasteners on clothing

____ Grasps crayon/pencil (thumb and finger) ____ Uses scissors

Comments: _____

<u>Elementary/Secondary:</u>

Handwriting issues,explain_____

VI. SPEECH AND LANGUAGE INFORMATION

How does your child communicate with you? (pointing, grunting, gesturing, words, sentences, sign language, bring parent to item, etc)

_____

Has speech development ____stopped? _____ reversed? If so, when, why, explain:

_____

<u>Please check any items listed below that are *DIFFICULT* for your child</u>:

___Eating a variety of foods ___Recognizing common words

___Understanding what he/she hears ___Rhyming

___Following directions or routines ___Getting his/her point across

___Answering questions ___Thinking of words for things

___Concepts of time (seasons, day/night, hours) ___Pronouncing words correctly

___Singing sounds/reciting nursery rhymes ___Using a straw

___Stating sounds of letters ___Telling/retelling stories

___Speaking in organizing/grammatically correct sentences ___Blowing bubbles

VII. EDUCATIONAL INFORMATION

Name of school/daycare provider (in/out of home):

_____

List number of hours per week child is around children his/her same age: _____

Describe your child's interaction with peers:

_____

_____

List your school/daycare schedule:

	Mon	Tues	Wed	Thurs	Fri
Hours:	____	____	____	____	____

Present classroom teacher / special education teacher / therapist's name: _____

Please check any areas of difficulty:

___Speech ___Writing sentences/paragraphs ___Organization

___ Handwriting ___Fine motor ___Reading ___Spelling ___ Math

___Attention ___Study habits ___Mobility ___Gym class

Please list your child's academic strengths:

_____

What kinds of grades/reports does your child receive?

_____

Describe your child's attitude toward school:

_____

Date of most recent educational evaluation (IEP), if applicable:

_____

VI. BEHAVIORAL HISTORY

Please check all that describe your child:

__Friendly/easy going	__Impulsive/impatient
__Difficulty leaving parent	__Difficulty sleeping
__Poor eye contact	__Plays well with others
__Hyperactive	__Overly sensitive to sound
__Cooperative	__Attentive
__Has temper tantrums	__Shows affection
__Sleeps well	__Eats well
__Daydreams often	__ Shy
__Plays make-believe	__Mouth breather/snores
__Takes turns/shares objects	__Doesn't like to be touched
__Poor memory	__Grinds teeth
__Easily frustrated	__Stubborn

VI. BEHAVIORAL HISTORY (Continued)

Please check all that describe your child:

__Still uses pacifier/sucks thumb __Clumsy/falls a lot __Cries easily

__ Distractible/short attention span

__ Will not eat/touch certain textures

__Fearful when moved/startles easily

__ Cannot easily shift from one activity to another

Please further explain as necessary:

_____

_____

_____

_____

VII. CHILD'S INTERESTS

Describe your child's play activities / hobbies:

_____

Approximate number of hours per week your child watches T.V.

_____

Does your child attend community recreation classes, if so, please list:

_____

_____

What incentives / rewards motivate your child? (stickers, food, privileges):

_____

What method of discipline do you practice at home with your child and is it effective?

_____

_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my child's identifiable health information __/__/__ (current date) to __/__/__ (maximum six months). I understand that this authorization is voluntary and may be revoked at any time. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Client Name: _____DOB: _____

Parent/Guardian Signature:
