1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER

excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

Sendan NEW PATIENT FORMS

Thank you for choosing Sendan Center! Our policies and procedures are all in service of our mission: excellence in child/adolescent mental and behavioral healthcare.

The forms that follow contain important information; please read carefully and initial/sign as indicated. There may be other documents for you to sign at your first appointment.

INFORMATION ALL PATIENTS NEED TO KNOW

Medical Records

Our medical charts, as in many doctor's offices, are electronic. All information you share with us becomes part of the medical record.

Confidentiality

We place an extremely high value on the confidentiality of our relationship with you.

We need your written permission to release information about you or your care here. There are a very few exceptions to this:

1. To the physician who referred you here – the law allows us to pass on information summarizing our evaluation, diagnosis and recommended treatment. You may ask us NOT to do that, if you wish.
2. We have concern that you are at immediate risk to harm yourself.
3. We have concern that you are at immediate risk to hurt someone else.
4. We have concern that you are not able to take care of your basic needs (such as food and shelter).
5. State law REQUIRES us to report any case of suspected child abuse or neglect.

If there are other individuals or agencies involved in your child's care, we may talk with you about signing a release of information so that all involved parties can communicate efficiently in the interest of providing the best care for your child.

HIPAA Notice of Privacy Practices

Please review this information carefully and save a copy for your records. The HIPAA Notice is available for download on our website and copies are available at the clinic.

Consultations

Sendan Center clinicians regularly participate in external peer professional consultation groups, and also receive consultation with experts in the field. This is a critical means of ensuring the quality of care we provide. Cases are discussed anonymously.

Sendan Center clinicians also discuss cases internally among relevant and appropriate clinical staff. Cross-disciplinary collaboration is an important part of our work, in the service of excellent care for your child.

BILLING AND INSURANCE

Billing and Payment Procedures depend on the service you are receiving. We know this information is complicated. We are always here to answer your questions.

In General:

Most insurances have an amount that is due at the time that services are delivered. These co-payments are due at the time of service. We accept cash, personal checks, Visa and Mastercard in payment.

If there is still a balance after we bill your insurance, we will bill you for that amount. These amounts are set by your insurance company, and may be due to a deductible or a combination of copayment (the amount you pay at the time of service) and/or a coinsurance amount.

You are responsible for understanding how your insurance works. We will try to be helpful with understanding those issues. You are also responsible for any amounts that your insurance will not pay for. If you change insurance providers without notifying us, we may not be able to retroactively bill the correct insurance – in that case you are responsible for paying for the treatment you received.

We charge a $5.00 fee on accounts with a patient-responsible balance owing where a payment was not made during the month.

We charge a flat fee of $20 per page for all documents requested by outside parties. These include, but are not limited to, preauthorization for medications (requested by your insurance company), disability forms (requested by the State), medication forms (requested by schools or camps). During treatment, you may ask for letters to be written, conferences with schools or outside agencies, or telephone consultations. Insurances typically do not pay for these types of services. You will be personally responsible for these charges. We do not charge for authorized exchange of information between Sendan Center and other providers, such as your physician or another therapist.

Let us know immediately if you expect to have trouble paying your bill.

If you have an insurance that we do not bill, you may wish to check to see if you have “out of network” coverage. If you do, you may be able to bill your insurance company yourself and receive partial reimbursement. We can provide you with the information necessary to do that billing on your own. You will need to pay in full for services at the time of service, and then be given a statement you can submit to your insurance company for reimbursement.

We reserve the right to submit unpaid bills to a collection agency. In some cases this may result in legal action, which the collection agency will initiate.

Mental health billing can, unfortunately, be extremely complicated, and there are multiple points in the billing process where someone (patient, insurance company, provider) can make an error. In our experience, billing and payment conflicts often arise when families disregard the policies and procedures described in this document. However, sometimes billing and payment conflicts occur despite everyone's best efforts. Our staff are dedicated to approaching billing and payment issues from a problem–solving perspective, with patience and goodwill.

Sendan Psychiatry and Psychotherapy

Payment is always due at the time of service. If the receptionist is not available, you may leave a check or cash with your therapist. Alternatively, you may send us your credit card number on your billing statement or pay over the phone.

If your minor or dependent child is unaccompanied to their appointment, arrangements should be made for payment of any charges due on the day your child is seen. For example, we can accept credit card payments over the phone if you do not wish to send payment with your child.

Sendan Center is only a preferred provider with Regence (and HMA, which uses Regence providers), Premera (and Lifewise, which is a part of Premera), and Kaiser Permanente. If you provide us with complete and accurate information, we will bill those insurance companies for you. When you have insurance changes, please be sure to let us know about them. We do not bill any other third-party payers or insurance companies. If you have any other insurances than those listed above, you are responsible for the bill at the time of service.

Sendan Autism Services*

Sendan Autism Services is contracted with the insurance companies listed above. Some of our providers also accept Molina and HCA Fee-For-Service for autism diagnosis evaluations and treatment (such as speech-language-communication therapy specific to an autism diagnosis). The front office can give you an estimate for diagnosis and/or treatment costs depending on the unique needs of your child, and the providers involved, and will guide you through the steps necessary for us to be able to bill your insurance.

Sendan ABA Services*

Sendan ABA Services is contracted with the insurance companies listed above, as well as Molina, DDA and HCAFee-For-Service. Each payor has a different process they will want you to go through before they will reimburse for ABA services. The front office can give you a rate sheet for all services and guide you through the steps necessary for us to be able to bill your insurance.

Sendan Learning Services*

Some Sendan Learning Services are billable to insurance, and others are not:

Language disorder assessment and therapy, tutoring and executive function coaching: Private pay only. We do not bill insurances, Molina, or HCA for these services. You will receive a rate sheet prior to treatment and will be billed monthly for services received. Payment is due upon receipt of the bill.

Speech-Language Therapy: Molina only

Occupational Therapy: Regence (HMA), Premera (Lifewise), Kaiser, Molina, HCA-Fee-For-Service

* We recognize how incredibly confusing it is to understand what services are and are not covered by which insurances. Insurances have a lot of rules that providers and patients must follow. Please contact us with your questions, and we will work together with you to figure out if we can bill your insurance for the services your child needs.

Appointment Policies

All Sendan Center Service programs will require the initial paperwork. Please bring completed forms to your first appointment or mail, fax or drop off prior to your appointment.

A Psychiatry and Psychotherapy evaluation at Sendan Center typically requires three sessions to complete and provide feedback regarding diagnosis, recommendations and prognosis. In the first session, parents may be seen alone, and in the second, the child may be seen alone. The third visit is usually a formal feedback session. The evaluation process for your child may be slightly longer or shorter, depending on the determined immediate needs of the child and family.

Initial Evaluations for Sendan Autism Services, Sendan ABA Services and Sendan Learning Services will vary depending on the needs of the child and family.

We charge you for missed appointments and visits cancelled with less than 48 hours' notice. Insurance will not reimburse for missed appointments; you are responsible for those charges at the full cost of the appointment.

Appointments

Please check in with the receptionist when you arrive. While we try to keep on schedule to avoid keeping you waiting, occasionally we can get behind because of unexpected clinical situations. The receptionist can keep you informed of any delays when you arrive.

If your child is young enough to need supervision while parents are meeting with a clinician at any time, you will need to arrange to have someone watch them.

Medication Refills

If you need a prescription refill, first contact your pharmacy. They will fax our office asking for a refill. We require 48 hours advance notice for such a request, and 72 hours' notice on Fridays.

If there are no refill authorizations on your current prescription, your child will need to be seen by Dr. Harle to renew the prescription. Please be sure you have scheduled an appointment with Dr. Harle well in advance of the prescription running out.

Stimulants and other medications may require handwritten prescriptions. If you do not have a prescription to fill, your child may need an appointment with Dr. Harle. Please be sure to schedule an appointment before you run out. Federal Law requires that patients on stimulants be seen every three months. Lack of timely appointments or notification of refill requests may lead to your child not being prescribed his/her medications. Your child's safety and wellbeing are our chief priority.

Telephone Calls

We try our best to return all Front Office calls within one business day and urgent calls sooner. Front Office days of business are Monday through Thursday. You can help us by leaving your phone number and good times to reach you when you leave your message.

Speaking with or consulting with individual clinicians by telephone is subject to clinical availability. If you need to speak with your clinician, it is best to schedule a phone appointment with the front office.

We do bill for telephone calls and letters written on your behalf, including those required to ensure prescribed medications are covered by your insurance. However, insurances do not typically pay for phone calls and writing letters. These charges are your responsibility.

Coverage

At times we will be unavailable for urgent/emergent needs and will arrange coverage for these periods with other professionals, as appropriate.

Emergencies

If you have an emergency, please call 911 or go to the emergency room nearest you. We are not able to safely handle emergencies during office hours, as we are providing patient care.

For urgent concerns (which are not emergent), you may leave a message and we will attempt to get back to you within one business day.

For non-emergent but clinically urgent issues after regular business hours, please call the main number and follow the after-hours paging instructions.

This page is deliberately left blank.

1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER

excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES

I acknowledge that I have read Sendan Center Policies and Procedures and have had the opportunity to ask questions about the information contained there. I acknowledge that knowledge and understanding of my insurance benefits is solely my responsibility.

I will be responsible for payment of uninsured charges, missed appointments, carrying charges, telephone calls, and collection charges. I grant permission for this practice to disclose information to my insurer as necessary to process my claims, and as legally permissible in the interest of my child's safety and wellbeing.

Please initial each section and sign below to acknowledge you have read, understand and accept the policies described in each section:

_____ Medical Records
Initial

_____ Confidentiality, HIPAA Notice
Initial

_____ Consultation
Initial

_____ Billing and Insurance
Initial

_____ Policies and Guidelines
Initial

_____ Appointments
Initial

_____ Medication Refills
Initial

_____ Telephone calls
Initial

_____ Coverage
Initial

_____ Emergencies
Initial

Signature	Printed name	Relation to Patient	Date

Name of Patient	Date of birth

YOUR BILLING INFORMATION

- o Regence (including HMA)
- o Premera (including Lifewise)
- o Kaiser Permanente
- o Molina: for some services only; please see details under Billing and Insurance Policies above
- o HCA Fee-For-Service: for some services only; please see details under Billing and Insurance Policies above
- o DDA (Developmental Disabilities Administration): for some services only; please see details under Billing and Insurance Policies above

(Other insurances are not billed)

Insurance ID# _____
Group Number _____
Name of Insured _____
Name of Guarantor_____ Guarantor's Date of Birth:_____
Guarantor's *address*:_____ *City*:_____
State: _____ *Zip code*:_____
Guarantor's best contact phone number:_____

Have you checked on your benefits with your insurance company? o Yes o No
(We strongly suggest that you do check this to be sure that you understand if you have any deductibles, what your copayment or coinsure amounts might be, whether the services you will be receiving are covered, and how many visits you may have available to you.)

Kaiser insurance requires preauthorization for all services. For Psychiatry and Psychotherapy services, please call the member services number on the back of your insurance card. For other services, please ask your child's primary care physician (PCP) to submit a referral. If you or your child's PCP need any information (such as provider names or billing codes) in order to submit that referral, we can provide that information.

Without that preauthorization, we cannot bill Kaiser for services.

Other insurances sometimes require referral and/or preauthorization for some services. In these cases we will let you know before your first visit what additional steps are required by your insurance company.

NAME OF PATIENT PATIENT'S DATE OF BIRTH

1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER
excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

(*PLEASE KEEP IN MIND THAT MANY OF THESE ARE EITHER STANDARD OR REQUIRED QUESTIONS; NOT WILL APPLY TO YOUR CHILD)*

SENDAN CENTER CHILD AND FAMILY INTAKE AND CONSENT FORM

Seeking (please circle): Diagnosis Treatment Both Not sure

This intake paperwork is for:
☐ Sendan Psychiatry / Psychotherapy ☐ Sendan ABA Services ☐ Not sure
☐ Sendan Autism Services ☐ Sendan Learning Services

Person filling out this form: _____ Relationship: _____
Person(s) who assisted in completing this form: _____
Date completed: _____ Current age of child: _____

Is treatment court-mandated? ☐ Yes ☐ No
If legally an adult, is the patient under the supervision of the Department of Corrections? ☐ Yes ☐ No

IDENTIFYING INFORMATION:
Child's name: _____ Date of Birth: _____
Ethnicity/race: _____ Primary Language:_____
Gender Identity: _____ Sex assigned at birth:_____ Pronouns:_____
Preferred Name: _____

FAMILY CONTACT INFORMATION:
Who has current custody/guardianship of Child? ☐ both parents ☐ mother ☐ father ☐ relative: _____
☐ other: _____
If the Legal Guardian is someone other than the parents, please complete the following:
Name: _____
Address: _____
Phone: _____
Relationship to child: _____

NOTE: If a parenting plan exists, please provide a copy.
Information about Parent 1: ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____
Name: _____DOB: _____
Address: _____
Home phone: _____ Work phone: _____ Cell phone: _____

Marital status: _____ Years of education/degree: _____
General health: _____

Information about Parent 2: ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____
Name: _____DOB: _____
Address: _____
Home phone: _____ Work phone: _____ Cell phone: _____

Marital status: _____ Years of education/degree: _____
General health: _____

Information about Parent 3 (if applicable): ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____
Name: _____DOB: _____
Address: _____
Home phone: _____ Work phone: _____ Cell phone: _____

Marital status: _____ Years of education/degree: _____
General health: _____

Information about Parent 4 (if applicable): ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____
Name: _____DOB: _____
Address: _____
Home phone: _____ Work phone: _____ Cell phone: _____

Marital status: _____ Years of education/degree: _____
General health: _____

Emergency Contact:
Emergency contact: _____ Relationship: _____

Family Members:
Please list all people currently living in your child's primary home:

NAME	GENDER	AGE	RELATIONSHIP

Please list other adults or children significant to your child who do not reside in the household:

_____

_____

Has the family moved in the past 12 months? ☐ Yes ☐ No
Has the family experienced homelessness in the past 12 months? ☐ Yes ☐ No
Is your current housing adequate to meet your family needs? ☐ Yes ☐ No

Please indicate any major stresses the family and/or child is currently experiencing or has experienced within the last year:

☐ marital discord/fighting ☐ loss of loved one ☐ parent/sibling death
☐ birth/adoption of another child ☐ parent emotionally/physically ill ☐ legal issues / juvenile court
☐ custody disagreement ☐ financial problems ☐ parent substance abuse
☐ abandonment by parent ☐ physical abuse ☐ sexual abuse

☐ child neglect ☐ sibling conflict ☐ separation
☐ parent/child conflict ☐ divorce ☐ other: _____

Do you have any family members in the area that you can rely on for help? ☐ Yes ☐ No
Do you have any friends in the area that you can rely on for help? ☐ Yes ☐ No
Do you have any other adults in the area that you can rely on for help? ☐ Yes ☐ No
Please describe activities that your family likes to do together:

_____
_____
_____

Are there currently any unusual stresses your family is experiencing? ☐ Yes ☐ No
Is there any problematic family conflict currently in the household in which the child resides? ☐ Yes ☐ No
Does the patient have a troubled sibling? ☐ Yes ☐ No
If you answered yes to any of the last three questions, please provide details and effect on child:

_____
_____
_____

Please provide a brief statement about parents'/ caregivers' own relationship:

_____
_____
_____

Has there been any domestic violence in the household in which the child resides? ☐ Yes ☐ No
If yes, please provide details (Police called? Legal consequences? Effect on child?):

_____
_____

Are there any guns in your home or any home your child visits? _____
If so, are the guns locked? ☐ Yes ☐ No If yes, how? _____
Does parent/caregiver have a history of alcohol or drug use, which disrupts his/her capacity to parent? ☐ Yes ☐ No
If yes, provide details _____
_____
Has parent/caregiver ever been involved in the criminal justice system? ☐ Yes ☐ No If yes, provide details: _____
_____

ADOPTION HISTORY IF APPLICABLE

At what age was the child adopted? _____ Date in home: _____
Date of legal adoption: _____
Type of adoption: Within family_____ U.S. _____ International _____
Country: _____
What has the child been told about the adoption? _____
_____
Does the biological parent see the child? If so, how often? _____

SEPARATION HISTORY IF APPLICABLE

Has the child ever been separated from his/her parents or primary caregivers for any significant period of time? ☐ Yes ☐ No

Provide information about the child's age and circumstances of the separation: _____

_____

_____

_____

How did the separation affect the child?: _____

_____

Is the child currently at risk for out-of-home placement? ☐ Yes ☐ No If yes, why: _____

_____

_____

REASONS FOR EVALUATION

Who referred you to Sendan Center? _____

What are your concerns about your child? Please provide as much detail as possible, including the nature of any symptoms or behaviors, onset, duration, frequency and severity: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Did a specific event lead to this request for evaluation/treatment? ☐ Yes ☐ No. If so, please describe: _____

_____

_____

_____

_____

What do you hope will come out of this evaluation/treatment?

_____

_____

_____

_____

_____

PRENATAL HISTORY

This information should be provided as it relates to the biologic parents of the child, if known.

Was the pregnancy planned? ☐ Yes ☐ No

Any difficulty becoming pregnant? If so, please explain: _____

_____

Was the mother exposed to any of the following:

Type	List Specific Substance	Amount	Month of Pregnancy
Drugs	☐ None		
Alcohol	☐ None		
Tobacco/Nicotine	☐ None		
Medications	☐ None		
X-Rays	☐ None		

Did the mother experience any health problems during pregnancy? ☐ Yes ☐ No If yes, please describe:

_____

Length of pregnancy: _____ Age of mother: _____ Weight gain: _____

Describe labor and/or delivery with this child: ☐ without problem ☐ difficult (please explain below) ☐ natural (Vaginal)
☐ C-section ☐ Forceps used
Please explain: _____

_____

_____

Did the baby cry immediately after birth? ☐ Yes ☐ No Apgar scores (if known): _____

Birth statistics: Weight: _____ Length: _____ Head circumference: _____

How soon after the birth did the mother see the baby? _____ Hold the baby? _____

Hospital where the child was born: _____

Duration of mother's hospital stay: _____ Baby's hospital stay: _____

Were there any problems noted by anyone while the baby was still in the hospital? (For example, prolonged jaundice, need for incubator/oxygen, infections, feeding problems, convulsions): _____

_____

_____

Were there any difficulties during the baby's first month of life? (Examples: excessive crying, health problems): _____

_____

_____

Was infant ☐ bottle or ☐ breast fed? Number of months breast fed: _____

Were there any difficulties with feeding? (Examples: recurrent vomiting, "colic", poor suck, low weight gain) _____

_____

Did parents have significant or unusual trouble adjusting to the new baby? _____

_____

Did biologic mother suffer with postpartum blues or depression? If so, please describe. _____

_____

_____

DEVELOPMENTAL HISTORY

Do you / did you have any concerns about your child's development? ☐ Yes ☐ No

Was development perceived as ☐ average? ☐ below average? ☐ above average?

Please identify your child's developmental progress in the following areas:

Areas of Development	***Compare your child's development to other children his/her age (please put an X in the box below):***			***Please comment on areas of strength and needs in your child's development:*** Please note any delay/ deterioration/ loss of skills
	Average	Slower	Faster	
Gross Motor Skills (running, throwing ball, bicycling)				
Fine Motor Skills (coloring, drawing, writing, scissors use)				
Speech & Language Skills (pronunciation, vocabulary)				
Social Skills (sharing, cooperating, taking turns)				
Self-Control Skills (impulse control, delaying gratification)				
Self-Concept (child's opinion of self, abilities, worth)				
Cognitive Skills (memory, comprehension, knowledge)				
Self-Care Skills (feeding, toileting, dressing)				

Has your child had any formal developmental testing? ☐ Yes ☐ No If yes, please provide details: _____

_____

_____

Has your child received any early intervention services? ☐ Yes ☐ No If yes, please provide details:_____

_____

_____

SPEECH AND LANGUAGE DEVELOPMENT

During the first two years, did your child demonstrate the following:

☐ babbling ☐ jargon (talking own language) ☐ phrases ☐ single words ☐ Short sentences

(IF APPLICABLE): What is the primary method your child uses for letting you know what he/she wants? (please check any that apply)

☐ looking at objects ☐ crying ☐ single words ☐ pointing at objects ☐ vocalizing

☐ 2-3 word combinations ☐ gestures ☐ physical manipulation ☐ sentences

HEALTH HISTORY

Who is your child's primary doctor? _____ Phone #: _____

Address: _____

Who is your child's primary dentist? _____ Phone #: _____

When was your child last seen by a medical professional? _____

For what reason? _____

Date and results of last physical examination: _____

Child's current height: _____ weight: _____ BMI: _____

Is your child's general physical health good? ☐ Yes ☐ No
Serious and / or chronic illness now (or in past)? _____

_____

Any sleep problems? _____
Typical range of times when your child falls asleep on school nights: _____ non-school nights: _____
Typical range of times when your child gets up on school days: _____ non-school days: _____
Does your child snore, gag or ever appear to stop breathing during sleep? _____
Does your child have any of these in the bedroom: ☐ computer ☐ television ☐ monitor for video games
Does your child have access to: ☐ video games or ☐ cell phone in the bedroom at night? _____
How does your child wind down at the end of the day? _____
Are immunizations up to date? ☐ Yes ☐ No
Does your child have any of the following impairments/conditions (documented)? ☐ none reported ☐ unknown ☐ developmental disability ☐ visual disability ☐ deaf ☐ hard of hearing ☐ medical/physical disability ☐ neurological disability ☐ fetal alcohol syndrome or effects
If yes, please provide details _____

_____

Has child had any history of seizures/convulsions (including with exercise, startle, or fright) or head injury/concussion? ☐ yes ☐ no
If yes, please provide details_____

_____

Has your child fainted, blacked out, or experienced episodes with loss of consciousness? ☐ yes ☐ no
If yes, please provide details_____

_____

History of medical hospitalizations and/or surgeries: ☐ None ☐ Unknown

Doctor or Hospital	Dates/duration:	Conditions treated:	Complications:	Discharge status:

Current ongoing use of non-psychotropic medications for physical health: ☐ None ☐ Unknown

Name of medications:	Conditions:	Prescribing MD:	Dose/Schedule:	Response/Side Effects:

1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER

excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

Use of vitamins, herbs, supplements, homeopathy, or naturopathic remedies? ☐ None ☐ Unknown

Current	Past	Name of treatment:	Conditions:	Prescribing MD:	Response/side effects:

Has your child had any of the following? (please give details):

☐ recurrent headaches _____
☐ recurrent stomach aches, nausea _____
☐ recurrent diarrhea _____
☐ recurrent vomiting _____
☐ constipation or soiling _____
☐ vision problems _____
☐ hearing problems _____
☐ ear infections _____
☐ recurrent respiratory infections (bronchitis/bronchiolitis or pneumonia) _____
☐ ALLERGIES (INCLUDING MEDICATION) _____
☐ wheezing or asthma _____
☐ problems with urination, including wetting _____
☐ weight loss or gain _____
☐ skin problems _____
☐ problems with bones, muscles or joints _____
☐ tremor, shakes or jitters _____
☐ unusual movements, including tics or twitches _____
☐ shortness of breath with exercise (more than other children of the same age) in the absence of an alternative explanation (e.g. asthma, sedentary lifestyle, obesity) _____
☐ poor exercise tolerance (in comparison with other children) in the absence of an alternative explanation such as asthma, sedentary lifestyle, or obesity _____
☐ palpitations brought on by exercise _____

Does your child have any pain issues or concerns? ☐ Yes ☐ No If yes, explain: _____

_____

Sexual Development IF APPLICABLE (menstruation history, sexual activity, use of contraception, pregnancy history): _____

_____

FAMILY HEALTH HISTORY:

Does anyone in your family have any of the following conditions?

Check all that apply, past or present:

Condition/Circumstance	Child / Patient	Mother	Father	Sibling(s)	Mother's Family	Father's Family
Pathological Gambling						
Suicide or Suicide Attempts						
Harm to Self: Cutting						
Harm to Self: Anorexia / Bulimia						
Violence / Harm to Others						
Birth Defect						
Cerebral Palsy						
Intellectual Disability						
Chromosomal / Genetic disorder						
Tuberous Sclerosis						
Epilepsy / Convulsions						
Severe Head Injury						
Migraine Headaches						
Alzheimer's Disease						
Parkinson's Disease						
Autism / Aspergers / PDD						
ADD or ADHD						
Learning Disorder						
Speech/Language Delay						
Motor Skills Difficulties						
Schizophrenia						
Alcohol Abuse						
Drug Abuse						
Physical Abuse						

1616 cornwall ave
suite 100
bellingham, wa
98225

tel 360.305.3275
fax 360.734.5503
sendancenter.com

Condition/Circumstance	Child / Patient	Mother	Father	Sibling(s)	Mother's Family	Father's Family
Sexual Abuse						
Emotional Abuse						
Depression						
Mania / Bipolar Disorder						
Nervousness / Anxiety						
Panic Attacks						
Obsessive Compulsive Disorder						
Psychiatric Hospitalization						
Deaf/ Hard of Hearing						
Tics or Tourette Syndrome						
Special education						
School suspension / expulsion						
Harassment by peers						
Juvenile Delinquency						
Arrests/Incarceration						
Homelessness						
Teen Pregnancy						
Cancer						
High Blood Pressure						
Heart Disease						
Stroke						
Hemophilia						
Kidney Disease						
Diabetes						
Multiple Sclerosis						
Sickle Cell Anemia						
Muscular Dystrophy						
Physical Handicap						
Food Allergy						

If there any known family history of the following heart problems: Long QT Syndrome, abnormal heart rhythm problems, Wolff-Parkinson-White syndrome, cardiomyopathy, heart transplant, pulmonary hypertension, unexplained motor vehicle collisions or drowning, or implanted defibrillator? ☐ Yes ☐ No ☐ Unknown

If yes, explain: _____

Please describe mother's childhood: _____

_____

_____

Please describe father's childhood: _____

_____

_____

PSYCHOLOGICAL HISTORY

How is your child's overall emotional health? _____

_____

Has the child engaged in any law-breaking behavior? ☐ Yes ☐ No If yes, please provide details: _____

_____

Has your child had any history of the following emotional/behavioral problems:

☐ specific phobias/fears: _____

☐ fire-setting: _____

☐ harming animals: _____

☐ hurting him/herself on purpose: _____

History of violence/grief and loss:

Has child been exposed to violence or fighting between parents? ☐ Yes ☐ No

Has child been a witness to violence or traumatic death? ☐ Yes ☐ No

Has child experienced death of parent/psychological parent/sibling? ☐ Yes ☐ No

Child abuse/neglect history: ☐ Not applicable

Child has a history of ☐ physical abuse ☐ sexual abuse ☐ persistent inadequate parenting or neglect?

If applicable, has abuse/neglect been documented by CPS/legal system? ☐ yes ☐ no

_____

Has the abuse history been previously addressed by a professional? ☐ yes ☐ no If so, how? _____

_____

_____

_____

List all current and past outpatient psychiatric/psychological/mental health services utilized: ☐ None ☐ Unknown

Provider Name(s):	Dates of Contact:	Services Provided:	Outcomes:	Termination Reason(s):

List any history of psychiatric hospitalization and/or residential treatment: ☐ None ☐ Unknown

Facility Name(s)	Dates of Contact:	Services Provided:	Outcomes:	Discharge Status:

List any use of psychotropic/psychiatric medicines: ☐ None ☐ Unknown

Current	Past	Name of medications:	Conditions:	Prescribing MD:	Dose/schedule:	Response/side effects:

Please list all other persons or agencies who have evaluated your child in the past:

Type of Service	Service Provider/address:	Results:	Dates:

SOCIAL HISTORY

Check the phrases that describe your child:

☐ Overly quiet ☐ Overly active ☐ Excessive tantrums ☐ Destructive ☐ Very shy ☐ Perfectionistic
☐ Friendly/outgoing ☐ Imaginative ☐ Plays well with other children ☐ Difficulty separating from parent

Does your child have behavior problems at home? If so, please specify:

_____
_____
_____

Does your child have behavior problems at school? If so, please specify:

_____
_____
_____

Does your child have behavior problems in the community (e.g. grocery store, daycare, public places, etc.)? If so, please specify:

_____
_____
_____

1616 cornwall ave
suite 100
bellingham, wa
98225

tel 360.305.3275
fax 360.734.5503
sendancenter.com

Does your child have any past or current substance use/abuse? ☐ cigarettes ☐ e-cigarettes ☐ drugs ☐ alcohol ☐ marijuana
☐ denies use ☐ none If yes, please describe substances used, amount, and effect on child: _____

_____

Please describe forms of discipline which have been used in the home and their effectiveness:

_____

_____

_____

Please make a brief statement about the relationship between your child and

Mother/maternal caregiver: _____

Father/paternal caregiver: _____

Siblings: _____

The closest relationship is between your child and _____

The most troubled relationship is between your child and _____

How has your child's problem affected each family member?

Mother: _____

Father: _____

Sibling(s): _____

Describe sleeping arrangements in the family:

_____

Does your child participate in community activities (e.g. sports, Boys and Girls Club, church)? ☐ Yes ☐ No

If yes, please describe: _____

_____

How many hours of physical activity / exercise does your child have on a weekday: _____ Weekend day: _____

Does your child have hobbies, interests, etc.? _____

_____

What games / activities does your child prefer? _____

_____

Does your child have a social media account (e.g. Twitter, Facebook)?_____

Do you have access to this? _____

Where are the televisions and computers in your home? _____

Do the computers have parental controls? _____

Does your child have any portable electronic devices that can access the internet? _____

How many hours does your child spend in front of any screen on a typical school day? _____

How many hours does your child spend in front of any screen on a non-typical school day? _____

Are chores routinely assigned to your child? ☐ Yes ☐ No If yes, which chores? _____

Does your child have as many friends as most other children his/her age? ☐ yes ☐ no

Does your child have friends come over and play/socialize at your house? ☐ yes ☐ no

Does your child play at the houses of his/her friends? ☐ yes ☐ no

Has your child had any friends stay overnight at your house, or has she/he stayed overnight at another friend's house? ☐ yes ☐ no
☐ not age-appropriate (child too young)

Has your child been persistently harassed or abused by peers? ☐ yes ☐ no

Please list those qualities about your child that you consider to be strong positive points/areas of strength:

_____

_____

_____

Please list those qualities about your child that you consider to be the most difficult or challenging.

_____

_____

_____

Please tell us about your family's strong positive points / areas of strength:

_____

_____

_____

EDUCATIONAL AND VOCATIONAL HISTORY

Is your child currently enrolled in school? ☐ yes ☐ no

Current school placement:

School Name: _____ Grade: _____

School District: _____ Phone #: _____

Teacher/Counselor/IEP Coordinator: _____

Any grades repeated: _____

Is your child enrolled in special education? ☐ yes ☐ no Current I.E.P.? ☐ Yes ☐ No

Child is designated: ☐ Seriously behaviorally disordered ☐ Learning disordered ☐ Health impaired

Child's classroom is: ☐ Regular Education ☐ Regular Education with pull-out to Resource Room ☐ Self-contained classroom

☐ Generic special education classroom ☐ Inclusion in regular education (_____ hours/day)

☐ Other: _____

How is your child currently functioning at school? _____

_____

_____

Review history of school placements and functioning: (including learning/behavior problems, multiple school placements, estimated level of achievement):

_____

_____

_____

_____

Has your child had any learning disability-related testing done before?

What kind of tests: _____

Where / by whom: _____

Dates: _____

Diagnosis / Diagnoses: _____

Please provide copies of test results and/or reports.

Does your child have an IEP or 504 Plan at school? ☐ Yes ☐ No

Please provide a copy of the school's most recent evaluation report and the current IEP or 504 Plan.

If your child is receiving services at school, what have you found most helpful and/or most challenging?

_____

_____

_____

_____

What does your child most enjoy about school?

_____

_____

_____

_____

What do you see as your child's primary learning strengths?

_____

_____

_____

_____

What areas do you see as your child's primary learning challenges?

_____

_____

_____

_____

Has your child received any academic tutoring outside of school?
Where/by whom: _____
Dates: _____
What helped? _____
What didn't help? _____

Educational History:
Have teachers expressed concerns about your child's skills or performance in school? If so, please begin with the grade your child was in when concerns first emerged and briefly note what teachers each year since then have expressed (For older students, you may choose to summarize only the initial concerns and the most recent 2-3 years)

_____

_____

_____

_____

Have you agreed or disagreed with the concerns that teachers or others have expressed? (If disagree, please explain).

_____

_____

_____

_____

Has your child been suspended/expelled in past 12 months? ☐ Yes ☐ No If so, how many times? _____

_____

What school interventions have been used to address problems: ☐ None ☐ Special seating arrangement ☐ Tutoring ☐ Token economy ☐ Groups ☐ Classroom aide ☐ Parent(s) called ☐ other: _____

Vocational History: ☐ Not applicable

Has your child had any paid employment? ☐ yes ☐ no If yes, provide details of employment history: _____

_____

Has your child had any significant volunteer experiences? ☐ Yes ☐ No If yes, provide details: _____

_____

1616 cornwall ave
suite 100
bellingham, wa
98225

SENDAN CENTER

excellence in child & adolescent behavioral health

tel 360.305.3275
fax 360.734.5503
sendancenter.com

CULTURAL HISTORY

Please answer these questions only if you feel the answers are helpful to our understanding of your child and family:
Ethnic/cultural identification of parent/child/extended family: _____

Language spoken at home: _____

Religious/spiritual practices of patient/caregivers/family: _____

Culturally/socially relevant beliefs regarding mental health and illness (include beliefs about the current problem, general beliefs about illness, health and treatment):

_____
_____

Is there anything else you would like us to know about your child or family that we did not ask?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Printed name of patient

Signature of Parent 1 Date Signature of Parent 2 if applicable Date

Printed name/s of signees

Relationship (Parent, legal guardian, personal representative)

1616 cornwall ave
suite 100
bellingham, wa
98225

tel 360.305.3275
fax 360.734.5503
sendancenter.com

Receipt of Sendan HIPAA Notice of Privacy Practices

The Sendan Center HIPAA Notice of Privacy Practices describes in detail your rights and our responsibilities regarding how your health information may be used and disclosed, and how you can access your information.

It is available on our website and in hard copy at our office.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Printed name of patient

Patient or legally authorized individual signature | Date | Time

Printed name if signed on behalf of the patient

Relationship (Parent, legal guardian, personal representative)

This form will be retained in the patient's medical record.

(Effective September 23, 2013)