SENDAN CENTER
excellence in child & adolescent mental and behavioral health

4201 Meridian Street, Suite 113
Bellingham, WA 98226
www.SendanCenter.com
p 360.305.3275
f 360.734.5503

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 at Sendan Center. If a client is 13 years old or over, we need that client to give written permission.

The **exceptions** to this rule are:

1. To the physician who referred you here – state 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 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. If we suspect child abuse or neglect, we are REQUIRED to report this by state law.

If there are other individuals or agencies involved in your or 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 you or 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.

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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.

TEENS AND PRIVACY RIGHTS

Teens have privacy rights for some health issues. To provide the best care and comply with state laws, we may ask to talk with your teen in private. The laws are about:

- Giving consent for care or treatment
- Privacy issues about confidential services for drug and alcohol abuse and mental health

As teens grow, so does their need for privacy and independence. We are committed to giving your teen the best care. We are able to do this by talking with them in private. We know there are times when teens will not tell us important information about their health if we do not give them a place to talk in private and keep their information private from their parents.

Involving parents in care

We are family-centered and strive to involve the parent or guardian in the care and well-being of their child. We encourage teens to talk with their parents or guardians about serious issues and will offer to help start the conversation if they would like that help.

Mental health

A teen who is 13 years old or older may give consent for outpatient care and treatment for mental health concerns. Consent from a parent or guardian is not required.

If a teen needs psychiatric treatment and refuses to consent for care, a parent, legal guardian or other adult caregiver may consent for outpatient care under Family-Initiated Treatment law.

Substance abuse

A teen who is 13 years old or older may give consent for substance use treatment without consent from a parent or guardian. Parents or guardians also can consent for a teen to receive substance use treatment under Family-Initiated Treatment law.

A teen's identity and all information related to the diagnosis and treatment of substance use is private. A teen must give written permission for information about substance use treatment to be released.

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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 may charge a fee for 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. If we charge, 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.

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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 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 (including Uniform and HMA, which use 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).

Sendan ABA Services*

Sendan ABA Services is contracted with the insurance companies listed above, as well as Molina, DDA and HCA Fee-For-Service. Each payor has a different process they will want you to go through before they will reimburse for ABA services.

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Sendan Learning Services*

Sendan Learning Services (language disorder assessment and therapy, speech therapy, tutoring, and executive functioning coaching) are not billable to insurance and are 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.

* 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

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 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 (2 business days)** notice. Insurance will not reimburse you 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 the 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.

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If receiving mental health services via telehealth, please log into HIPAA-compliant website Doxy.me for tele-health. You can find links to all psychiatry and psychotherapy clinicians on our website, by clicking on "COVID-19 FAQs" and scrolling to the bottom. While we try to keep on schedule to avoid keeping you waiting, occasionally we can get behind because of unexpected clinical situations or technology issues. If you are waiting longer than 10 minutes in the Doxy.me waiting room, please call Sendan Center at (360) 305-3275 to check on status updates.

Please make sure that if you are engaging in telehealth, you have headphones and a private location to support confidentiality and privacy laws.

Medication refills

If you need a prescription refill, first contact your pharmacy. They will contact our office asking for a refill. We require 48 hours (2 business days) advance notice for such a request.

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

Stimulants and other medications may require specially mediated or handwritten prescriptions. If you do not have a prescription to fill, your child may need an appointment. Please be sure to schedule an appointment before you run out. Federal Law requires that patients on stimulant medications (e.g. methylphenidate, Ritalin, Concerta, Adderall, mixed amphetamine salts, Vyvanse, dexmethylphenidate, Focalin) be seen every three months. Lack of timely appointments or notification of refill requests may lead to your child not being prescribed their 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 Friday. 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.

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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.

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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 the 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

_____
Patient signature (if 13 years of age or older) Date Time

_____
Parent or legally authorized individual signature Date Time

_____
Printed name if signed on behalf of the patient Relationship (Parent, legal guardian, personal representative)

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YOUR BILLING INFORMATION

Please check one:

- o Regence (including HMA and Uniform)
- o Premera (including Lifewise)
- o Other Blue Cross Blue Shield plan
- 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; 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 Number: _____
Group Number (if shown on card): _____
Name of Insured (the child):_____
Name of Guarantor (the policy holder):_____
Guarantor's Date of Birth:_____ Guarantor's gender (as listed with insurance):_____
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 may require preauthorization for 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 the child's primary care physician 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 may not be able to 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.

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

SENDAN CENTER CHILD AND FAMILY INTAKE AND CONSENT FORM

Seeking (please circle): Diagnosis Treatment Both Not sure

This intake paperwork is for (select any that apply):

- ☐ Psychiatry - *evaluation, diagnosis, medication management*
- ☐ Psychotherapy - *counseling, talk therapy*
- ☐ Psychological testing - *series of testing sessions to pinpoint or rule out specific diagnoses*
- ☐ I'm not sure
- ☐ ABA Services - *behavioral therapy primarily for children on the Autism spectrum*
- ☐ Sendan Learning Services
- ☐ Speech and language therapy

Person filling out this form: _____ Relationship to child:_____

Person(s) who assisted in completing this form: _____

Date completed: _____ Current age of child: _____

Is the individual under department of corrections (DOC) supervision? ☐ Yes ☐ No

Is the individual under civil or criminal court ordered mental health or substance use disorder treatment? ☐ Yes ☐ No

Is there a court order exempting the individual participant from reporting requirements? ☐ Yes ☐ No

If 'Yes', a copy of the court order must be provided.

IDENTIFYING INFORMATION:

Child's name: _____ Date of Birth: _____

Ethnicity/race: _____ Primary Language:_____

Current gender identity: _____ Sex assigned at birth:_____

Pronouns:_____ Preferred Name(s) if different from above:_____

FAMILY CONTACT INFORMATION:

Who has current custody/guardianship of Child? ☐ both parents ☐ mother ☐ father ☐ relative: _____

NOTE: If a parenting plan exists, please provide a copy. ☐ other (please explain below)

If the Legal Guardian is someone other than the parents, please complete the following:

Name: _____

Address: _____

Phone: _____

Relationship to child: _____

Information about Parent/Caregiver 1: ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____

Name: _____ Date of birth: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N

Email address: _____

Marital status: _____ Years of education/degree: _____

Occupation: _____

General health: _____

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Information about Parent/Caregiver 2: ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____

Name: _____DOB: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N

Email address: _____

Marital status: _____ Years of education/degree: _____

Occupation: _____

General health: _____

Information about Parent/Caregiver 3 (if applicable): ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____

Name: _____DOB: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N

Email address: _____

Marital status: _____ Years of education/degree: _____

Occupation: _____

General health: _____

Information about Parent/Caregiver 4 (if applicable): ☐ Biologic ☐ Adoptive ☐ Stepparent ☐ Other:_____

Name: _____DOB: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N Ok to leave detailed message? ☐ Y ☐ N

Email address: _____

Marital status: _____ Years of education/degree: _____

Occupation: _____

General health: _____

Emergency Contact:

Emergency contact name: _____ Phone Number: _____

Relationship: _____

Family Members:

Please list all people currently living in the child's primary home:

NAME	GENDER	AGE	RELATIONSHIP

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Please list other adults or children significant to the 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 with each other:

_____

_____

_____

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 the child visits? _____
If so, are the guns locked? ☐ Yes ☐ No If yes, how? _____

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Does an parent/caregiver have a history of alcohol or drug use, which disrupts their 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 their 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 the 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: _____

_____

_____

_____

_____

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_____

_____

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

_____

_____

_____

_____

PRENATAL HISTORY

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

The word "mother" is used in this section to refer to the person who carried and gave birth to the child.

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: _____

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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 the child's development? ☐ Yes ☐ No

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

Please identify the 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 the child had any formal developmental testing? ☐ Yes ☐ No

If yes, please provide details (organization/provider, approximate dates, outcomes, etc.): _____

_____

_____

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

_____

_____

SPEECH AND LANGUAGE DEVELOPMENT

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

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

(IF APPLICABLE): What is the primary method the child uses for letting you know what they want? (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 the child's primary doctor/pediatrician? _____ Phone #: _____

Address: _____

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

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

For what reason? _____

Date and results of last physical examination: _____

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

Is the 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 the child falls asleep on school nights: _____ non-school nights: _____

Typical range of times when the child gets up on school days: _____ non-school days: _____

Does the child snore, gag or ever appear to stop breathing during sleep? _____

Does the child have any of these in the bedroom: ☐ computer ☐ television ☐ monitor for video games

Does the child have access to: ☐ video games or ☐ cell phone in the bedroom at night? _____

How does the child wind down at the end of the day? _____

Are immunizations up to date? ☐ Yes ☐ No

Does the 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 ☐ Other (not listed):_____

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 the child fainted, blacked out, or experienced episodes with loss of consciousness? ☐ yes ☐ no

If yes, please provide details_____

_____

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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:	Purpose	Response/Side Effects:

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

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

Has the 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 _____

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☐ 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 the child have any pain issues or concerns? ☐ Yes ☐ No If yes, please elaborate: _____

_____

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

_____

FAMILY HEALTH HISTORY:

Does anyone in the child's 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						

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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						

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Is 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, elaborate: _____

Please describe mother's childhood: _____

_____

_____

Please describe father's childhood: _____

_____

_____

PSYCHOLOGICAL HISTORY

How is the child's overall emotional health? _____

_____

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

_____

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

☐ specific phobias/fears: _____

☐ fire-setting: _____

☐ harming animals: _____

☐ hurting themselves 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 any of the following: ☐ 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 (including therapists/counselors):

☐ None ☐ Unknown

Provider/Clinic Name:	Date range of service:	Services Provided:	Outcomes:	Termination Reason(s):

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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:	Prescriber's name:	Dose/ schedule:	Response/ side effects (if any):

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

Type of Service	Evaluating Provider/Organization:	Results:	Dates of evaluation:

SOCIAL HISTORY

Check any of the phrases below that describe the child:

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

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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Does the 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 the child and

Mother/caregiver 1: _____

Father/caregiver 2: _____

Siblings: _____

The closest relationship is between the child and _____

The most troubled relationship is between the child and _____

How have the child's challenges affected each family member?

Mother: _____

Father: _____

Sibling(s): _____

Describe sleeping arrangements in the family:

_____

Does the 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 the child have on a weekday: _____ Weekend day: _____

Does the child have any particular hobbies or interests? _____

_____

What games or activities does the child prefer? _____

_____

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

Do you have access to this? _____

Where are the televisions and computers in your home? _____

Do the computers have parental controls? _____

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

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

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

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

Does the child seem to have as many friends as most other children their age? ☐ yes ☐ no

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

Does the child play at the houses of their friends? ☐ yes ☐ no

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

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

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

_____

_____

_____

Please list those qualities about this 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 the child currently enrolled in school? ☐ yes ☐ no

Current school placement:

School Name: _____ Grade: _____

School District: _____ Phone #: _____

Teacher/Counselor/IEP Coordinator: _____

Any grades repeated: _____

Is the child enrolled in special education? ☐ 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 the child currently functioning at school? _____

_____

_____

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

_____

_____

_____

_____

Has the 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 ☐ In Progress

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

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

_____
_____
_____
_____

What does the child most enjoy about school?

_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

Has the child received any academic tutoring outside of school?
Where/by whom: _____
Dates: _____
What helped? _____
What did not help? _____

Educational History:
Have teachers expressed concerns about the child's skills or performance in school? If so, please begin with the grade the 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).

_____
_____
_____
_____

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Has the 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 (Work) History: ☐ Not applicable

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

_____

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

_____

CULTURAL HISTORY

Please answer these questions only if you feel the answers are helpful to our understanding of the child and your family:

Ethnic/cultural identification of parent/child/extended family: _____

Language(s) 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): _____

_____z_____

_____

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

_____

_____

_____

_____

_____

_____

_____

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Consent for Treatment

By my signature below I consent to the child named below receiving mental and behavioral health (and related services, as appropriate, e.g. speech language or learning services) assessment, evaluation and/or treatment at Sendan Center.

Patient Printed Name

Patient signature (if 13 years of age or older) Date Time

Parent or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship (Parent, legal guardian, personal representative)

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.

Patient Printed Name

Patient signature (if 13 years of age or older) Date Time

Parent or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship (Parent, legal guardian, personal representative)

TO BE SIGNED BY THE EVALUATING CLINICAL STAFF:

I hereby acknowledge that I have read and reviewed the Sendan Center New Patient forms and Family-submitted Intake Questionnaire:

Clinical Staff signature Date

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

(Effective September 23, 2013)