dell children's
medical center of central texas
A member of the Seton Family of Hospitals

Texas Child Study Center
PATIENT INFORMATION

Date_____

Name_____Nickname:_____

DOB_____ Age_____ Sex____ Race/Ethnicity_____

Language(s) spoken at home_____

Person completing form_____ Relationship to Child_____

Child's Address_____

City_____ State_____ Zip_____

Home Phone_____ Other (e.g. Child's Mobile):_____

Email _____

Medical Doctor_____ Phone_____

Referred by_____ Phone_____

Pharmacy _____ Phone _____

Caregiver Information (Custodial)

Name_____Age____ Sex___

Relationship to Child_____

Address (if different from above)_____

Work Phone _____Other Phone_____

Please indicate if we may leave a message at ☐ Home ☐ Work ☐ Other

Employer_____Position_____

Caregiver Information (Custodial)

Name_____ Age____ Sex___

Relationship to Child_____

Address (if different from above)_____

Work Phone _____ Other Phone_____

Please indicate if we may leave a message at ☐ Home ☐ Work ☐ Other

Employer_____Position_____

Caregiver Information (Non-Custodial)

Name_____ Age____ Sex___

Relationship to Child_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone _____ Other_____

Please indicate if we may leave a message at ☐ Home ☐ Work ☐ Other

Employer_____Position_____

In Case Of Emergency Notify:

Name_____ Relation_____

Phone_____ Other#_____

CURRENT CONCERNS

Please tell us what type(s) of services you are seeking:

☐ Therapy (if so, what type:_____)

☐ Evaluation (if so, what type:_____)

☐ Medication

Briefly, please describe the concerns about your child and/or reason you are seeking services (e.g., any behavioral, emotional, or learning concerns at home and or school, difficulties with peer relationships, ect.)

_____

_____

_____

_____

_____

When did your child first start experiencing the problem(s)?_____

_____

How often does the problem occur? _____

_____

How long does it last? _____

_____

Recent Events:

Have any of the following events occurred in the past 12 months?

☐ Divorce or separation	☐ Change in parent's job or schedule	☐ New baby at the home
☐ Family accident or illness	☐ Death of family member or friend	☐ Conflict in the family
☐ Financial stress	☐ Family moved	☐ Change in school
☐ Change in who is living in the home	☐ Legal stress	☐ Other:_____

Additional Information:

_____

_____

Is there any history of physical or sexual abuse? ☐ Yes ☐ No

If yes, please explain _____

_____

Is there a Child Protective Services Report? ☐ Yes ☐ No

If yes, please explain _____

PREVIOUS EVALUATIONS AND TREATMENTS

Previous evaluations or assessments
Including medical, neuropsychological, educational, speech/language, ect.

Date	Type of Testing	Where was the testing done? (e.g., School, Private Psychologist, etc)

Previous interventions or services
Including therapy (family, group, individual), occupational therapy, parent skills training, ect.

Professional's Name/Specialty (e.g. psychiatrist, psychologist, social worker, school counselor)	Start Date	End Date	Type of services received

Has your child ever been hospitalized for behavioral or emotional problems? ☐ Yes ☐ No

If yes, please explain _____

_____

Medication History:

Medication	Dosage	Frequency	Start	End	Prescribed By	Adverse Effects

Please List ANY Drug or Food Allergies_____

If your child takes any other medication or supplements for any other reason, please list:

_____

_____

FAMILY INFORMATION

Parents' Marital Status

☐ Married for _____ years ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed

If separated or divorced, how long? _____

If parents are divorced, who has primary conservatorship of this child (who has the right to consent to psychological services)?_____

****A COPY OF THE DIVORCE DECREE IS REQUIRED IN ORDER FOR US TO SEE YOUR CHILD. PLEASE MARK THE APPROPRIATE PAGE NUMBER INDICATING YOUR RIGHT TO CONSENT TO PSYCHOLOGICAL SERVICES**

Contact with non-custodial parent or custody arrangement, if any:_____

Any special circumstances in the family situation? _____

_____

Family members living in the home:

Name	Age	Gender M / F	Relationship to Child	Highest Grade Completed

Family members living outside the home:

Name	Age	Gender M / F	Relationship to Child	Highest Grade Completed

DEVELOPMENTAL HISTORY

Prenatal History

Did the mother have any accidents, infections, or any other problems during pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

_____

Were any medications taken during pregnancy? ☐ Yes ☐ No

If yes, please list and explain: _____

Did the mother smoke during pregnancy? ☐ Yes ☐ No

If yes, how many cigarettes per day _____

How much alcohol did the mother consume during pregnancy (ex. 1 drink per day, week, month)? _____

Did the mother use any drugs during pregnancy (i.e., marijuana, cocaine)? ☐ Yes ☐ No

If yes, please list and explain: _____

Please mark any of the following conditions that may have occurred during the pregnancy and explain in the space below:

☐ Edema	☐ Limited prenatal care	☐ Preclampsia/toxema
☐ Emotional stress	☐ Anemia	☐ Eclampsia
☐ Hospitalization	☐ Diabetes	☐ Insufficient amniotic fluid
☐ Fever	☐ High blood pressure/hypertension	☐ Placentia Previa
☐ Pre-term labor	☐ Epilepsy/seizures	☐ Other

Please explain: _____

_____

Birth History

Age of mother at child's birth: ____ yrs Age of father at child's birth: ____ yrs

Was the baby on time? ☐ Yes ☐ No

If no, was he/she ☐ Early ☐ Late and by how many weeks? _____

Type of labor onset: ☐ Induced ☐ Spontaneous

Type of birth: ☐ Vaginal ☐ C/Section (planned? ☐ Yes ☐ No emergency? ☐ Yes ☐ No)

Birth weight: _____

Any problems during labor or delivery?_____

Any problems after birth? _____

Infancy/Toddler

Describe your child as an infant and toddler: _____

Please mark the following problems that may have occurred after the child's birth:

☐ Yes	☐ No	Problems with feeding	☐ Yes	☐ No	Easily overstimulated
☐ Yes	☐ No	Colicky/difficult infancy	☐ Yes	☐ No	Withdrawn
☐ Yes	☐ No	Irritable	☐ Yes	☐ No	Didn't like to be held
☐ Yes	☐ No	Overactive	☐ Yes	☐ No	Difficult to soothe
☐ Yes	☐ No	Difficulty taking naps	☐ Yes	☐ No	Difficulty sleeping at night

Developmental Milestones

Indicate the age at which your child achieved the following:

Age

_____Sit up

_____Walk independently

_____Says 1st word other than "mama" or "dada"

_____Says two word phrases

Age

_____Says 3 or more word phrases/sentences

_____toilet trained (urine)

_____toilet trained (bowel)

SCHOOL INFORMATION

Name of School:_____ School District:_____

Phone:_____

Main Teacher: _____ Current Grade: _____

Current class placement: ☐ Regular Class ☐ Bilingual ☐ English as a Second Language ☐ Other

Has testing been completed by school? ☐ Yes ☐ No If yes, when? _____

Has your child ever been suspended or expelled? ☐ Yes ☐ No If yes, please describe? _____

_____

Has your child ever been retained? ☐ Yes ☐ No If yes, please describe? _____

_____

Briefly describe any *academic* school problems: _____

_____

Briefly describe any *behavioral* school problems: _____

_____

Educational Programs

Has your child ever participated in the following programs?

Placement and/or Services (current or past)	No	Yes	When?
Early Childhood Intervention (ECI)			
Special Education / IEP			
Section 504 services			
Resource Room Support			
Advanced Academic Curriculum			
Gifted and Talented			
Behavioral/Emotional Disorders Class			
Counseling (school based)			
Speech and Language Therapy			
Alternative School Placement			
PPCD			
Other:			

Please describe any current special education services (e.g. IEP, 504 Plan, resource room support):

_____

_____

MEDICAL HISTORY

Please check any of the following your child has experienced and note the age, any complications, and frequency below:

Yes	No		Yes	No	
☐	☐	Hospitalizations	☐	☐	Vision problems
☐	☐	Surgery	☐	☐	Hearing problems
☐	☐	Trauma (stiches/broken bones)	☐	☐	Asthma
☐	☐	Head trauma	☐	☐	Allergies
☐	☐	Loss of consciousness	☐	☐	Stomach Aches
☐	☐	Coma	☐	☐	Excessive vomiting
☐	☐	Seizures	☐	☐	Pica (eating nonfood items)
☐	☐	Tics (motor)	☐	☐	Diabetes
☐	☐	Ticks (vocal)	☐	☐	Malnutrition
☐	☐	Staring Spells	☐	☐	Gastrointestinal difficulties
☐	☐	Tremor	☐	☐	Chronic ear infections
☐	☐	Poor muscle tone	☐	☐	Ear tubes placed
☐	☐	Falls frequently	☐	☐	Elevated lead levels
☐	☐	Anemia	☐	☐	Accidental poisoning
☐	☐	Persistent high fever	☐	☐	Cancer Specify _____
☐	☐	Headaches	☐	☐	Blood Disorder Specify _____
☐	☐	Migraine Headaches	☐	☐	Genetic Disorder
☐	☐	Pain	☐	☐	Obesity/Weight problems
☐	☐	Respiratory Difficulties	☐	☐	Stool soiling
☐	☐	Endorcrine/Thyroid problems	☐	☐	Colic
☐	☐	Cardiovascular/heart disease	☐	☐	Bedwetting
☐	☐	abnormal heart rhythm / heart abnormality	☐	☐	Sleep problems
			☐	☐	Other: _____

Additional Information:

_____

_____

_____

FAMILIY HISTORY

Does anyone in the child' **biological** family have:

			Biological Relationship to child			
			Immediate Family			Mother's / Father's Relatives
Condition:	**No**	**Yes**	**Dad**	**Mom**	**Sibling**	(e.g., maternal brother)
Attention problems/ADHD						
Behavior problems in youth						
Learning Disability						
Seizures						
Mental Retardation						
Down Syndrome						
Autism / PDD / Asperger's						
Speech Delay						
Birth Defects						
Cerebral Palsy						
Tics/Tourette's Syndrome						
Neurological Disorders						
Epilepsy/Seizure Disorder						
Diabetes/Hypoglycemia						
Chronic Pain						
Thyroid Problems						
Heart Problems before age 50						
Depression						
Bipolar Disorder						
Anxiety						
Panic Attacks						
Obsessive Compulsive Disorder						
Schizophrenia						
Eating Disorder						
Alcohol Problems						
Drug Problems						
Trouble with the law						
Other:						

Has anyone in the family been known to have a defibrillator, or an abnormal heart rhythm or someone who died from heart abnormalities? If yes, please explain:

_____

_____

Any other significant family medical or psychiatric history_____

_____

Significant psychiatric, behavioral or medical problems in step-, adoptive, or foster family: _____

_____

BEHAVIOR AND DISCIPLINE

Please describe briefly any *behavioral* problems at home: _____

_____

Who ordinarily disciplines your child? _____

Please check the types of discipline used with your child:

- ☐ Verbal reprimands
- ☐ Time out
- ☐ Ignoring your child's behavior
- ☐ Reasoning
- ☐ Sending child to room
- ☐ Removal of privileges
- ☐ Physical Punishment
- ☐ Other:

Which form(s) of discipline has proven to be the most effective? _____

How often do you need to use discipline? _____

PERSONAL/SOCIAL

How many close friends does your child have? _____

How easily does your child make friends?

☐ Better than average ☐ Average ☐ Worse than average

How well does your child get along with friends?

☐ Better than average ☐ Average ☐ Worse than average

Who does your child get along best with?

☐ Older children ☐ Children of the same age ☐ Younger children

Does your child have problems keeping friends? ☐ Yes ☐ No

Are there any problems with bullying or teasing? ☐ Yes ☐ No

Please describe toys and/or activities your child enjoys during free time: _____

_____

OTHER INFORMATION

What are your child's strengths?

_____

_____

What are your family's strengths?

_____

_____

Please add any other information you feel may help us understand your child:

_____

_____

Thank you for your time in completing this form
PLEASE REMEMBER TO BRING THE FOLLOWING ITEMS TO THE INTAKE (IF APPLICABLE):

1) Name, address, and phone number of previous therapist(s) and current school/teacher(s)
2) Divorce decree
3) Previous reports (i.e., neuropsychological, educational, emotional, speech/language)

Texas Child Study Center

1600 W. 38th St., Suite 212
Austin, TX 78731

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ SOCIAL SECURITY # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my health information:**

_____

_____

_____

PATIENT:

X _____ _____ _____

Signature of Patient or Legal Representative | Date | Witness Signature

OFFICE USE ONLY:

☐ Accepted
☐ Denied

_____ _____ _____

Signature | Title | Date

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Texas Child Study Center

Policies and Consent for Services

This form describes the policies of the Texas Child Study Center. Please read it carefully and note any questions or concerns you have so we may discuss them. Your signature at the end of this form indicates that you agree to our policies for services.

Nature of Services: At the Texas Child Study Center, we provide individual, group, and family psychotherapy, psychological testing, and psychiatric services for toddlers, preschoolers, children and adolescents referred for behavioral, emotional, and social concerns. The approach, goals, and duration of therapy will be discussed with each patient/family on an individual basis. Developmental, psychological and neuropsychological evaluations are provided for youth referred because of concerns about possible autism spectrum disorder, anxiety disorders, mood disorders, emotional challenges, learning disabilities, attention problems or broader neuropsychological problems related to certain medical conditions or brain injury. These assessments aid in educational and intervention planning, such as developing special school goals and recommending strategies for teaching new skills. Follow-up consultation to the child's school may be provided to assist in implementing recommendations in school, home, or other settings. We do not provide forensic assessments or assessments for custody trials.

Texas Child Study Center is also operated as a training facility for students in doctoral psychology programs and the social work training programs at the University of Texas, as well as psychology, social work interns, and resident physicians. Trainees' work is directly supervised by licensed psychologists and psychiatrists. Trainees will identify themselves as trainees and identify who on the faculty is his or her supervisor(s).

Confidentiality: In general, the law protects the privacy of all communications between a patient and providers of mental health services. In most situations, we can only release information about your treatment or testing to others if you sign a written authorization to release information. There are exceptions and limits to confidentiality. If a patient is a danger to him or herself or others, if child abuse is suspected or reported, we are obligated to divulge information and/or take protective actions. In the case of receiving a legal subpoena for records or testimony, we will notify the parent/guardian prior to fulfilling the obligation to give information so as to allow for suppression of the subpoena if desired.

At the Center, we consult with one another on treatment plans and progress, and some of our therapists and evaluators are in training. Consultation and/or supervision may include discussion of your child's treatment. Anyone providing consultation and supervision on your child's treatment is legally bound to keep information about patients confidential.

If your child is under eighteen years of age, you have the right to examine your child's treatment records. Generally, it is desired for best treatment that confidentiality between the clinician and child patient is respected. Parents/Guardians will be kept informed about the progress and issues in the treatment of their child. We strive to do this while still preserving the confidentiality between the clinician and child that is essential for the best outcome.

HIPAA Privacy Policy: Please read the HIPPA Privacy Policy and note that you have read it at the bottom of this form.

Fees: You will be informed of the fees for services provided at the Center at the time the appointment is set, if possible. Fees for services are required to be paid at the time of the service. If there are questions or problems about fees they should first be discussed with the treating/evaluating clinician. This includes any changes in insurance coverage.

Cancellation Policy:
Therapy/Medication: Cancellations require 24 hour notice. Late cancellations or missed appointments will be charged at our full rate. Please note that insurance companies will not pay for missed sessions and payment for these sessions are the responsibility of the parents or guardians of the patient. If you do not show up for two appointments in a row without notifying the Center, it will be assumed that you have terminated your services. To re-establish treatment after it has been terminated, you must initiate a new call to the Center to reestablish a financial and therapeutic relationship.

Testing:
If you are unable to keep a psychological and neuropsychological testing appointment, please call to cancel as soon as possible. Given the lengthy time taken for an assessment a full day's time is saved for you. A fee of $400 will be charged for appointments that are not cancelled at least 24 hours in advance, except in the case of an emergency or prior arrangement.

Medication Monitoring: A patient followed for medication must be seen by a psychiatrist a minimum of every three months for medication management and much more frequently as medications are started or changed. Sometimes the psychiatrist may feel that psychotherapy is essential for optimal treatment in addition to medications. If therapy is refused under this recommendation, the psychiatrist may refuse to continue to prescribe the medication and refer the patient to another provider with a 60 day time notification.

Potential Negative Effects: Mental health services can have many positive benefits; however receiving psychotherapy, testing, or medication may involve some risks or discomforts.

Therapy often involves discussing problems that may lead to unpleasant feelings. You or your child may experience some discomfort when talking about these problems or experiences. Also, although each treatment is designed to help youth with emotional and behavior problems, there is no guarantee your child will improve. In any of these events, you and your child have the right to withdraw from services at any time without penalty.

Neuropsychological, Psychiatric, and Psychological assessment is not psychotherapy. Completion of an assessment does not imply an on-going clinical relationship with the evaluator without an agreement on a treatment plan. At times, patients and families find the results of evaluations or testing disappointing, discouraging, or unhelpful. Finally, Neuropsychological and Psychological testing results may prove invalid due to a variety of factors, including changes in disease status, some types of on-going medication or medical treatment, lack of motivation, or attempts to manipulate the testing results on the part of the patient.

If your child is receiving medication for emotional or behavioral problems through the Center, your psychiatrist will discuss the potential benefits and potential side effects of these medications with you on an individual basis.

Refill Policy: Due to our physicians having obligations outside of TCSC, we require 48 hours (2 business days) to refill medications.

Complaints: Please do not hesitate to discuss any concerns with the individual providing your mental health services. Often frustrations and upsets in the treatment context yield opportunities for benefit when discussed freely with your clinical provider. If you feel that supervisory issues or operational issues are unresolved you may contact one of our Center's directors: William C. Streusand, M.D., Medical Director or Kevin Stark, Ph.D., Chief of Psychology. If you have a complaint about the Center or a particular provider that you cannot resolve with us, you have the right to call the Texas State Board of Examiners of Psychologists at (512) 305-7709 or Texas State Board of Medical Examiners at (800) 201-9353.

Alternative Services: There are many types of mental health services available within this Center as well as within the city of Austin. You have the right to withdraw from our services at any time and we will assist you with finding an appropriate referral.

Emergencies: For medical emergencies or danger to self or other issues you should call 911. After hours psychiatric coverage by a Child and Adolescent Psychiatrist can be accessed by calling the operator at Dell Children's Medical Center at 324-0000 and asking the operator to page the psychiatrist on-call. Routine medication refills will only be handled during regular hours of the Texas Child Study Center.

Your signature indicates that you have read, understand, and agree to the policies and procedures of the Texas Child Study Center.

_____
Parent printed name

_____ _____
Signature Date

□ I have read the HIPAA privacy form and received a copy for my files.

_____
Provider printed name

_____ _____
Signature Date