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PSYCHOLOGY SERVICES, LLC

Jennifer Tarbox, PhD, HSPP & Stephanie Ridel, PsyD, HSPP (317) 775-3942

PARK TUDOR PATIENT REGISTRATION

It is required that ALL minors be accompanied by a parent or legal guardian at the initial visit.

PATIENT NAME

LAST:_____ FIRST:_____ MI:____

NICKNAME: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SSN: _____SEX: MALE / FEMALE

EMAIL ADDRESS:

_____

STREET ADDRESS: _____

APT NUMBER: _____

CITY: _____ STATE: _____ ZIP: _____

*Primary Telephone: _____ Secondary Telephone: _____

*Primary number will be the first number we utilize to contact you.

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP:_____

HOME PHONE:_____ CELL PHONE:_____

PARENT / GUARDIAN INFORMATION

Are the child's biological parents currently married? [ ] Yes [ ] No

If No, custody is with [ ] Mother primary [ ] Father primary [ ] Joint

Other _____

Are there any legal custody restrictions that we should be aware of? Please describe:

_____
_____
_____
_____

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FATHER

NAME: _____ DATE OF BIRTH:_____

SSN: _____ OR DRIVERS LICENSE NUMBER_____

ADDRESS:

_____

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

MOTHER

NAME: _____ DATE OF BIRTH: _____

SSN: _____ OR DRIVERS LICENSE NUMBER: _____

ADDRESS:

_____

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

LEGAL GUARDIAN (if applicable)

NAME: _____ DATE OF BIRTH: _____

SSN: _____ OR DRIVERS LICENSE NUMBER: _____

ADDRESS:

_____

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____WORK PHONE: _____

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PRIVATE PAY SERVICES CONSENT

By my signature below: I understand that the services rendered by the service providers of Bloom Psychology Services, LLC for the Park Tudor Application process are not covered by my insurance carrier. Therefore, I will be responsible for all charges incurred with Bloom Psychology Services, LLC.

I AGREE AND CONSENT TO PARTICIPATE IN THE SERVICES offered and provided by Bloom Psychology Services, LLC and all affiliate providers of Bloom Psychology Services, LLC.

I CONSENT TO RECEIVE TELEPHONE CALLS (live and pre-recorded), TEXT, or EMAILS for purposes including but not limited to scheduling, appointment reminders, billing and account collections and general office notifications.

[ ] By checking this box I am declining this service.

Signature of Patient/Personal Representative: _____ Date: _____

HISTORY QUESTIONNAIRE

MENTAL HEALTH HISTORY

Has your child ever been abused (emotionally, physically, or sexually)? [ ] YES [ ] NO Explain:

_____

_____

_____

Has your child ever experienced any other emotional or physical trauma? [ ] YES [ ] NO Explain:

_____

_____

_____

Has your child ever:

a) been in counseling [ ] YES [ ] NO

b) been hospitalized for emotional or alcohol/drug problems [ ] YES [ ] NO

c) been professionally evaluated [ ] YES [ ] NO

d) received special education services [ ] YES [ ] NO

If yes to any of the above, please provide dates, names of agencies, reason for service, & outcome.

_____

_____

Please list any medications your child currently takes for emotional or behavior problems. [ ] NONE

_____

_____

Please list any medications your child has taken in the past for emotional or behavioral problems. [ ] NONE

_____

_____

Please list any family history of mental health/substance abuse problems.

_____

_____

GENERAL MEDICAL HISTORY

Height:_____ Weight: _____ Are immunizations up to date? [ ] YES [ ] NO

Please list all allergies, childhood illnesses (including chronic illnesses and infectious diseases), accidents, injuries, hospitalizations, and surgeries.

_____

_____

_____

List all prescription and over-the-counter medications your child takes for any medical reason (include any vitamins & herbal supplements).

_____

_____

_____

Please list any family history of medical problems.

_____

_____

_____

FAMILY STATUS

Please describe your child's living arrangements, including visitation with the other parent if applicable.

_____

_____

_____

_____

List all people currently residing in your home, and the relationship of each to your child.

_____
_____
_____
_____

Are there any traditions/events that are important to your child?

_____
_____
_____
_____

Is there any additional information you feel would be helpful to the treatment of your child?

_____
_____
_____
_____

DEVELOPMENTAL HISTORY

Pregnancy

Was the pregnancy planned? [ ] YES [ ] NO Mother's age at delivery _____

Please check any of the following experienced during mother's pregnancy with the child being evaluated.

[ ] Excessive vomiting [ ] Excessive spotting/blood loss [ ] Threatened miscarriage [ ] Toxemia/Infection

[ ] Smoking [ ] Alcohol consumption [ ] Prescription medications [ ] Hospitalization (other than delivery)

[ ] Drug use [ ] Illness [ ] X-rays

Were there any complications with the pregnancy?

_____
_____

Was Pregnancy: [ ] Full Term [ ] Premature – how much? _____ [ ] Late – how much? _____

Were there any complications with the delivery?

_____
_____

List your child's birth weight. ___ pounds, ___ ounces

Was your child healthy at birth? [ ] YES [ ] NO Please explain:

_____

_____

Early Childhood

Milestones ~ Please report ages or if you cannot remember check one of the following:

Smiled	_____	[ ] Early	[ ] Average	[ ] Late
Crawled	_____	[ ] Early	[ ] Average	[ ] Late
Sat up on own	_____	[ ] Early	[ ] Average	[ ] Late
Stood unassisted	_____	[ ] Early	[ ] Average	[ ] Late
Walked unassisted	_____	[ ] Early	[ ] Average	[ ] Late
Spoke first words	_____	[ ] Early	[ ] Average	[ ] Late
Said sentences	_____	[ ] Early	[ ] Average	[ ] Late
Toilet Trained	_____	[ ] Early	[ ] Average	[ ] Late
Ran	_____	[ ] Early	[ ] Average	[ ] Late
Fed Self	_____	[ ] Early	[ ] Average	[ ] Late
Dressed Self	_____	[ ] Early	[ ] Average	[ ] Late

Were there any illnesses, behavioral difficulties, or discipline problems during early childhood?

_____

_____

_____

Did your child have temper tantrums? [ ] YES [ ] NO Describe:

_____

_____

_____

What discipline techniques were used?

_____

Did the parents use consistent discipline? [ ] YES [ ] NO

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EDUCATIONAL HISTORY

School: _____ Grade: _____

How many different schools has your child attended? _____

Has she/he ever repeated or skipped a grade? [ ] YES [ ] NO Which one? _____

What is her/his attendance like at school? _____

Has she/he had any discipline problems at school and/or been suspended or expelled? _____

_____

_____

What are her/his grades like? _____ Have they changed recently? [ ] YES [ ] NO

With which subject does she/he experience difficulty? _____

Does she/he have any learning disabilities or attend special education services? [ ] YES [ ] NO

Briefly describe services: _____

_____

SOCIAL HISTORY

Does your child make friends easily? [ ] YES [ ] NO

Does your child have difficulty keeping friends? [ ] YES [ ] NO

Does your child avoid making eye contact? [ ] YES [ ] NO

Briefly describe any peer interaction problems experienced by your child. _____

_____

_____

Have there been any losses, changes, or transitions in your child's life? _____

_____

_____

Does the family have any spiritual, cultural, or religious beliefs that influence the child? _____

_____

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Please describe your child's strengths, weaknesses, accomplishments, talents, and areas of interest.

_____

_____

_____

CHILD PROBLEM CHECKLIST

Below are some common problems of children and/or teenagers. Please read each item carefully. If an item applies to the child, please mark appropriately. Feel free to write it any comments.

Behavior Problems

[ ] Violates Curfew
[ ] Destroys Property
[ ] Steals
[ ] Lies often
[ ] Has been in trouble with police/probation
[ ] Has run away from home
[ ] Has attempted or talked about suicide
[ ] Argues when told to do something
[ ] Is cruel to animals
[ ] Rarely sits still
[ ] Has to have everything her/his own way
[ ] Acts like a younger child
[ ] Has problems with anger
[ ] Sets fire
[ ] Prefers to be alone

Academic Problems

[ ] Is truant from school
[ ] Does not complete assignments in the classroom
[ ] Does not do homework
[ ] Is in special education classes
[ ] Feels unfairly treated by teachers/administrators
[ ] Has a short attention span
[ ] Often clowns in class
[ ] Makes below average grades
[ ] Is too often out of seat at school
[ ] Has trouble following directions
[ ] Cheats

Problems with Feelings

[ ] Is upset by any changes in routines/schedules
[ ] Has a lot of fears
[ ] Lacks self confidence
[ ] Feels sad a lot
[ ] Easily irritated
[ ] Does not seem to feel guilt
[ ] Is extremely critical
[ ] Cries easily or often
[ ] Does not like to be touched
[ ] Resents even gentle criticism
[ ] Has an "I don't care" attitude
[ ] Feels bored a lot
[ ] Has frequent nightmares

Problems with Thinking

[ ] Says and does things over and over
[ ] Hears or sees things that aren't there
[ ] Has trouble concentrating
[ ] Has ideas that don't make sense

Family Problems

[ ] Avoids contact with family members
[ ] Gets along poorly with parent(s)
[ ] Gets along poorly with siblings
[ ] Parents get along poorly with each other
[ ] Clings to parent(s)

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Social Problems

[ ] Hangs around with a bad crowd
[ ] Is too easily led by others
[ ] Chooses friends a lot younger
[ ] Chooses friends a lot older
[ ] Teases other children
[ ] Doesn't like being alone
[ ] Has few friends
[ ] Tattles on other children
[ ] Seems shy
[ ] Often boasts
[ ] Often interrupts others
[ ] Won't argue/fight back when most would
[ ] Fights

Drug/Alcohol Abuse

[ ] Uses alcoholic beverages
[ ] Uses drugs
[ ] Sells drugs
[ ] Smokes cigarettes

Physical Complaints

[ ] Has a lot of physical complaints
[ ] Has trouble sleeping
[ ] Sleeps a lot
[ ] Is seriously overweight
[ ] Is seriously underweight
[ ] Has lost a lot of weight recently
[ ] Has gained a lot of weight recently
[ ] Has poor bladder control at night
[ ] Has poor bladder control during the day
[ ] Has poor bowel control at night
[ ] Has poor bowel control during the day
[ ] Is clumsy or awkward