East Texas Psychological Services, PLLC
(903) 675-9570 FAX (903) 675-9577

CHILD
PSYCHOLOGICAL HISTORY-CONFIDENTIAL

Date: _____ Child's Name: _____ DOB: _____

Address: _____ City: _____ ST:_____ Zip:_____

Phone: _____ E-mail:_____

SS#:_____ Child's Height:_____ Child's Weight:_____

Biological Mother's Name:_____ DOB:_____

Biological Father's Name:_____ DOB:_____

Name Of Legal Guardian:_____

Person Completing Questionnaire:_____ Relation to Child:_____

Referred By: _____

Reason for your visit: _____

List Any Medications/Supplements/Vitamins Child Takes Regularly: _____

_____

_____

Have you had previous psychological testing or psychiatric/psychological treatment for your child? If so, please list type or treatment, date, and location?

_____

_____

_____

_____

_____

PROBLEMS OR CONCERNS

Please list, in order of urgency, the problems or concerns and the age you first noticed the problems that you are seeking help with:

1._____

2._____

3._____

4._____

Has your child ever talked about or shown suicidal/self-harming behaviors?_____
If yes, please describe:

_____

_____

_____

Has your child ever talked about or displayed violent behaviors?_____
If yes, please describe:

_____

_____

_____

Please list any important changes in your child's life or any events/stressors which you feel had a significant impact on your child and their behavior:
Date/Age Event

_____

_____

_____

_____

_____

_____

FAMILY PSYCHIATRIC HISTORY

Please list anyone in the child's biological family that has difficulties with:

Bipolar Disorder_____

Depression_____

Anxiety or Excessive Worry_____

Extreme Shyness_____

Obsessions-Compulsions_____

Explosive Temper_____

Convulsions/Seizures_____

Sleep Problems_____

Learning Problems_____

Mental Retardation_____

Hyperactivity_____

Attention Problems_____

Alcohol/Drug Problems_____

Criminal Record_____

History of Spousal Abuse_____

History of Sexual Abuse_____

PREGNANCY, BIRTH, &DEVELOPMENTAL HISTORY

Age of Parents at time of Child's Birth: Mother_____ Father_____

Please list any difficulties the child's mother had during pregnancy:

_____

_____

Was the baby full term? _____ If not, how many weeks premature? _____

Was the child an easy baby to care for?_____

Please list any conditions present during or soon after delivery:

_____

_____

Please list any known problems that occurred during infancy through toddler:

_____

_____

How do you feel your child developed in the following areas-average, slower than average, faster than average:

Physical &Motor_____
Talking & Language_____
Social & Interpersonal_____

Please list any other relevant developmental information:

_____

_____

FAMILY HISTORY

Please List all individuals living in the home with their age and relation to the child:

_____ _____

_____ _____

_____ _____

Please describe the child's relationship with:

Mother:_____

Father:_____

Legal Guardian:_____

Siblings:_____

Other Family Members in the Home:_____

_____

SOCIAL HISTORY

Please describe the child's interactions:

Early Peer interactions:_____

Current Peer interactions:_____

Teacher interactions:_____

Please list any social problems the child has at school:

_____ _____

_____ _____

Please list the child's current enrolled activities:

_____ _____

_____ _____

Please list the child's Hobbies/interests:

_____ _____

_____ _____

Please list your child's:

Strengths: Limitations:

_____ _____

_____ _____

_____ _____

EDUCATION

School Name _____ Current Grade _____

Has your child ever repeated a grade? _____ If yes, please state what grade and for what reason:

_____

_____

Did your child attend daycare? _____ If yes, please state the child's reaction to daycare:

_____

_____

Please list problems areas in your child's school performance:

_____

_____

Please list any recent changes in your child's school performance:

_____

_____

SPIRITUAL HISTORY

Religious Preference of the family:_____

Child's Level of involvement:_____

Spiritual Beliefs that could impact treatment:

_____

_____

_____

_____

INFORMATION AND CONSENT

We are pleased that you have selected East Texas Psychological Services as your mental health provider. This document is to inform you about our background and to ensure that you understand our professional relationship and the services we offer.

We accept only clients that we believe have the capacity to resolve their own problems with our assistance. We believe that as people become more accepting of themselves and more knowledgeable, they are more capable of finding happiness and contentment in their own lives. However, self-awareness and self-acceptance are goals that take time to achieve, some clients only need a few counseling sessions to achieve their goals. AS a client, you are in complete control and may end our professional relationship at any point. We will be supportive of that decision. If counseling is successful, you should feel that you are able to face life's challenges in the future without our ongoing support and/or intervention. You are always welcome to return for a "tune up" should you feel the need.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to the sessions you arrange with your counselor. Please do not invite your counselor to social gatherings, offer him/her gifts, or ask him/her to relate to you in any other way outside of the professional context of your counseling/treatment. You can expect to learn a great deal about your counselor as you work together during the counseling/treatment experience. However, it is important for you to remember that you are experiencing your therapist in his/her professional role.

We will keep anything you say to us strictly confidential, with the following exceptions: (a) you direct us to share information with someone else; (b) I determine that you are a danger to yourself or others; or (c) I am ordered by a court to disclose information.

If at any time, for any reason you are dissatisfied with our services, please let us know. If we are not able to resolve your concerns, you may report your complaint to the appropriate licensing agency. Also, please be advised that excessive "no-shows", failure to comply with treatment recommendations, inappropriate or "rude" behavior with office staff, and other extenuating circumstances may ethically require us to withdraw as your mental health provider.

Our services will be rendered in a professional manner consistent with accepted ethical standards. Sessions are typically 45-50 minutes in duration. You will be billed for scheduled appointments, not cancelled 24 hours in advance except in the case of emergency or at the discretion of your counselor. Phone calls after hours will be charged after 15 minutes at the usual hourly rate. Payment is expected that the time of service. We will be happy to bill all accepted insurances, you will be responsible for your co-pay. Please feel free to discuss sliding scale payment options with our office staff as we are not interested in financially burdening you. We do have a licensed psychologist on staff at UT Health Athens Emergency Room in the event of crisis or emergency.

Psychological testing is a service provided by our office. Testing can take approximately 4-5 hours for a full evaluation. These services must be authorized by your insurance company prior to services being rendered. Our policy for testing requires three appointments at minimum. Your first appointment will be to meet with the psychologist and get background information as well as the reason for the testing. Once your testing is approved by insurance you will be scheduled to come in and complete the testing, the scoring process can take up to 2 weeks. After the scoring is complete, we will schedule an appointment to come back and review your results with you and answer any questions you may have.

If you have any questions, please feel free to ask our office staff or your counselor.

Have you ever been involved in a lawsuit against a physician or other healthcare provider? Yes_____ No_____

I authorize East Texas Psychological Services to provide services to myself and/or to my minor child _____.

I authorize East Texas Psychological Services to file for insurance or other benefits on my behalf and I assign all such benefits to East Texas Psychological and Neurobehavioral Services.

I authorize East Texas Psychological Services to disclose information obtained from me for the purpose of filing for insurance or other benefits.

I understand that I am responsible for any part of the fee which is not covered by insurance or other benefits.

_____ _____

Printed name of client Signature of Client/Guardian Date

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ DOB:_____

Name and address of person/ agency/ institution ☐Receiving ☐Releasing information:

_____

_____

_____

_____

_____

Name and Address of Primary Therapist:

_____

East Texas Psychological Services
700 S Palestine St/ PO Box 2536
Athens, TX 75751
Phone: 903-675-9570
Fax: 903-675-9577

I hereby authorize the physician, psychologist, therapist, hospital, agency, or institution mentioned above having medical, psychiatric, psychological, or other records and information to the person shown above as authorized to receive such information. I further authorized Dr. McBride and associates to release their findings to the party named above and to discuss the case as it will benefit my care.

I hereby authorize the physician, psychologist, therapist, psychiatrist, hospital, institution, agency, or keeper of records of the above institution/agency supplying medical, psychological, psychiatric and/or other information/records from all legal responsibility and liability for release of all such information and/or records.

This Authorization to Release Information is valid for the duration of active treatment of the above named patient/client.

_____

Signature of Client/Guardian Date

Agreement to Receive Electronic Communication

Patient Name:_____ DOB:_____

(Initial Below)

_____ I DO Agree

_____ I DO NOT Agree

That East Texas Psychological Service may communicate with me electronically at the email address/ mobile phone number listed on the new patient forms.

I am aware that there is some level of risk that third parties might be able to reads unencrypted emails. I further agree that I am responsible for providing East Texas Psychological Services any updates to my email address and/or mobile phone number.

My preferred method of electronic communication:

_____ Text Messaging

_____ Email

_____ Voice Call

I can withdraw my consent to electronic communications at any time by calling 903-675-9570.

Signature:_____ Date:_____