General Information

Suzanne M. James, Psy.D., LLC
Licensed Psychologist
305 Artillery Park Drive
Fort Mitchell, KY 41017
859-426-0200,
859-426-0042.

Patient Information: Date:_____

Patient Name:_____
Last First Middle

Address:_____

City:_____ State:_____ Zip:_____

Phone Home:(_____)_____-_____Cell:(_____)_____-_____Work:(_____)_____-_____

OK to leave message at this number? (Y/N) Home: _____ Cell: _____ Work: _____

Email: _____ OK to send email to this address> Y/N: _____

Patient Social Security #: _____ Date of Birth:_____-_____-_____

Gender: [ ] Male [ ] Female

Marital Status: [ ] Married [ ] Single [ ] Divorced
[ ] Separated [ ] Widowed [ ] NA (children)

Employment Status: [ ] Employed [ ] Student [ ] Unemployed

Primary Care Physician:_____ Phone:_____

Is it ok to exchange information with your primary care physician: _____YES _____NO

Insured's Information:
If the insurance you are using is provided to you through a family member you must complete the following for us to bill the insurance on your behalf.

Insured's Name: _____

Insured's Social Security #: _____ **Date of Birth:**_____-_____-_____
Insured's place of employment: _____

If different from above:
Address:_____

City:_____ State:_____ Zip:_____

Home Phone:(_____)_____-_____ Employer: _____

In Case of Emergency, Contact:

Name:_____ Relationship:_____

Phone:_____

Insurance Authorization Number: _____ (If known)

Who referred you to our practice? _____ May we thank them: [ ] Yes [ ] No

Are you seeking counseling related to a court order or legal proceedings? [ ] Yes [ ] No

Informed Consent for Receipt of Psychological Services (Adult or Minor)

This form is to document that I, _____ give voluntary permission and consent to receiving psychological services from Suzanne M. James, Psy.D., LLC.

_____ **Purpose and Background:**
The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of KY to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise.

While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Dr. Suzanne James. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

_____ **Confidentiality:**
I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Cases are also reviewed during Peer Review. In Peer Review the names of clients and/or identifying clinical information are not used. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released/ viewed for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment. Also included is any correspondence needed with administrative personnel.

_____ **HIPAA**
I understand that this consent form acknowledges my right to privacy and the limitations on my privacy, I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of Dr. Suzanne James' "Notice of Privacy Practices", that were effective of as their start of business on March 1st, 2004. I acknowledge I was offered this policy statement on the date indicated by my signature below.

_____ **Attendance:**
I understand that regular attendance, a willingness to be open and honest and follow-through on treatment suggestions will produce maximum benefits, but that the final decision on what to do is always up to me. In addition, I understand that I am free to discontinue treatment at any time. A termination session may be requested in order to provide for any continuing areas of concern.
I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the rate of $60 per missed appointment. Further, I understand that my insurance will not cover these charges in any way, and I will be liable for all charges that result from a missed appointment without sufficient (24 hour) notice.

_____ **Telepsychology:**
If at any time during treatment, the use of phone or skype is utilized, it is important to understand that there are limitations. This is an innovative method of treatment and as changes occur, this consent will be updated. Current risks include:

1. Risks of confidentiality of information due to technology. Please note that rules of confidentiality outside of technology related issues will remain in effect.
2. Reporting of self-harm, suicidal and homicidal behavior will continue to remain in effect and local authorities to the client will be called.
3. Risk of disruption of service due to technology problems. If this occurs, this therapist will contact client as soon as possible. If the problem persists, this therapist will use an alternative method for rescheduling the appointment.
4. If this therapist determines that treatment through telepsychology is not effective and face-to-face needs to occur, a referral will be made.
5. Please note that emails and texting are not appropriate ways of communicating therapeutic issues. If an email or text is received regarding psychological concerns, thoughts, or feelings, these will be discussed in the following session.

_____ **Contact Information:**
The office address for Suzanne M. James, Psy.D. is 305 Artillery Park Drive, Suite 102 Fort Mitchell, KY 41017. I understand that for routine appointments and information I may call (859) 426-0200, ext. 1. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned as soon as possible by my therapist. If I have an after-hours crisis or need assistance more quickly I can call my therapist at the crisis contact number provided in their regular voicemail box, however, I understand this number is for crises only. If I feel I need immediate psychiatric admission to a hospital for stabilization, I understand that I may be referred to the nearest hospital emergency room.

_____ **Complaints Procedure:**
If I am dissatisfied with any aspect of the services I receive, I understand that I can and am encouraged to raise my concerns with my therapist immediately. Dissatisfactions will make working together slower and more difficult if not resolved. If I feel that I have been treated unfairly or unethically and cannot resolve this problem directly, a complaint procedure is available through your therapist's state licensing agency, which may be contacted in Frankfort, KY 40602.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.

I release and hold harmless Dr. Suzanne James and agents from any action or liability arising out of my participation in treatment.

_____ _____
Signature of client/ or responsible party if client is a minor Date

_____ _____
Signature of Witness Date

305 Artillery Park Drive
Fort Mitchell, KY 41017
859-426-0200
859-426-0042. ext. 1

Consent To Bill Third Party Payer

Use of Insurance:
As a part of receiving psychological services through Suzanne M. James, Psy.D., LLC I understand that I will be responsible for the financial expenses incurred as the result of my participation in treatment. I further understand that I may elect to use a third party payer, i.e. medical insurance, to help cover the cost associated with treatment. However, I understand that if I elect to use a third party payer to help offset the cost of my treatment, I will be required to consent to the release of information for billing purposes. This will definitely mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and at times may constitute the release of treatment planning information.

Payment:
I understand that payment is expected at time of service. If I wish to pay for services out of pocket, or for the purposes of making my co-payment, should I elect to use my insurance, I may make payments via cash or check. I understand all checks returned unpaid will be subject to a $25.00 service fee, and if they remain unpaid for more than three months, may be turned over to a collection agency for the purpose of recovering lost funds.

Use of Insurance and Authorization for Treatment:
If I chose to use medical insurance, it is important that I be aware of my coverage and limits. I am responsible for amounts and/or services not covered by my insurance. I am also responsible for payment of amounts not covered because of failure to obtain a referral or not following necessary guidelines set by my insurance company for accessing mental health benefits. I understand I will be charged $60.00 for missed or cancelled appointments unless prior notification is given 24 hours prior to the time of the appointment, I understand that insurance companies do not cover the costs of missed appointments and I will be billed directly.

I, _____,

☐ wish to use my medical insurance to off-set the cost of treatment, and in so doing give Dr. Suzanne James permission to release any information necessary to process this claim and collect payment for the services rendered. I permit direct payment to my therapist any benefits due me for services rendered. I understand I am financially responsible for all services rendered, if not otherwise satisfied through my medical insurance.

☐ do not wish to use any medical insurance benefit to cover services I receive through Dr. Suzanne James. I understand that I am financially responsible for all expenses incurred for my treatment, and will make all payments at the time of service.

_____ _____
Signature of Client/Responsible Party Date

_____ _____

CHILD INTAKE

305 Artillery Park Drive
Fort Mitchell, KY 41017
859-426-0200
859-426-0042. ext. 1

Name_____ Age:_____ Date of Birth:_____

General

1. Why have you come to Dr. Suzanne James?

_____
_____
_____

2. How long has this been an issue? _____

3. What have you tried to do to resolve this issue?

_____
_____

4. What are your goals for counseling/assessment?

_____
_____

5. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems and chemical dependency/use)

_____
_____
_____

6. Who is primarily responsible for the care of your child? List all that apply.

Name	Age	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Who resides with you in your home?

Name	Age	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Are disciplinary techniques used consistently and with good follow-through?

☐ No ☐ Yes

10. Are current disciplinary techniques effective at controlling undesirable behaviors?

☐ No ☐ Yes

11. Does your child respond to one parent or care-taker's disciplinary measures better than another?

□ No □ Yes: If yes, who _____

12. Has your child experienced any of the following?

□ Parental Divorce	□ Parental Separation	□ Death of Parent
□ Death of Sibling	□ Death of Grandparent	□ Death of Close Friend
□ Financial Problems	□ Parental Alcoholism	□ Parental Drug Abuse
□ Domestic Violence	□ Physical Abuse	□ Verbal Abuse
□ Sexual Abuse	□ Family Bankruptcy	□ Prolonged Marital Discourse

13. Has any member of your family ever been diagnosed with a mental illness or substance abuse problem including alcoholism/

□ No □ Yes: If yes please provide further details.

_____

_____

_____

14. Was your child born premature?

□ No □ Yes

_____

_____

15. Birth Weight: _____ lbs. _____ oz.

16. Approximate age when your child first began:

_____ Walking _____ Talking _____ Toileting

Family History

17. Is the child adopted? [ ] Yes [ ] No

18. If so, with which parent(s) (if any) does the child live? [ ] Natural [ ] Adoptive

19. Child's age at adoption: _____

20. Status of parents' marriage: [ ] Married How long married? _____
[ ] Separated [ ] Divorced How long divorced? _____ Child's age at divorce: _____
[ ] Widowed [ ] Single

21.	Birth Mother	Birth Father
Age:	_____	_____
Highest grade completed:	_____	_____
Diploma/ Degree:	_____	_____
Occupation:	_____	_____

22. Siblings:

Name	Sex	Age	In Home?

Biological Extended Family

23. Do any extended family (maternal/paternal grandparents, uncles, aunts, cousins) suffer from a problem with inattentiveness or hyperactivity; epilepsy, migraines, alcoholism or substance abuse; psychological, emotional, or personality difficulty; learning problems or developmental disabilities; and/or a "nervous" or neurological disorder; etc? [ ] Yes [ ] No If so, please list relationship to child, disorder and any treatment received:

Matural (mother's side)	Paternal (father's side)

24. Please provide any other information about the child's family or origin and child's extended family that might help us understand the child's needs (medical, developmental, behavioral, educational, emotional or psychological).

Medical History

26. The child's current health is: [ ] Poor [ ] Fair [ ] Good [ ] Excellent

27. Is your child currently under the care of a physician?

☐ No ☐ Yes: If yes, by whom and for what conditions?

Doctors Name: _____ Phone: _____

Conditions being treated: _____

_____

_____

28. Is your child currently on any medication?

☐ No ☐ Yes

Medication	Dosage	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

29. Please put an "X" by any of the following that your child has experienced:

[ ] a. Allergies
[ ] b. Asthma
[ ] c. Bedwetting
[ ] d. Bladder Infections
[ ] e. Constipation
[ ] f. Ear Infections
[ ] g. Eating Problems
[ ] h. Epilepsy
[ ] i. Small-motor coordination difficulties
[ ] j. Gross-motor difficulties
[ ] k. Headaches
[ ] l. Overweight
[ ] m. Poor bowel control
[ ] n. Nightmares
[ ] o. Sleep problems
[ ] p. Stomach Aches
[ ] q. Stuttering
[ ] r. Teeth Grinding
[ ] s. Underweight
[ ] t. Unusual Vomiting
[ ] u. Vision Problems
[ ] v. Infections

30. Please put an "X' by any of the following that are a problem with this child?

[ ] 1. Anxiety
[ ] 2. Tiredness/Fatigue
[ ] 3. Self-Critical
[ ] 4. Easily Upset
[ ] 5. Overly Sensitive
[ ] 6. Easily Frustrated
[ ] 7. Shyness
[ ] 8. Depression/Sadness
[ ] 9. Over-Dependency
[ ] 10. Guilt Feelings
[ ] 11. Withdrawn
[ ] 12. Fears/Phobias
[ ] 13. Rituals
[ ] 14. Nail Biting
[ ] 15. Thumb Biting
[ ] 16. Jealousy/Ruminative
[ ] 17. Overactive
[ ] 18. Obsessive/Ruminative
[ ] 19. Underactive
[ ] 20. School Problems
[ ] 21. Lying/Dishonesty
[ ] 22. Temper Tantrums
[ ] 23. Head Banging
[ ] 24. Destructiveness
[ ] 25. Running away
[ ] 26. Drug/Alcohol
[ ] 27. Sexual Problems
[ ] 28. Stealing
[ ] 29. Cruelty
[ ] 30. Clumsiness

31. Does your child have any immediate health problems (colds, injuries)?

☐ No ☐ Yes

_____

32. Does your child have any chronic (long term) health problems (asthma, seizures, allergies, etc.)?

☐ No ☐ Yes

_____

33. Has your child ever sustained any serious head injuries (unconscious, auto accident, fight, etc.)?

☐ No ☐ Yes

_____

34. Does your child have any developmental disorders (mental retardation, learning disabilities, hearing disabilities, speech problems, etc.)?

☐ No ☐ Yes

_____

35. Please list all previous mental health medications:

Medication	Dosage	Date Started	Date Stopped
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

36. Please rate the nutritional value of your child's diet. Good ___ Fair___ Poor___

If fair or poor, please explain: _____

37. Check any of the following that apply.

☐ Significant weight gain/loss in lat 6 months ☐ Problems chewing or swallowing
☐ Food/drug allergies ☐ Dieting
☐ Overeating or eating too little
If any box is checked please explain: _____

38. Has your child had a recent vision check?

☐ No ☐ Yes: If yes, describe results: _____

39. Has your child had a recent hearing exam?

☐ No ☐ Yes: If yes, describe results: _____

40. Has your child had an auditory processing exam?

☐ No ☐ Yes: If yes, describe results: _____

Birth and Developmental History

Pregnancy

41. Length in months: _____

42. Any illnesses or complications while pregnant? [ ] Yes [ ] No If so, please explain:
_____

43. Medications taken by the mother during pregnancy?
_____

44. Alcohol, Cigarettes, Substances and/or Drugs used during pregnancy:
_____

45. Was the father taking any medications or drugs at time of conception? [ ] Yes [ ] No If so, what?
_____

46. How many pregnancies and/or miscarriages has the mother had?
_____

Labor and Delivery

47. Was the birth of the child "normal"? [ ] Yes [ ] No If no, please explain:

48. Do you think the child's problems might be related to pregnancy, labor or delvery? [ ] Yes [ ] No
If yes, please explain: _____

_____

_____

Perinatal History

49. Birth weight _____ Length _____ APGAR scores
_____

50. Did mother or baby stay in Special or Intensive Care? [ ] Yes [ ] No

51. Please describe any problems:
_____

_____

_____

52. Please list any birth defects:
_____

_____

_____

Infancy and Early Childhood

53. Please rate the child on the following behaviors: Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4. If there are two behaviors listed (e.g., tantrums and head banging), please check the one that was present.

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	[ ] Tantrums [ ] Head Banging
Cautious and careful	1	2	3	4	5	[ ] Accident Prone [ ] Daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with people

53. Other problems or comments regarding infancy or early childhood development:

54. Did any event, health condition, separation, etc., disturb early infant/mother bonding or the developing toddler/mother relationship? [ ] Yes [ ] No
If yes, please explain:

55. Please describe the child as an infant (temperament, sleeping, eating patterns, etc.):

56. Ages at Milestones

Gross Motor Skill	Age	**Language Skill**	Age
Crawled	_____	Used single words	_____
Walked alone	_____	Used sentences (2+ words)	_____
Ran well	_____	Described Activity	_____

Fine Motor Skill	Age	**Social/ Adaptive Skill**	Age
Fed self with spoon	_____	Potty trained/day	_____
Scribbled	_____	Potty trained/night	_____

57. Rate of development overall: [ ] Slow [ ] Normal [ ] Fast

Educational History

58. What grade is your child currently in? _____

59. Where does your child attend school? _____

60. Circle any grade(s) failed. K 1 2 3 4 5 6 7 8 9 10 11 12 None

61. Circle any grades skipped. K 1 2 3 4 5 6 7 8 9 10 11 12 None

62. What grades does your child normally get in school? (Circle all that apply)

A B C D F

63. Have there been any tendencies toward improving or deteriorating school performance over the years?
□ No □ Yes: If yes please provide further details.

_____

64. What are your child's strongest subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies N/A

65. What are your child's weakest subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies N/A

66. Has your child ever been:

Reprimanded at school:	☐ No	☐ Yes
Served detention:	☐ No	☐ Yes
Been suspended:	☐ No	☐ Yes
Been expelled:	☐ No	☐ Yes

If yes to any, please explain: _____
_____

67. Has the school ever performed psychological or educational testing on your child?

☐ No ☐ Yes

If yes, describe results: _____
_____

68. Please describe any special education or tutoring:

_____ _____

_____ _____

69. Please describe any grades repeated or subjects failed:

_____ _____

_____ _____

_____ _____

_____ _____

70. Has the child been placed in gifted class or special education program currently or in the past?

[ ] Yes [ ] No

If yes, please describe:

Category: _____

71. What advanced placements or other educational adaptions have this child received?

72. What are his/her favorite subjects?

73. What special school problems does this child have?

74. What Psychological or Educational tests has this child had previously?

75. What were the results or scores? Attach reports if available.

76. How does this child's teacher describe his/her behavior at school?

77. What games or particular interests does this child enjoy?

78. What else does this child like to do?

79. How many close friends does the child have?
_____

Psychological History

80. Do you see the child as being [ ] hyperactive? [ ] inattentive? [ ] a behavior problem?

81. Does the child seem to be able to control his or her behavior and attention? [ ] Yes [ ] No

If no, please explain: _____

82. Has the child ever been diagnosed by a psychologist, physician, or other professional as having ADHD (Attention-Deficit/Hyperactivity Disorder) [ ] Yes [ ] No

If yes, when? _____

83. What treatment has the child had for ADHD (other than medication)?

84. What medication(s) has the child received for ADHD (include dosage and times)?

85. What were this child's strong points, favorable characteristics or "good" behaviors?

86. How does he/she get along with boys and girls on the same age?

87. How does he/she get along with older playmates or adults?

Social Development

88. Does your child have many friends?
☐ No ☐ Yes

89. Does your child make friends easily?
☐ No ☐ Yes

90. What are the most common activities that your child engages in? (bike riding, playing with friends, TV, etc.)

Behavioral Assessment

91. Has your child ever been in trouble with the law?
☐ No ☐ Yes: If yes, please explain.

_____
_____

92. To your knowledge, does your child use tobacco?
☐ No ☐ Yes

93. To your knowledge, does your child drink alcohol?
☐ No ☐ Yes: If yes, how often, how much and for how long?

_____

When was the last time? _____ How many drinks? _____

94. What problems has your child suffered as a result of his/her drinking?
☐ Arrest ☐ DUI ☐ Peer problems
☐ Public intoxication ☐ Financial problems ☐ Arguments
☐ None of the above

95. To your knowledge, has your child ever tried drugs?
☐ No ☐ Yes: If yes, what drug/s? _____

96. To your knowledge, does your child regularly us any drugs?
☐ No ☐ Yes: If yes, how often, how much and for how long?

_____

When was the last use? _____ What drug/s was used? _____

97. To your knowledge, is your child sexually active?
☐ No ☐ Yes

98. Does your child have concerns about his/her sexual orientation or sexual experiences?
☐ No ☐ Yes

99. Is your child pregnant or the parent of a child?
☐ No ☐ Yes

100. Who has legal custody of your child?
☐ Both parents ☐ Mother only ☐ Father only ☐ Other guardian

If other guardian, please indicate name: _____