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Alan Ikeda, MD  
Nicola Longo, MD, PhD  
Lisa Majlessi, MD  
Katherine Marzan, MD  
Nik Abdul Rashid, MD  
Alexandra Walsh, MD

Welcome to the offices of Children's Specialty Center of Nevada. We appreciate the confidence and trust that you have placed in our office and look forward to meeting you personally and professionally. Our goal is to provide the highest quality care in a friendly, caring and efficient environment.

It is also our goal to provide you timely visits with your physicians. Please arrive on time to your appointment with paperwork completed to avoid the risk of your appointment being rescheduled.

We ask that you bring the following items to our office for your first visit:

- Current insurance card & driver's license or government issued photo ID

Our Las Vegas office is located at 3121 S. Maryland Parkway, **Suite 216**, Las Vegas, NV 89109 (closest intersection is Desert Inn and Maryland Parkway).

Should you have any questions or need any additional information please don't hesitate to call our office at 702-862-1147.

We look forward to seeing you at our office. Thank you for giving us the opportunity to serve you.

Sincerely,

The Staff of Children's Specialty Center of Nevada

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## Patient Registration & Insurance Information

Please verify patient's information and change if incorrect. The front desk is available if you have any questions.

**ALL ITEMS MUST BE COMPLETED – DO NOT LEAVE ANY BLANKS**

PATIENT INFORMATION									
PATIENT NUMBER			DATE						
PATIENT LAST NAME			FIRST NAME		MIDDLE INIT	SSN		SUFFIX	
ADDRESS 1					CITY		STATE	ZIP	
HOME TEL #		WORK TEL #		CELL #			SEX	AGE	
BIRTHDATE	EMPLOYER			E-MAIL ADDRESS					
USUAL PROVIDER			REFERRING PHYSICIAN			PRIMARY CARE PHYSICIAN			
MARITAL STATUS		EMPLOYMENT STATUS <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed			STUDENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student			REL TO GUARANTOR	
ETHNICITY (select 1) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown/Refused				LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> _____			INTERPRETER NEEDED <input type="checkbox"/> Yes <input type="checkbox"/> No		
RACE (select 1) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown/Refused									

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE)									
GUARANTOR LAST NAME			FIRST NAME		MIDDLE INIT	SSN		SUFFIX	
ADDRESS 1					CITY		STATE	ZIP	
HOME TEL #		WORK TEL #		CELL #			SEX	EMERGENCY CONTACT <input type="checkbox"/> Yes <input type="checkbox"/> No	
BIRTHDATE	EMPLOYER			E-MAIL ADDRESS					

INSURANCE INFORMATION									
PRIMARY INSURANCE					SECONDARY INSURANCE				
CARRIER NAME					CARRIER NAME				
CARRIER ADDRESS					CARRIER ADDRESS				
CERTIFICATE ID #					CERTIFICATE ID #				
GROUP NAME					GROUP NAME				
CLAIM/GROUP NO					CLAIM/GROUP NO				
CARRIER PHONE #					CARRIER PHONE #				
SUBSCRIBER NAME					SUBSCRIBER NAME				
SUBSCRIBER D.O.B.					SUBSCRIBER D.O.B.				
SUBSCRIBER SSN					SUBSCRIBER SSN				
RELATIONSHIP TO PATIENT					RELATIONSHIP TO PATIENT				

EMERGENCY CONTACT INFORMATION									
1	EMERGENCY CONTACT #1							SUFFIX	
	PHONE #1		PHONE #2			PHONE #3		RELATIONSHIP TO PATIENT	
2	EMERGENCY CONTACT #2							SUFFIX	
	PHONE #1		PHONE #2			PHONE #3		RELATIONSHIP TO PATIENT	

## Psychological History Questionnaire – Parent

Today's Date: \_\_\_\_\_  
 Child's Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_  
 School: \_\_\_\_\_ Classroom: Regular  Other   
 Your Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

What are your primary concerns you have for your child at this time? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### FAMILY HISTORY

Are you aware of anyone on either the biological (natural) mother's or father's side of the family who has had any of the following problems? (Please check all that apply)

	<u>Mother's side</u>	<u>Father's side</u>
1. Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
2. Reading problems	<input type="checkbox"/>	<input type="checkbox"/>
3. Spelling problems	<input type="checkbox"/>	<input type="checkbox"/>
4. Arithmetic problems	<input type="checkbox"/>	<input type="checkbox"/>
5. Early speech or language problems	<input type="checkbox"/>	<input type="checkbox"/>
6. Motor incoordination	<input type="checkbox"/>	<input type="checkbox"/>
7. Drug or alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>
8. Depression	<input type="checkbox"/>	<input type="checkbox"/>
9. Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
10. Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
11. Psychosis; Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
12. Mental hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
13. Hyperactivity/restlessness/fidgetiness	<input type="checkbox"/>	<input type="checkbox"/>
14. Motor or vocal tics	<input type="checkbox"/>	<input type="checkbox"/>
15. Problems paying attention/concentrating	<input type="checkbox"/>	<input type="checkbox"/>
16. Anxieties/fears/phobias	<input type="checkbox"/>	<input type="checkbox"/>
17. Significant shyness	<input type="checkbox"/>	<input type="checkbox"/>
18. Significant mental illness	<input type="checkbox"/>	<input type="checkbox"/>
19. Autism or Asperger's Disorder	<input type="checkbox"/>	<input type="checkbox"/>
20. Criminal activity	<input type="checkbox"/>	<input type="checkbox"/>
21. Other significant behavioral/emotional problems	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any items checked: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY RELATIONSHIPS**

Please list the members of the child's current household:

<u>Full Name</u>	<u>Relationship to Child</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list other relatives not living with the child (i.e., biological or step parents or siblings; grandparents; etc.):

<u>Full Name</u>	<u>Relationship to Child</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child recently experienced any significant family-related stress or change (e.g. death of a loved one, a recent move, illness in a family member, significant conflict, birth of a sibling, etc.)?  Yes  No

If yes, please explain the stress/change and how your child reacted to it: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have there been any other significant family or marital problems?  Yes  No

If yes, how were these problems manifested in the home (e.g., yelling, physical violence, divorce) and how did your child react to the problems? \_\_\_\_\_  
 \_\_\_\_\_

**PRENATAL (PREGNANCY) HISTORY**

- Did mother smoke cigarettes while pregnant with this child?  Yes  No  
If yes, how many cigarettes a day on average? \_\_\_\_\_
- Did mother drink alcoholic beverages while pregnant with this child?  Yes  No  
If yes, how many days a week on average? \_\_\_\_\_ How many drinks at a time on average? \_\_\_\_\_  
What types of alcohol? \_\_\_\_\_
- Did mother use illicit drugs while pregnant with this child?  Yes  No  
If yes, which ones? \_\_\_\_\_
- Did mother use prescribed medications while pregnant with this child?  Yes  No  
If yes, which medications and why? \_\_\_\_\_
- Did mother have bleeding while pregnant with this child?  Yes  No  
If yes, at what point(s) during the pregnancy? \_\_\_\_\_
- Check any medical conditions mother had while pregnant with this child:
 

<input type="checkbox"/> prenatal infections	<input type="checkbox"/> loss of consciousness
<input type="checkbox"/> prenatal growth problems	<input type="checkbox"/> emotional problems
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> diabetes
<input type="checkbox"/> low blood pressure	<input type="checkbox"/> nutritional deficiency
<input type="checkbox"/> toxemia	<input type="checkbox"/> other (specify) _____

7. Did any of these problems appear to affect the fetus?  Yes  No  
If yes, which ones and how? \_\_\_\_\_

8. Mother's weight gain was considered  low,  normal,  high.

**PERINATAL/NEONATAL HISTORY**

1. Age of mother at birth of this child: \_\_\_\_\_
2. Was pregnancy full term?  Yes  No  
If no, was birth between 32-37 weeks of gestation (preterm)?  or fewer than 32 weeks (very preterm)?
3. Birth was  head first,  breech,  cesarean?
4. Birth weight was \_\_\_\_\_ pounds \_\_\_\_\_ ounces.  
If exact birth weight is not recalled, was it referred to as low birth weight (under 5 lbs. 8 oz.)  or extremely low birth weight (under 2 lbs. 3 oz.) ?
5. What were baby's Apgar scores at 1 minute \_\_\_\_\_ 5 minutes \_\_\_\_\_?

**INFANCY**

1. Was baby in any kind of distress at birth?  Yes  No  
If yes, explain: \_\_\_\_\_
2. Did baby require delivery room resuscitation?  Yes  No
3. Was baby placed in Neonatal Intensive Care Unit (NICU)?  Yes  No
4. If yes, for how long? \_\_\_\_\_ For what reason(s)? \_\_\_\_\_
5. Check any medical conditions at birth:
- A. Brain/Central Nervous System
- Bleed
  - Neonatal Convulsions
  - Spina Bifida
  - Hydrocephalus
  - Tumor
  - Other; please explain: \_\_\_\_\_
- Please explain any checked items: \_\_\_\_\_
- B. Blood and Circulatory System
- Anemia  Leukemia
  - Other; please explain: \_\_\_\_\_
- Please explain any checked items: \_\_\_\_\_
- C. Respiratory System
- Bronchopulmonary Dysplasia
  - Cystic Fibrosis
  - Other; please explain: \_\_\_\_\_
- Please explain any checked items: \_\_\_\_\_
- D. Jaundice  Yes  No If yes, was it:  Mild  Severe
- E. Other, please explain: \_\_\_\_\_
6. Was baby colicky?  Yes  No If yes, when did colic go away? \_\_\_\_\_ months

7. Approximate age baby sat up alone \_\_\_\_\_ crawled \_\_\_\_\_ walked \_\_\_\_\_
8. Were parents or baby's physician concerned about slower than normal motor development?  Yes  No
9. Approximate age baby said first word \_\_\_\_\_ first phrase \_\_\_\_\_
10. Were parents or baby's physician concerned about slower than normal language development?  Yes  No
11. Did baby have any significant problems napping/falling asleep?  Yes  No  
If yes, please explain: \_\_\_\_\_
12. Did baby have any significant problems eating?  Yes  No If yes, please explain: \_\_\_\_\_

13. Baby was: (Please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> anxious             | <input type="checkbox"/> easy           |
| <input type="checkbox"/> difficult           | <input type="checkbox"/> happy          |
| <input type="checkbox"/> cranky              | <input type="checkbox"/> calm           |
| <input type="checkbox"/> overactive          | <input type="checkbox"/> underactive    |
| <input type="checkbox"/> difficult to soothe | <input type="checkbox"/> easily soothed |

**EARLY CHILDHOOD HISTORY (AGES 2-4)**

1. At what age was your child successfully toilet trained? \_\_\_\_\_ Was training  difficult?  easy?
2. After toilet training, did your child lose control of his/her bladder repeatedly:  
During the day?  Yes  No During the night?  Yes  No
3. After toilet training, did your child lose control of his/her bowels repeatedly:  
During the day?  Yes  No During the night?  Yes  No
4. Was your child: (Please check all that apply)
- |   |  |
|---|--|
| <input type="checkbox"/> anxious or extremely shy | <input type="checkbox"/> overly aggressive             |
| <input type="checkbox"/> clumsy                   | <input type="checkbox"/> too energetic/restless        |
| <input type="checkbox"/> hard to discipline       | <input type="checkbox"/> unable to understand language |
| <input type="checkbox"/> inarticulate             | <input type="checkbox"/> uncoordinated                 |
| <input type="checkbox"/> inattentive              | <input type="checkbox"/> unhappy                       |
| <input type="checkbox"/> noncompliant             | <input type="checkbox"/> destructive                   |
| <input type="checkbox"/> demanding                | <input type="checkbox"/> dependent                     |
5. Did your child attend preschool?  Yes  No
6. Were there significant problems **at preschool**?  Yes  No  
If yes, what were these problems? (Please check all that apply)
- |   |   |
|---|---|
| <input type="checkbox"/> overaggressive                 | <input type="checkbox"/> unable to share  |
| <input type="checkbox"/> too energetic                  | <input type="checkbox"/> uncoordinated  |
| <input type="checkbox"/> shy                            | <input type="checkbox"/> withdrawn  |
| <input type="checkbox"/> slow to learn                  | <input type="checkbox"/> difficulty getting along with other kids                 |
| <input type="checkbox"/> significant trouble separating | <input type="checkbox"/> crying/significant distress                              |
| <input type="checkbox"/> clingy                         | <input type="checkbox"/> didn't obey  |
| <input type="checkbox"/> didn't listen                  | <input type="checkbox"/> worried excessively about something happening to parents |
| <input type="checkbox"/> temper tantrums                | <input type="checkbox"/> other (specify) _____                                    |

7. Were there significant problems **at home** during the preschool years?  Yes  No

If yes, what were these problems? (Please check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> overaggressive                 | <input type="checkbox"/> unable to share  |
| <input type="checkbox"/> too energetic                  | <input type="checkbox"/> uncoordinated  |
| <input type="checkbox"/> shy                            | <input type="checkbox"/> withdrawn  |
| <input type="checkbox"/> slow to learn                  | <input type="checkbox"/> difficulty getting along with other kids                 |
| <input type="checkbox"/> significant trouble separating | <input type="checkbox"/> crying/significant distress                              |
| <input type="checkbox"/> clingy                         | <input type="checkbox"/> didn't obey  |
| <input type="checkbox"/> didn't listen                  | <input type="checkbox"/> worried excessively about something happening to parents |
| <input type="checkbox"/> temper tantrums                | <input type="checkbox"/> other (specify) _____                                    |

**MEDICAL HISTORY**

1. Place a check next to any illness or condition your child has had. When you check an item, also note the approximate age(s) and grade(s) of your child when he / she had the illness or condition.

Illness or condition

Age(s) & Grade(s)

- |  |       |
|--|-------|
| <input type="checkbox"/> Seizures unrelated to high fevers | _____ |
| <input type="checkbox"/> Convulsions                       | _____ |
| <input type="checkbox"/> Epilepsy                          | _____ |
| <input type="checkbox"/> Cerebral Palsy                    | _____ |
| <input type="checkbox"/> Meningitis                        | _____ |
| <input type="checkbox"/> Encephalitis                      | _____ |
| <input type="checkbox"/> Tumor                             | _____ |
| <input type="checkbox"/> Leukemia                          | _____ |
| <input type="checkbox"/> High fever (above 104 degrees)    | _____ |
| <input type="checkbox"/> Fainting spells                   | _____ |
| <input type="checkbox"/> Dizziness                         | _____ |
| <input type="checkbox"/> Frequent headaches                | _____ |
| <input type="checkbox"/> Extreme fatigue                   | _____ |
| <input type="checkbox"/> Significant head injury           | _____ |
| <input type="checkbox"/> Loss of consciousness             | _____ |
| <input type="checkbox"/> Hearing difficulties              | _____ |
| <input type="checkbox"/> Vision problems                   | _____ |
| <input type="checkbox"/> Allergies                         | _____ |
| Please list:   | _____ |
| <input type="checkbox"/> Hay fever                         | _____ |
| <input type="checkbox"/> Asthma                            | _____ |
| <input type="checkbox"/> Chronic lung disease              | _____ |
| <input type="checkbox"/> Broken bones                      | _____ |
| <input type="checkbox"/> Ear infections                    | _____ |
| <input type="checkbox"/> Tube placement in ear(s)          | _____ |
| <input type="checkbox"/> Anemia                            | _____ |
| <input type="checkbox"/> Diabetes                          | _____ |
| <input type="checkbox"/> Cardiovascular disorder           | _____ |

2. Has your child ever suffered from any serious illness / condition not listed above?  Yes  No  
If yes, list condition(s) and age(s)? \_\_\_\_\_
3. Has your child ever had any significant accidents?  Yes  No  
If yes, list nature of accidents and age(s): \_\_\_\_\_
4. Has your child ever been hospitalized?  Yes  No If yes, at what age(s)? \_\_\_\_\_  
For what reasons? \_\_\_\_\_
5. Has your child ever had any surgeries?  Yes  No  
If yes, list procedure(s) and age(s)? \_\_\_\_\_
6. Did your child ever develop motor tics (sudden, brief, recurrent, meaningless movements), such as:  
 mouth movements  finger movements  
 arm jerks  head jerks  
 eye blinking  imitation of someone else's movements  
 facial gestures  abdominal tensing  
 shoulder shrugs
7. If so, at approximately what age(s)? \_\_\_\_\_ Did they last for over one year?  Yes  No
8. If any still exist, which ones? \_\_\_\_\_
9. Do they significantly interfere with social, familial, or academic functioning?  Yes  No  
If so, how? \_\_\_\_\_
10. Did your child ever develop vocal tics (simple, sudden, meaningless sounds or noises), such as:  
 barking/grunting  sniffing  
 repeating his/her own sounds or words  snorting  
 repeating socially unacceptable/obscene words  throat clearing  
 repeating someone else's sounds or words
- If so, at approximately what age(s)? \_\_\_\_\_ Did they last for over one year?  Yes  No  
If any still exist, which ones? \_\_\_\_\_  
Do they significantly interfere with social, familial, or academic functioning?  Yes  No  
If so, how? \_\_\_\_\_
11. Please list any medications your child is currently taking (and dosage, if known): \_\_\_\_\_
12. Who is your child's pediatrician? \_\_\_\_\_

### ACADEMIC SKILLS

1. Has your child ever had any of the following problems with reading?  
 reading accuracy  
 reading comprehension  
 reading speed  
 trouble with phonics (the sounds of language)



2. Was your child entered into:
- Reading Improvement Program (RIP)? If yes, which grade(s)? \_\_\_\_\_
  - Title I Reading Class? If yes, which grade(s)? \_\_\_\_\_
  - Resource Room (special education) placement? If yes, which grade(s)? \_\_\_\_\_
3. Has your child ever had trouble with spelling in the following areas:
- writing letters backward
  - print or write neatly under time pressure
  - needing a lot of help learning weekly spelling words
  - sloppy handwriting a possible reason for poor spelling
  - making a lot of spelling errors when writing sentences or compositions
  - good performance on weekly spelling tests, but difficulty spelling sentences on his/her own
  - learning spelling words, but forgetting them a week or so later
4. Has your child ever had trouble with arithmetic in the following areas (if age-appropriate):
- learning basic addition facts
  - learning basic subtraction facts
  - learning to borrow in subtraction
  - learning multiplication tables
  - poor handwriting that interferes with writing numbers neatly in columns
  - making careless arithmetic errors when left alone to do arithmetic homework
  - understanding arithmetic concepts
  - understanding math word problems
  - learning and using decimals
  - learning and using fractions
  - learning and using percentages
  - algebra
  - geometry
5. Has your child ever had trouble:
- understanding the speech of others
  - with unclear speech / articulation
  - with stuttering
  - expressing ideas using age-appropriate words
  - with late developmental onset of speech
6. Was your child ever placed in speech or language therapy?  Yes  No  
If so, in what grade(s)? \_\_\_\_\_
7. Has your child ever had difficulty learning how to:
- |   |   |
|---|---|
| <input type="checkbox"/> print or write in cursive neatly     | <input type="checkbox"/> walk gracefully                                    |
| <input type="checkbox"/> hold a pencil correctly              | <input type="checkbox"/> run gracefully                                     |
| <input type="checkbox"/> color neatly                         | <input type="checkbox"/> tie own shoes (if over 8 years of age)             |
| <input type="checkbox"/> button buttons                       | <input type="checkbox"/> hold and use utensils correctly                    |
| <input type="checkbox"/> use scissors                         | <input type="checkbox"/> hop on one foot                                    |
| <input type="checkbox"/> throw or catch a ball                | <input type="checkbox"/> ride a two-wheeled bicycle without training wheels |
| <input type="checkbox"/> copy information from the blackboard |   |
8. Did you or teachers ever consider retaining your child in grade?  Yes  No

9. Was your child ever actually retained in grade?  Yes  No  
If yes, which grade(s)? \_\_\_\_\_
10. Has your child ever:
- had problems listening
  - become easily distracted
  - had difficulty following instructions
  - daydreamed frequently
  - had trouble concentrating
  - made careless mistakes in schoolwork or other activities
  - had difficulty organizing tasks and activities
  - often lost things necessary for tasks or activities (e.g. school assignments, pencils, books, tools, etc.)
  - become fidgety, squirmy, restless
  - had trouble remaining seated in class
  - become excessively talkative
  - often run around or climbed excessively in inappropriate situations
  - had difficulty playing or occupying self quietly
  - remained constantly "on the go"
  - behaved in an excessively impulsive fashion
  - had trouble waiting turn in groups
  - often interrupted or intruded on others
  - often blurted out answers before questions were completed
11. Has anyone ever used the word "hyperactive" to describe your child (teacher, family member, etc.)?  Yes  No  
If yes, who: \_\_\_\_\_
12. Has your child ever been placed on any medicine for attentional/hyperactive disturbance?  Yes  No  
If yes, which medicine(s)? \_\_\_\_\_  
At what age? \_\_\_\_\_ For how long? \_\_\_\_\_  
Was it effective?  Yes  No  Unsure

**SOCIAL / EMOTIONAL DEVELOPMENT**

1. Has your child ever have more than mild difficulty:
- showing interest in social games
  - liking "peek-a-boo" and "pat-a-cake" (ages 1-3)
  - playing cooperatively with other children (ages 3 and over)
  - making/maintaining eye contact with people outside immediate family
  - learning how to share and take turns
  - being touched, held, or cuddled
  - tolerating the way things smell, feel, taste, or sound
  - adapting to changes in routine
  - repeating words or phrases over and over
  - speaking with normal vocal tone and/or inflection
  - invading the personal space of others (e.g., standing too close to others)
  - changing topics during social conversation
  - making and keeping friends

2. Has your child ever:

- feared separation from home or parents
- feared harm would befall to parents
- feared going to school
- had excessive fear of being alone
- felt reluctant to go to sleep at night
- felt reluctant to stay with a baby-sitter when you went out at night
- felt afraid to be away from home overnight
- had repeated nightmares with the theme of separation from parents
- complained of physical symptoms (e.g. headaches, stomachaches, etc.) when separating from parents
- worried about peer acceptance
- worried about school performance
- appeared very tense, anxious, or nervous
- developed any compulsive behaviors (e.g., hand washing, ordering or checking things)
- repeatedly lost his/her temper
- often argued with adults
- often defied adult requests or rules
- deliberately annoyed other people
- often blamed others for his/her mistakes
- become easily annoyed by others
- become easily angry and resentful
- become easily spiteful or vindictive
  
- had excessive fear of weight gain
- had excessive fear of weight loss
- refused to maintain a minimally normal weight for his/her age and height
- dieted excessively
- evaluated him / herself excessively based on his / her body weight
- used laxatives, diuretics, or speed
- self-induced vomiting after meals
- engaged in binge eating
- fasted or exercised excessively
- missed at least three consecutive menstrual periods (in a menstruating female)
  
- exhibited a significantly irritable, depressed, or sad mood lasting at least several days
- exhibited the loss of pleasure in usual activities that he/she enjoyed
- complained of appetite changes or sudden weight gain or loss
- had frequent problems with insomnia or hypersomnia (problems falling asleep or oversleeping)
- seemed noticeably lethargic, fatigued, or listless for at least several days in a row
- felt worthless or excessively guilty (low self-worth)
- seemed pre-occupied with thoughts of death or suicide
- attempted suicide
- had periods of enormous energy with little need to sleep
- become excessively involved in pleasurable activities with negative consequences (buying sprees, sexual indiscretion, reckless driving, etc.)

3. Has your child ever:
- threatened or intimidated others
  - initiated physical fights
  - used a weapon in a fight
  - acted in a physically cruel manner to animals
  - acted in a physically cruel manner to people
  - stolen while confronting a victim
  - forced someone into sexual activity
  - set at least one significant fire
  - deliberately destroyed the property of others
  - broken into someone's house, building, or car
  - often lied to obtain something
  - stolen valuable items without confronting victim (shoplifting, forgery, etc.)
  - often stayed out at night despite parental prohibition
  - run away from home overnight more than once
  - often engaged in truancy from school, beginning before age 13
4. Did any of these behaviors begin before your child was 10 years old? If yes, which one(s)? \_\_\_\_\_
- 
5. Was there ever any Juvenile Court involvement? If yes, what were the charges? \_\_\_\_\_
- 
6. Has your child ever used:
- alcohol?
  - amphetamines (crystal meth, speed, ice, diet pills, etc.)?
  - marijuana?
  - any form of cocaine?
  - downers, Valium, Xanax, sleeping pills?
  - LSD, acid, peyote, or mushrooms?
  - glue, paint, cleaning agents, solvents, or gas (huffing)?
  - heroin, morphine, codeine, etc.
  - PCP (hog, rocket fuel, tranq, angel dust, etc.)?
  - Ecstasy (MDMA, XTC, X, etc.)
  - ketamine (Special K, Vitamin K, etc.)?
  - GHB (liquid ecstasy, soap, etc.)?
  - rohypnol (roofies, etc.)?
7. Has your child ever (while not using drugs or alcohol):
- heard voices talking to him/her
  - had bizarre or very unusual thoughts
  - experienced visual hallucinations
  - seemed out of touch with reality
8. Has your child ever complained of:
- |   |   |
|---|---|
| <input type="checkbox"/> frequent headaches   | <input type="checkbox"/> vision troubles (double vision, blindness, etc.) |
| <input type="checkbox"/> frequent backaches   | <input type="checkbox"/> dizziness or light-headedness                    |
| <input type="checkbox"/> frequent muscle aches, soreness, tension                     | <input type="checkbox"/> shortness of breath                              |
| <input type="checkbox"/> frequent stomach problems (nausea, diarrhea, bloating, etc.) | <input type="checkbox"/> problems with balance or coordination            |

9. When interacting with peers, does your child:

- |   |   |
|---|---|
| <input type="checkbox"/> not compromise easily            | <input type="checkbox"/> act like a poor loser at games               |
| <input type="checkbox"/> get his/her feelings hurt easily | <input type="checkbox"/> act overly shy                               |
| <input type="checkbox"/> get picked on by other children  | <input type="checkbox"/> want to run things                           |
| <input type="checkbox"/> have trouble making friends      | <input type="checkbox"/> express fear that peers did not like him/her |

10. Has the child experienced any sexual abuse? If yes, please describe? \_\_\_\_\_

\_\_\_\_\_

11. Has the child experienced any physical abuse or neglect? If yes, please describe? \_\_\_\_\_

\_\_\_\_\_

12. Has the child suffered any severe trauma? If yes, please describe? \_\_\_\_\_

\_\_\_\_\_

## FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

If you have insurance, Children's Specialty Centers of Nevada (CSCN) will gladly process your claim. However, we require that your estimated portion is paid when services are rendered.

**IF YOU ARE NOT COVERED BY INSURANCE**, we will provide an estimate of the cost of your care. This estimate will include anticipated charges based on the recommended treatment plan. If your plan of treatment changes, you may be asked to agree to a new estimate and estimates may vary due to a variety of factors.

If you are a **SELF-PAY** patient or if you have a financial obligation after your insurance has fulfilled its responsibility, you will be expected to pay the balance due. If you cannot pay your balance in full, payment arrangements may be possible. For payment options, including sliding fee scales, you must speak with our Business Office Representative.

For further understanding of our billing process, please feel free to contact a member of the business office staff.

**Please initial each line:**

\_\_\_\_\_ I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to CSCN for all pharmaceuticals, tests, procedures, equipment, supplies, physician/nursing services--including major medical benefits, or services provided to me by CSCN.

\_\_\_\_\_ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the above mentioned medical services to CSCN, my insurance carrier, state, federal accreditation agency, or other medical entity. A copy of this authorization will be sent to my insurance carrier, or other medical entity, if requested. The original authorization will be kept on file by CSCN. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within CSCN.

\_\_\_\_\_ I understand that it is my responsibility to notify CSCN of any changes in my health care coverage, insurance carrier, change of address, change of employer or any change in legal guardianship of the minor/patient.

\_\_\_\_\_ I understand that I am financially responsible to CSCN for any charges not covered by health care benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by CSCN and/or my health care insurer, if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility and am agreeing to pay for any/all above described medical services received. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for service.

\_\_\_\_\_ I understand that there is a **\$25.00** charge for all returned checks.

\_\_\_\_\_ I understand that there is a **\$25.00** charge for all missed or cancelled appointments that are not cancelled within 24 hours of the scheduled appointment time.

**\*\* THIS ACKNOWLEDGEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING \*\***

*By signing this document, I also acknowledge that I have been made aware of CSCN's **Notice of Privacy Practices**, as is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights as well as **Understanding our Billing Process**. I have read and, if requested, received a copy of the above statement and Privacy Practices and accept the terms. A duplicate or facsimile transmission of this statement is considered the same as original.*

Signature of Insured/Parent/Guardian: \_\_\_\_\_ Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name of Insured/Parent/Guardian: \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize Children's Specialty Center of Nevada to (initial all that apply):

\_\_\_\_\_ Exchange with \_\_\_\_\_ Release to \_\_\_\_\_ Obtain from the parties I have indicated below

Person/Organization receiving/communicating the information:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Description of individually identifiable health information to be released/exchanged/obtained (initial all that apply):

_____ Entire Record	_____ Psychotherapy Notes	_____ Treatment Plan(s)
_____ Session Dates	_____ Psychological Testing	_____ Legal Records
_____ Diagnosis	_____ Psychological Report	_____ School Records
_____ Other _____		

The purpose of this release is (initial all that apply):

_____ To facilitate treatment program	_____ Psychological Evaluation
_____ Subpoena or other legal process	_____ Court-ordered evaluation
_____ Other _____	

**\*\*\*\* THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM  
THE DATE OF THE SIGNATURE BELOW. \*\*\*\***

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for privacy of Individually Identifiable Health Information and/or state laws. I understand that my records may contain information on regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information. I further understand that by signing below, I am authorizing the release or exchange of these records to/from the parties named above.

Signature of Parent/Guardian: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Witness: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_

## REVOKE CONSENT

I wish to revoke this authorization; however, I understand that it will not have any effect on any information that Children's Specialty Center of Nevada released before I revoked my consent.

Signature to Revoke Consent: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_



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## **INFORMED CONSENT FOR PSYCHOLOGICAL/NEUROPSYCHOLOGICAL SERVICES**

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### **CLINICAL SERVICES**

Dr. Bello provides psychological therapy, psychological testing, and neuropsychological testing. Testing and psychotherapy are two different services.

Psychotherapy is an intervention process that attempts to reduce patient symptoms. It may involve one-on-one sessions, family sessions, or parent sessions. A treatment plan will be discussed and goals of therapy will be set, though these may change over time. At the time of discharge, if required by referring source, a discharge summary will be written describing treatments provided number of sessions attended, progress made, and presence of possible residual problems.

Psychological/ neuropsychological testing will help the patient and family understand the relationship between behavior and nervous system functioning. The information obtained will help define the existing problem(s) and determine treatment options. The testing process involves an interview (as well as possibly interviewing of others) and the completion of psychological tests. The total time of the evaluation may vary, and it will depend upon the reason for referral, presenting concerns by the patient/parent, and questions that the doctor or the test administrator may have. The time for the interview may be between one to two hours in length, and the time for the testing may be between three to six hours. Common features of evaluations typically include the following:

- **Review of Relevant Records** – background information that enables the doctor to have a historical context that benefits the testing situation.
- **Clinical Interview** – the interview with the patient/collateral typically includes (1) his or her background information, such as family history and past/present physical health, (2) mental health concerns, such as symptoms of distress, and (3) educational and employment history.
- **Testing** – tests will assess cognitive ability as well as emotional status; these are either computerized or paper and pencil tests. Most tests are interactive and will be administered by a neuropsychologist or by a qualified and well-trained testing technician under the supervision of the neuropsychologist.
- **Validity Assessment** – assessment of truthfulness based on the patient's presentation during the clinical interview, effort on testing exercises, and response patterns on the administered tests. It is extremely important that best effort is put forth and complete honesty is given at all times during the testing process.
- **Feedback of Results** – review of the testing results and recommendations with the patient and/or parents.

### **FREEDOM TO WITHDRAW**

The patient/parent has the right to end the evaluation at any time. If the patient wishes to do so, they can be provided the names of other qualified professionals that may help in completing the evaluation.

### **CONFIDENTIALITY**

Confidentiality regarding your treatment is extremely important. Both the state of Nevada and the American Psychological Association Ethical Principles for psychologists require that all information disclosed during the evaluation is kept private and protected. Information that is shared will be kept strictly confidential and will not be disclosed without the patient's written consent. Our staff has been counseled and strictly adheres to these guidelines. If you feel that confidentiality has been breached, please discuss this issue expediently with Dr. Bello or a staff member.



No information will be communicated to other individuals or agencies unless authorized in written form by your signature or the signature of a parent or legal guardian, if you are a minor. However, the following are exceptions:

- If a clear emergency exists where there may be a danger to you or others (e.g., potential suicide/homicide);
- If it is necessary to comply with state and legal status (e.g., known or suspected neglect or child abuse);
- If ordered by the court of law to disclose the information;
- When reimbursement from third party payers is sought (e.g., completing insurance claims for filing);
- When a patient initiates a litigation against the therapist;

In treatment of children and adolescents, the parent is the holder of the privilege of confidentiality. However, if Dr. Bello were to reveal the content of all individual therapy sessions with a minor to his/her parents, a therapeutic bond could not be formed and therefore progress in therapy would be limited. Therefore, we request of parent the same confidentiality with minor children that they would hold as adults. Dr. Bello will review with parents the focus of treatment and specific goals set for treatment with parents of minor children. However, the content of the sessions must remain confidential between Dr. Bello and the minor child with the exception of the above-mentioned limits to confidentiality.

### **RECORD RETENTION POLICY**

Per NRS 629.051, Section 7, psychologists are required to maintain records for adult clients over 23 years of age, for five years. Children's records will be maintained until 23 years of age. After that time, records may be destroyed.

My signature or the signature of parent or guardian below indicates that I have read, understand, and accept the preceding statements. I have had an opportunity to ask questions about them. I hereby give my consent for an evaluation and /or treatment of self and/or my child.

**Please sign, date, and return this copy.**

**Patient Name:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_ **Date Signed:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Relationship to Minor:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date Signed:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature of Witness:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date Signed:** \_\_\_\_/\_\_\_\_/\_\_\_\_