

Please complete at your
earliest convenience and:
____ Return in enclosed envelope.
____ Bring to first appointment.

Fredric Provenzano, Ph.D., NCS

Private Practice in Psychology
5506 33rd Ave. NE, suite D
Seattle, WA 98105

Fredric Provenzano, Ph.D., NCS, *Psychologist, WA lic. # PY00001022*
Lauren Christophersen, *Office Coordinator*

Phone: 206/361-2343
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www.drfredprovenzano.com

STUDENT & CHILD INTAKE

Today's date: _____

Referred by: _____

Child's Name: _____ Birthdate: _____ Age: _____

School: _____ Grade: _____ Circle one: Male Female

Ethnicity: _____

Parent 1 Name: _____ Is this person the child's legal guardian? Yes No

Parent 1 Address: _____ City/State: _____ Zip: _____

Parent 1 Home Phone: _____ Cell Phone: _____ Fax: _____

Parent 1 Employer: _____ Work Phone: _____ Can you be called at work? Yes No

Parent 2 Name: _____ Is this person the child's legal guardian? Yes No

Parent 2 Address: _____ City/State: _____ Zip: _____

Parent 2 Home Phone: _____ Cell Phone: _____ Fax: _____

Parent 2 Employer: _____ Work Phone: _____ Can you be called at work? Yes No

Please list names of all persons who have legal authority to consent to psychological evaluation/treatment and/or release of records for this child:

Child's Primary Care Physician: _____ Physician Phone: _____

Name of Emergency Contact: _____ Contact's Phone: _____

Please list below the name and address of the person who is the responsible billing party:

Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Signature: _____

Insurance Carrier: _____ Insurance Phone: _____

Insurance Co. Address: _____ City/State: _____ Zip: _____

Subscriber ID Number: _____ Group #: _____

Name of Subscriber: _____ Subscriber's Birthdate: _____

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STUDENT & CHILD HISTORY

Client Name _____ Birthdate _____ Age _____

Parent 1 Name _____ Birthdate _____

Parent 1 Occupation & Employer _____

Parent 2 Name _____ Birthdate _____

Parent 2 Occupation & Employer _____

Parents' Marital Status _____

Others in Home:

Name _____ Relationship to Client _____ Age _____ School/Occupation _____

Significant others outside of the home (include relationship to client, age, where they reside):

Developmental History

1. Pregnancy with client was:

Uneventful Complicated (explain) _____

2. Client's birth occurred:

At full term Prematurely, by _____ weeks Late, by _____ weeks

3. Please list any complications during or immediately following the birth:

4. At approximately what age did the client begin to (If unsure of exact age, please indicate "early," "normal," or "late"):

Walk _____ Say first words _____ Put words in sentences _____

Establish bladder control _____ Establish bowel control _____

Medical History

1. Please list medications currently taken by client, including dosage:

Medication _____ Dosage _____ For What Condition _____

Medication _____ Dosage _____ For What Condition _____

2. Please list the physicians most familiar with the client's medical history:

Physician Name _____ Specialty _____ Location _____

Physician Name _____ Specialty _____ Location _____

3. Please list any significant illnesses, injuries, or hospitalization/surgeries experienced by the client:

Illness/Injury Approximate Date Hospitalized? Enduring Effects

4. Has the client ever experienced any of the following:

Describe Condition & Approximate Dates

- a. Sleep problems _____
- b. Eating problems _____
- c. Unusual weight gain/loss _____
- d. Vision/hearing problems _____
- e. Chronic ear infections _____
- f. Allergies/Asthma _____
- g. Convulsions or seizures _____
- h. Nervous tics _____
- i. Chronic stomachaches _____
- j. Chronic headaches _____
- k. Recreational drug/alcohol/tobacco use _____

5. Please list any significant medical history in parent 1's immediate or extended family:

6. Please list any significant medical history in parent 2's immediate or extended family:

7. Please list any significant medical history in the client's siblings:

8. If there are any other current medical or psychological issues in the immediate or extended family that are contributing significant stress to the client:

Educational History

1. Please list the schools the client has attended, beginning with the current school and working backward.

<u>School/Location</u>	<u>Dates Attended</u>	<u>Grades Attended</u>

2. Please rank the client's current academic achievement levels in comparison to their classmates.

<u>Academic Subject</u>	<u>Above Average</u>	<u>Average</u>	<u>Below Average</u>	<u>Receiving Assistance/Tutoring</u>
1. Reading	_____	_____	_____	_____
2. Math	_____	_____	_____	_____
3. Spelling	_____	_____	_____	_____
4. Handwriting	_____	_____	_____	_____
5. Written Expression	_____	_____	_____	_____
6. Science	_____	_____	_____	_____
7. Social Studies	_____	_____	_____	_____
8. Foreign Language	_____	_____	_____	_____

3. Please list any special talents (artistic, dramatic, musical, etc.) that the client has displayed:

4. Has the client ever: (If yes, please describe when, for what purpose, & results)

- Repeated or skipped a grade? _____
- Received remedial assistance? _____
- Qualified for special education/IEP? _____
- Received academic accommodations (504 plan or otherwise)? _____
- Received psychological or individualized education testing? _____

Language & Speech Function

1. Client's primary language is: _____ English _____ Other (please indicate) _____

List any other languages understood/spoken by the client: _____

2. Describe any unusual difficulties the client shows in understanding spoken language: _____

3. Describe any unusual difficulties the client shows in using spoken language: _____

Physical development

1. Please rank the client's physical coordination in the following:

Above Average Average Below Average

1. Running	_____	_____	_____
2. Skipping	_____	_____	_____
3. Balancing on one foot	_____	_____	_____
4. Catching a ball	_____	_____	_____
5. Throwing a ball	_____	_____	_____
6. Drawing	_____	_____	_____
7. Using Scissors	_____	_____	_____

2. Please list any sports or physical activities for which the client shows interest or talent: _____

Work history

1. What chores does the client regularly perform around the home? _____

2. Please list any paid or volunteer work experience:

Type of Work Performed Employer Dates of Employment

Emotional/Behavioral/Social Development

1. Describe the client's temperament: _____

2. Describe any unusual behaviors or reactions to the following:

- a. Unusual Fears _____
- b. Mood patterns _____
- c. Psychosomatic complaints _____
- d. Impulsivity, fidgeting, hyperactivity _____
- e. Distractibility/poor concentration _____
- f. Anger/Oppositional behavior _____
- g. Physical Aggression _____
- h. Misconduct problems _____
- i. Repeated habits/mannerisms _____
- j. Other concerns _____

3. Describe list the names of client's previous therapists and approximate dates of service:

4. How does the client get along with

a. Peers: _____

b. Siblings: _____

c. Parents: _____

d. Other Authority Figures: _____

5. What methods are used to encourage or reward the client? _____

6. What methods are used as consequences for inappropriate behavior? _____

7. Does the client have a police or court record or any pending legal action? _____

What other information do you think I should know to help me work with this client? _____

What are the goals you'd like addressed by our work with the client?

1. _____

2. _____

3. _____

4. _____

5. _____

Thank you for your assistance in providing this information. It will help in understanding and facilitating the changes that are the goal of these services.

Signature of person completing this form

Relationship to client

Date

Signature of person completing this form

Relationship to client

Date

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client Signature (Parent/Guardian if Minor)

Date

Printed Name

Co-Signature (if required)

Date

Printed Name of Co-Signer

Original 4/14/03; Revised 8/18

Note: A complete text of this agreement is included in your packet. Please sign and date this copy for Dr. Provenzano's records. You do not need to sign the copy of the agreement in your packet.

Please complete other side >>>>

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Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

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Request for Confidential Handling of Health Information

A. I, _____, request that
(Print First & Last Name of patient/recipient or parent/guardian)

Fredric Provenzano, Ph.D. handles my confidential health information regarding me/my child in the following way:

All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe the alternative means (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Note: E-mail communication is not provided by Dr. Provenzano.

Telephone (please indicate: home / work / cell)

Voicemail (please indicate: home / work / cell)

U.S. mail

Fax (If marked: should we call before faxing to insure confidentiality? _____)

Other (please describe): _____
_____.

B. All reasonable requests to receive communication of your health information to alternative locations will be granted. Please list an alternate address below *only if you want communications regarding your health care information sent to an address that is different from your residence.*

(Street Address)

(City)

(State)

(Zip Code)

(Signature)

(Date)