

FACE SHEET: Child & Adolescent

Child Name: _____ **Date:** _____

Address: _____

Date of Birth: _____ **Sex:** M F

Parent A's Name: _____ **Parent B's Name:** _____

Address: _____ **Address:** _____

Home Phone: _____ **Home Phone:** _____

Cell Phone: _____ **Cell Phone:** _____

Employer Phone: _____ **Employer Phone:** _____

Work Phone: _____ **Work Phone:** _____

Occupation: _____ **Occupation:** _____

Email: _____ **Email:** _____

Preferred Contact Number: _____

RESPONSIBLE PARTY INFORMATION:

Name: _____

Date of Birth: _____ **Social Security #:** _____

I understand payment is due at the time services are rendered.

Signature Required

Will you be billing your insurance company? Y N
If yes, please complete insurance information on reverse side.

CONSENT:

I authorize release of any medical information necessary to process this claim.

INSURANCE INFORMATION:

(Parent or Guardian)

Name of insured:

Insured's Social Security # or Member ID #:

Group #:

Insured's Employer:

Insured's Birthdate:

Insurance Company:

Insurance Company Phone #:

Claims Address:

State

Zip



5420 S Quebece St, Suite 103
Greenwood Village, CO 80111
Phone: 303-221-STAR (7827)
Fax: 303-322-5550

Office Use
NAME _____
DOE _____
DOB _____
CA _____

CONFIDENTIAL PERSONAL HISTORY FOR CHILDREN AND YOUNG ADULTS

Today's Date: _____ Completed by: _____

Last Name: _____ Child's Name: _____

Address: _____ Birthdate: _____ Age: _____

City, State, Zip _____ Gender: _____

_____ Ethnicity: _____

CONTACT INFORMATION

Parent A's Name: _____ Parent B's Name: _____

Address: _____ Address: _____

Home phone: _____ Home phone: _____

Cell phone: _____ Cell phone: _____

Emergency Contact: _____

Name	Relationship	Phone
------	--------------	-------

School: _____ **Grade in School:** _____

Teacher's Name: _____ Type of Classroom: _____

Child's Physician's or Health Care Providers (including Primary Care Physician):

Name: _____ Profession: _____ Phone: _____

Address: _____

Name: _____ Profession: _____ Phone: _____

Address: _____

Name: _____ Profession: _____ Phone: _____

Address: _____

Date of Child's Last Medical Checkup: _____ Height: _____ Weight: _____

What are the presenting problems for your child? (All categories below may not apply.)

Academic: _____

Activities of daily life (eg. eating, dressing) _____

Relationships: _____

Sensory: _____

Motor: _____

Play: _____

Other: _____

What kind of interests and activities does your child have? (hobbies, sports, clubs)

Please list them in order of preference beginning with the favorite activity.

Has your child been diagnosed with (PLEASE CHECK ALL THAT APPLY):

- ADD
- ADHD
- Anxiety Disorder or Mood Disorder (specify): _____
- Autistic Spectrum Disorder
- Cognitive Delay
- Down Syndrome
- Dyslexia
- Emotional disorder (specify): _____
- Fragile X Syndrome
- Learning Disabilities (specify if possible): _____
- Sensory Processing Disorder or Sensory Integration Dysfunction
- Tourette's Syndrome
- Other (specify): _____

Please note, who provided the diagnosis and based on what criteria i.e., test scores, comprehensive clinical evaluation, genetic study, etc.): _____

MEDICATIONS

List any medications has your child received **in the past**:

Medication: _____ Purpose: _____ When taken: _____

Medication: _____ Purpose: _____ When taken: _____

Medication: _____ Purpose: _____ When taken: _____

Medication: _____ Purpose: _____ When taken: _____

Medication: _____ Purpose: _____ When taken: _____

List any medications your child is **currently** taking, its purpose and frequency of dosage:

Medication: _____ Purpose: _____ When taken: _____

Medication: _____ Purpose: _____ When taken: _____

Medication: _____ Purpose: _____ When taken: _____

Medication: _____ Purpose: _____ When taken: _____

Medication: _____ Purpose: _____ When taken: _____

FAMILY ADAPTATION

How would you describe your child's general adjustment at home? Poor ___ Fair ___ Good ___ Excellent ___

How does your child get along with each member of the family?

Father _____

Mother _____

Siblings _____

Have there been any traumatic family events in the course of this child's development?

Have there been any major moves? (city to city, country to country)

PREGNANCY (If child is adopted, skip to Adoption Section)

What kind of experience was the pregnancy for both mother and father?

Parent A _____

Parent B _____

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Was it planned?	_____	_____	_____
Were there complications?	_____	_____	_____
shock	_____	_____	_____
severe stress	_____	_____	_____
loss of a loved one	_____	_____	_____
accident	_____	_____	_____
health problems, specify	_____	_____	_____
confinement to bed	_____	_____	_____
other	_____	_____	_____
Was mother exposed to loud noises?	_____	_____	_____
Did mother smoke?	_____	_____	_____
Did mother consume alcohol?	_____	_____	_____
Did mother take any medication? specify	_____	_____	_____
Did mother talk much?	_____	_____	_____
Was mother physically active?	_____	_____	_____
Were any previous pregnancies complicated?	_____	_____	_____

LABOR AND DELIVERY

Describe your experience during labor and delivery _____

		Comments
Length of labor?	_____ hrs	_____
Premature: specify	Yes____ No____	_____
Forceps used	Yes____ No____	_____
High forceps required	Yes____ No____	_____
Suction	Yes____ No____	_____
Delivery position (ex: breech)	_____	_____
Caesarean birth (reason)	Yes____ No____	_____
Birth weight	_____ lbs _____ oz	_____
APGAR ratings (if known)	_____	_____
Cried immediately	Yes____ No____	_____

Required special treatment
(i.e. required oxygen,
had jaundice, etc.) Yes ___ No ___ _____

Birth injuries: specify Yes ___ No ___ _____

Did the newborn have
immediate physical contact
with the mother? Yes ___ No ___ _____

Was there a positive bonding
experience between mother
and newborn at birth? Yes ___ No ___ _____

Describe any separations from
mother during first days of life _____

Did mother experience any
post-partum depression? Yes ___ No ___ _____

ADOPTION

Describe the circumstances surrounding the adoption.

More specifically:

Age when adopted: _____

Prior foster homes: _____

Physical appearance: _____

Response to new home: _____

Is your child aware of his/her adoption? _____

INFANCY & TODDLERHOOD

Going back to the **first two years** of the child's life, what type of baby was he/she?
(feeding, sleeping, activity level)

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Breastfed	_____	_____	_____
Extended separations during first two years (over 3 days)	_____	_____	_____
Specific health problems during this period	_____	_____	_____
Thumb sucking / pacifier (until what age)	_____	_____	_____
Feeding problems	_____	_____	_____
Sleeping problems	_____	_____	_____
Colic or "fussy baby"	_____	_____	_____
Prefer certain positions as an infant (describe)	_____	_____	_____
Dislike lying on stomach	_____	_____	_____
Dislike lying on back	_____	_____	_____
Able to self soothe	_____	_____	_____
On a regular schedule	_____	_____	_____
Enjoy bouncing	_____	_____	_____
Become calmed by car rides or infant swings	_____	_____	_____
Become nauseated by car rides or infant swings	_____	_____	_____
Crawled (at what age)	_____	_____	_____
Toe walker (until what age)	_____	_____	_____
Go through "terrible twos"	_____	_____	_____
Describe your child's toddler stage:	_____		

CHILDHOOD ILLNESSES / PROBLEMS

	Age	Comments / Deficits
_____ ear infections	_____	None / A Couple / Many _____
_____ tubes in ears	_____	_____
_____ respiratory problems	_____	_____
_____ high fever	_____	_____
_____ meningitis	_____	_____
_____ adenoid problems	_____	_____
_____ frequent colds	_____	_____

strep throat _____
 allergies If yes, please specify: _____

Check the items below which have been a problem and provide details:

Asthma _____
 Bronchitis _____
 Skin problems _____
 Gastro-Intestinal problems _____
 Seizures _____
 Epilepsy _____
 Nightmares _____
 Sleep _____
 Bedwetting _____
 Nail Biting _____
 Broken limbs _____
 Other _____

Has he/she ever been hospitalized? Yes _____ No _____
 If yes, list reasons: _____

Has he/she ever had a serious accident/injury? Yes _____ No _____
 If yes, list accidents: _____

Are there any other medical illnesses or conditions which have been diagnosed?

Is your child in good general health at the present time? _____

DEVELOPMENTAL MILESTONES

(Give approximate ages if remembered, or comment on anything unusual)

Rolling over _____ Walk _____ Say words _____
 Sit alone _____ Chew solid food _____ Say sentences _____
 Crawl _____ Drink from a cup _____

Was crawling phase brief? Yes _____ No _____ Absent? Yes _____ No _____

Did child use a walker (rolling plastic seat)? Yes _____ No _____ If yes, how often? _____

Experience hesitancy or delays in learning to go down stairs? Yes _____ No _____

VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision? _____

Are there any current problems of which you are aware? _____

When was the last time his/her eyesight was tested? _____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (operations, infections, tubes)

Ear infections? seldom ____ sometimes ____ often ____
 mild ____ moderate ____ severe ____

Are there any current hearing problems of which you are aware?

SPEECH AND LANGUAGE DEVELOPMENT

How would you describe your child's speech and language development?

normal ____ delayed ____ advanced ____

Did your child begin speaking in single words, then two, then a sentence? Yes No

Did your child not talk for a long while, then all of a sudden speak in complete sentences? Yes No

Do you or others have difficulty understanding what child says? Yes No

First words and at what age: _____

Describe any speech related problems: _____

SENSORY and MOTOR DEVELOPMENT

Please check any that apply:

_____ My child seems to be overly sensitive to sensory experiences more so than most people:

_____ auditory _____ tactile _____ visual _____ movement _____ taste _____ smell

___ My child doesn't seem to react to sensory experiences as readily as most people:
 ___ auditory ___ tactile ___ visual ___ movement ___ taste ___ smell

___ My child actively seeks out sensory experiences more so than most people:
 ___ auditory ___ tactile ___ visual ___ movement ___ taste ___ smell

___ My child has difficulty differentiating sensory experiences.
 (ex. confuse sounds, can't find objects in drawer or bag without looking, bumps into things)

Describe: _____

___ My child has trouble learning new movements.

___ My child tends to be clumsy and has balance and coordination problems.

PREVIOUS TESTING AND TREATMENTS

Has your child had any previous ASSESSMENTS or TREATMENT
Please attach relevant reports.

	ASSESSMENTS			TREATMENT		
	Yes	No	Place / Date	Yes	No	Place / Date
Medical	___	___	_____	___	___	_____
Audiological	___	___	_____	___	___	_____
Speech	___	___	_____	___	___	_____
Educational	___	___	_____	___	___	_____
Psychological	___	___	_____	___	___	_____
Occ. Therapy	___	___	_____	___	___	_____
Other	___	___	_____	___	___	_____

Comments: _____

Have there been any specific events or traumas linked with the onset of your child's difficulties?

Is your marital situation stable and positive at this time? _____

What, if any, stresses are affecting your family at this time?

Which language(s) is spoken at home? _____

Are there other individuals or family members living at home? (other than immediate family)

EDUCATION

How did your child adapt to the first day(s) at school or pre-school:

Mostly positive _____ Mixed _____ Mostly negative _____

How old was he/she? _____ How much time did he/she attend per week? _____

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience:

Initial school adjustment _____

Pre-school/Daycare _____

Primary (K-Gr. 3) _____

Junior (Gr. 4-6) _____

Intermediate (Gr. 7-8) _____

High School (Gr. 9-12) _____

Has there been remedial help given **inside** the school system? Yes _____ No _____

If yes, describe: _____

Please fill out names and ages for a family tree chart.

PARENT A

PARENT B

Grandparents

**Biological
Aunts/Uncles**

Cousins

Parents

**Brothers/
Sisters**

Child at STAR

Pets

GOALS

What are your goals for your child's program? Please be as specific as possible.

1. _____

2. _____

3. _____

4. _____

5. _____

How did you hear about STAR Center? _____

If you were referred:

Referred by: _____ Profession: _____

Address: _____

STAR Center has my permission to send a thank you letter to my referral source indicating the my child has been seen for an evaluation.

Parent or Guardian: _____ Date: _____

Video and Photo Release

The Sensory Processing Disorder (SPD) Foundation and the STAR (Sensory Therapies And Research) Center are research and education organizations. As such, we often video or photograph children or family members participating in treatment or research projects. The video and photos may include interviews, assessments, treatment and/or other group activities. The rights, titles and interests of these materials belong to the SPD Foundation and/or the STAR Center, which reserves the right to edit the material.

I (please print name) _____ voluntarily consent to the taking of photographs or video of myself and/or my child (please print child's name) _____.

I understand that these photographs or videos may be used for educational or scientific purposes in educational training programs, medical/scientific publications or media publications. I realize that the photographs or videos may be used to create educational training tapes and may be used at SPD Foundation or STAR Center seminars, workshops, on the SPD Foundation or STAR Center websites and/or in paid webcasts/e-Learning presentations. Some video or photographic material may be included in future training that may be sold to support further research and treatment of children with Sensory Processing Disorder. Specific names of children and other family members seen in photos or videos will not be disclosed.

_____ I give permission for use of photographs or video to be used for educational purposes

_____ I **do not** give permission for use of photographs or video to be used for educational purposes

_____ I give permission for use of photographs or video to be used for news or other media purposes

_____ I **do not** give permission for use of photographs or video to be used for news or other media purposes

Print your Child's Name

Parent or Legal Guardian Signature

Print your Name (Parent or Legal Guardian)

Date



Acknowledgment of Receipt of Privacy Practices

I, _____ have received a copy of STAR Center's Notice of Privacy Practices with an effective date of April 14, 2003.

Name of Client: _____

Address of Client: _____

Signature of Client: _____ **Date:** _____

Name of Witness:

Signature of Witness: _____ **Date:** _____



CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby authorize
(Name of Client or Parent/Guardian)

STAR Center to release and share any and all information pertinent to:

(Last name of Client) (First) (MI) (Date of Birth) (SS#)

the client's pediatrician and/or primary care physician

(Name of Physician and Practice)

(Address) (City) (State/Zip code)

(Telephone)

I do understand that this release and sharing of information will include, but not be limited to conversations, the sessions, records, reports, determinations, evaluations and factual information regarding myself and/or family member(s) who are minors. I understand that this action is taken to assist STAR Center in working with me and my family.

This authorization is voluntary and remains in effect until _____, unless specifically revoked by written notice to the agency or person. A photocopy of this release is as effective as the original.

DATE

SIGNATURE OF CLIENT IF 18 OR OLDER

DATE

SIGNATURE OF PARENT/GUARDIAN



Financial Agreement

11.8.06

Payment for Services

Payment is due at the time service is rendered. A 10% pre-pay discount is offered towards the treatment program if the treatment program is paid in full on the first day of treatment. We accept cash, checks and major credit cards. Returned checks will be subject to a \$25.00 returned check fee.

Billable Services

While there is no ordinary charge for a brief telephone consultation, more lengthy or complex situations may result in charges. Some reports and consultations may also result in charges

Family Discount

Immediate family members are eligible for a 10% Family Discount. This discount applies only when payment is made at the time services are rendered.

Late Cancellations

STAR Center reserves the right to charge for any appointment that is missed or canceled without a one business day advance notice. Please note that insurance companies do not reimburse for cancellation fees.

Illness

Please do not have your child attend treatment if he/she is feeling ill. Our gym must be germ-free to maintain the health of our clients and staff. If your child is not well enough to go to school, he/she is not well enough to attend therapy. If you arrive for a session during which the OT determines your child is too sick to participate in treatment (coughing, feverish) your session will be cancelled and rescheduled.

Bad Weather Cancellations

Please contact STAR Center if driving conditions are poor and you are unable to attend treatment as a result. We will contact you if one or all of our therapists are unable to get to our location due to hazardous weather.

Insurance Coverage

Our services are not guaranteed to provide insurance coverage. We will give you a superbill at the time of services. You are responsible for billing your insurance company and insurance reimbursement, if provided, will be sent directly to you.

I acknowledge that I have read and understand my responsibility to pay for services. By signing this agreement, I agree to the terms of this document.

Client/Parent or Guardian Printed Name

Client/Parent or Guardian Signature

Date

PERMISSION TO PARTICIPATE IN RESEARCH

To Whom It May Concern:

I _____, give my permission for the Sensory Processing Disorder Foundation staff to contact me regarding participation in a research project.

Name: _____

Child's Name: _____

Phone: _____

E-mail: _____