



Powers Ferry Psychological Associates, L.L.C.

The Offices of:

Gerald S. Drose, Ph.D.
Dina M. Zeckhausen, Ph.D.
Steven Perlow, Ph.D.

David M. Schwartz, Ph.D., ABPdN
Abby L. Friedman, Ph.D.
Kimberly Smiley, Psy.D.
Jennifer Spring, Ph.D.

And the Offices of:

Martin Fleet, Ph.D.
Susan Berel, Ph.D.
Elaine Eassa, Ph.D.
Keith Helmken, LCSW

Jennifer Swales, Ph.D.
Rachel Scheinfeld, Ph.D.
Brian Smith, Psy.D.
Katherine Higgins, Ph.D.

OFFICE POLICIES

We would like to welcome you to the practice of David M. Schwartz, Ph.D., ABPdN. For your convenience we would like to provide the following helpful information. A copy is provided to you for future reference:

OFFICE HOURS

Dr. Schwartz is typically in the office from 8:30 a.m. through 5:00 p.m. However, office staff may not be available until 9:00 a.m. or past 5:00 p.m. After hours, please leave a message on Dr. Schwartz' Voicemail. His phone number is 770.973.7401.

CANCELLATION OF APPOINTMENTS

Your appointment time has been reserved for you. Unlike other doctors, psychologists do not schedule several patients at a time. When you miss or cancel your appointment at the last minute, this time cannot be offered to another patient. If you find that you cannot keep your scheduled appointment, please notify the office **at least 24 hours** prior to your appointment. Any scheduled appointments which are missed or are not cancelled within 24 hours will be billed to you. You will be responsible for the charges for missed appointments. We will do our best to see you at your scheduled time. If you come late for your appointment, you will be seen for the remainder of the time scheduled for you. It would not be fair to other clients to delay the start of their sessions.

PAYMENT AND INSURANCE

The fees for services provided by the independent psychologists affiliated with PFFA are among the lowest in Atlanta. Why? One reason is that we share expenses and overhead so that we keep our costs as low as possible. Another reason is that we share a belief that psychological services should be as widely available as possible. For this reason, all of us are on at least some insurance panels and have a policy of using a "sliding scale" to make services easier to afford. Each of the independent psychologists affiliated with PFFA has determined his or her fees, so feel free to discuss the fees with our business office representatives. Dr. Schwartz' patients should check with Tamara Onley at the Front Desk, by phone at 770.953.4744, ext. 26 or by email at tonley@powersferrypsychology.com.

Do you have Insurance? If you do have insurance with mental health benefits, then some or all of the fees for our services may be covered. This is by no means a sure thing, however. First, find out if Dr. Schwartz is "in network" and if so what your co-pay and deductible if any will be. If he is not in the network, it still might work out for you to use your insurance to see Dr. Schwartz. Often insurance companies will pay a percentage of the fees for "out-of-network" providers, but at a lower rate than an "in-network" provider. Check with your insurance company to find out what your deductible and percentage co-pay will be for out-of-network providers. Please be sure to view the patient agreement to pay for services that are not covered or limited by your insurance company.

Marietta/East Cobb

1827 Powers Ferry Rd., Bldg. 22
Atlanta, GA 30339
Office: 770.953.4744 / Fax: 770.953.4640

Buckhead

2964 Peachtree Road, Suite 324
Atlanta, Georgia 30305
(770) 953-4744

Canton

250 East Main Street, Suite 201
Canton, Georgia 30114
(770) 704-6159

PROFESSIONAL SERVICES AGREEMENT

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our time together. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. I am a part of Powers Ferry Psychological Associates, L.L.C. (PFPA). We are a group of professionals who share office and administrative resources; however, we practice independently of one another. This means that I, alone, am fully responsible for providing you or your child with clinical services.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office during regular business hours, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail that I monitor. I will make every effort to return your call as soon as possible. If you are difficult to reach, please inform me of some times when you will be available. If you have an emergency and are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, call 911, or call the nearest emergency room and ask for the psychologist or psychiatrist on-call. If I will be unavailable for an extended time, I will always have a colleague available for you to contact in case of emergency.

CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information to others about your treatment (or your child's treatment) if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this current agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel it is important for our work together. I will note all consultations in your Clinical Record (which is called PHI in my notice of psychologists policies and practices to protect the privacy of your health information)
- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling, billing and

communication with insurance companies. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her and/or to contact family members, or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist/patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children Services (DFCS). Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon him or her, other than by accidental means, or that he or she has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once I have filed such a report, I may be required to provide additional information.
- If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and /or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you or your child in two sets of professional records. One set constitutes your Clinical Record. It includes information about: your reasons for seeking my services, a description of the ways in which your or your child's problem impacts on your life, diagnosis, the goals that we set for treatment, progress towards those goals, medical and social history, treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself, your child, or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person (or if information is supplied to me confidentially by others), you or your legal representative may examine and /or receive a copy of your or your child's Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I require that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request.

In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you or your child with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your or your child's treatment. They also contain particularly sensitive information that you or your child may reveal to me that is not required to be included in your Clinical Record and information supplied to me confidentially by others. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you. They also cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your or your child's record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this agreement; the attached notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated, as well as their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy and treatment is often crucial to successful progress, particularly with teenagers, it is typically my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. The results of psychological testing of a minor typically will be shared with parents or guardians. They may also be shared with other entities such as schools or physicians with parental consent.

FINANCIAL AGREEMENTS

PROFESSIONAL FEES

The Diagnostic Interview is billed at \$200 per hour. The fee for an evaluation is \$2500. This fee includes the Assessment and Report Writing, as well as the Results/Feedback session up to a total of 10 hours. If the Assessment takes more than 9 total hours, additional time will be billed at the cost of \$200 per hour.

In addition to scheduled appointments, this office charges \$200 per hour for other professional services you may need, though we will break down the hourly cost for periods of less than one hour. Other services that are billed include school meetings, employer meetings, family consultations, preparation of records or treatment summaries, filling out forms, and other services that are requested.

You will be charged \$100 if you do not provide 24 hours-notice of a cancelled evaluation appointment (unless, in either situation, we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled appointments. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation for depositions, court testimony, and transportation costs, even if I am called to testify by another party. The fee for testifying in court is \$250 per hour, "door-to-door." You will be charged for waiting time.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time of service, unless you have consulted with our front office to make other arrangements. **The Diagnostic Interview is due and payable on the day of the Diagnostic Interview. The cost of the evaluation is split into two parts, with one-half due on the first day of testing and the other half due before the written report is released.** ***No written evaluation reports will be provided until your outstanding balance is paid or approval is given by our business office.*** Verbal feedback will be provided after the evaluation. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

We are a Fee-for-Service practice. Your balance is due and payable as outlined above. Our office will be glad to help you submit insurance forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled. ***However you, not your insurance company, are responsible for full payment of the charges.*** It is very important to determine exactly what mental health and/or medical services your insurance policy covers prior to your appointment or evaluation. You should also be aware that your contract with your health insurance company may require that we provide it with information relevant to the services that were provided to you. We may be 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. Although 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.

We will assist you in submitting the appropriate bills to your insurance company and try to remedy any denial or payment problem related to billing. If after these attempts, the insurance company still refuses to reimburse you, there is very little we can do after that.

If you or your child is covered by a secondary insurance plan, we will be happy to provide you with appropriate billing forms and Explanation of Benefit (EOB) forms from your primary plan. You are responsible for payment of the portion of services not covered by your primary plan and you need to seek reimbursement from the secondary plan for yourself.

Typical insurance plans such as HMO's and PPO's are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more treatment after a certain number of sessions. We will assist you in obtaining authorization for further sessions. While much can be accomplished in short-term treatment, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow us to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your treatment.

A copy of your evaluation report will be sent, with your permission, to your referring doctor(s). There will be no charge for any additional copies.

If you have any questions regarding office policy, please do not hesitate to contact us. We will be happy to work with you in any way that we can.

Thank you for choosing our practice and we look forward to seeing you.

Please sign the next page to indicate that you have read and understand the office policies and have received a copy for your reference.

SIGNATURE PAGE FOR OFFICE POLICIES

By signing this Agreement, I acknowledge that I have been made aware of David M. Schwartz', Ph.D., ABPdN Office Policies and agree to abide by them. I also agree that his office can provide any requested medical, psychological and/or neuropsychological information to my carrier, or its agents, if required for determination or payment of benefits. I am also assigning benefits to David M. Schwartz, Ph.D. for any clinical services that are provided.

I am eligible for coverage under more than one health insurance policy (please circle): Yes No

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Client signature _____ **Date** _____

Guarantor (if different) _____ **Date** _____

Witness _____ **Date** _____



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NOTICE OF PSYCHOLOGIST’S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment, and Health Care Operations”
 - Treatment refers to when I provide, coordinate or manage your health care, and provide other services related to your health care. An example of treatment is when I consult with another health care provider, such as your family physician or another psychologist.
 - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care, or to determine eligibility or coverage.
 - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities; business-related activities, such as audits and administrative services; and case management and care coordination activities.
 - “Use” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. Psychotherapy Notes are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

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You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- Health Oversight Activities – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
- Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will make this information available either by mail or by request for a review of this information.

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Steven Perlow, Ph.D., Privacy Officer, at 770-953-4744 x14. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date

This notice will go into effect on April 14, 2003.



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NOTICE OF PSYCHOLOGIST'S POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

I, the undersigned, acknowledge that I have received, read and understand the *"Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information"* form from Powers Ferry Psychological Associates (Version 04/14/2003).

This policy became effective April 14, 2003 as required by law under HIPAA (Health Insurance Portability and Accountability Act).

Signature: _____ Date: _____

or

Signature: _____ Date: _____
(Parent, Guardian, or Legal Representative)

If applicable, secondary party/ parties , 18 years of age or older, participating in treatment:

Signature of Secondary Party/Parties: _____ Date: _____

Name(s) of Secondary Party/Parties (Please Print): _____
and Relationship to Patient

Signature Treating Psychologist: _____ Date: _____

Name of Treating Psychologist: _____

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PAYMENT FOR SERVICES AGREEMENT

Provider/Supplier Notice to Beneficiary Regarding Service(s) That May Be Denied Payment by Your Insurance Carrier as "Not Reasonable and Necessary"

Notice to Beneficiary:

Your insurance company: _____ may only pay for services that *it* determines to be "**reasonable and necessary**" under their contract with you/the enrolled individual and Dr. Schwartz. If your insurance company determines that a particular service, is "*not reasonable and necessary*" or viewed as a "*not-covered service*" or the evaluation leads to diagnosis that is not covered, your insurance company may deny payment for that service.

You, alone, are responsible for payment of services and the insurance company may or may not reimburse you.

By signing this Agreement, I acknowledge that I have been made aware of Dr. Schwartz' Payment for Services Agreement and agree to abide by it. I also agree that his office can provide any requested medical, psychological and/or neuropsychological information to my carrier, or its agents, if required for determination or payment of benefits.

I am eligible for coverage under more than one health insurance policy (please circle): Yes No

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Client signature _____ Date _____

Guarantor (if different) _____ Date _____

Witness _____ Date _____



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NEUROPSYCHOLOGICAL HISTORY

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

Form completed by: _____ Relationship to child: _____

Date form completed: _____ Email Address: _____

Child's Name: _____ Gender: Male Female
First Middle Last

Date of Birth: _____ Age: _____

Address (home): _____ Phone: _____

Race: _____ Eyes: _____ Hair: _____ Height: _____ Weight: _____

Ethnic/Cultural Background (optional): _____

Primary language spoken in the home: _____ Other language spoken in the home: _____

School: _____

Father - Age: _____ Occupation: _____ Education: _____

Mother - Age: _____ Occupation: _____ Education: _____

Birth Order – Brothers: _____ Sisters: _____

Reason for Referral: _____

Who referred you to our office? How did you hear about our office? _____

****If you DO NOT want us to send a copy of our report to the referral source, please mark here**

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250 East Main Street, Suite 201
Canton, Georgia 30114
(770) 704-6159

CURRENT CONCERNS

What is the main reason for your child's referral today? _____

How long has your child had these problems? _____

What are you hoping to achieve at the completion of this evaluation? _____

Is your child currently receiving psychological treatment? Yes No If yes, with whom and how often?

What else have you tried to do to help your child with these problems, and how effective were these interventions? _____

FAMILY

(Please circle: Birth, Adoptive, or Foster)

Birth / Adoptive / Foster Mother's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Birth/Adoptive/Foster Father's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Stepmother's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Stepfather's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Other Guardian's Name: _____ Age _____ Education (Yrs) _____

Address (if different from child's) _____

Occupation: _____ Employer: _____

Work Phone: _____ Home Phone: _____

Relationship to child: _____

FOSTER/ADOPTIVE INFORMATION

(Please complete this information only if the child has ever been adopted or placed in foster care)

At what age was the child first placed in foster care?: _____ Why was the child placed in foster care?: _____

Who has legal custody of the child?: _____

Name of child's social worker: _____ Phone number: _____

Social worker address: _____

Has the social worker provided consent for this evaluation?: Yes No

(If YES, please attach authorization; If NO, please request authorization from county social services)

Is the child adopted?: Yes No If yes, specify country of origin if international: _____

Age when child was first in home: _____ Date of legal adoption: _____

If the child was adopted, do they know they were adopted?: Yes No

How many different foster care/adoptive placements has the child experienced?: _____

What type of placements has the child experienced (e.g., orphanage, foster home, group home, shelter care, kinship home, hospitalization, etc.): _____

Does the child have any contact with biological parents?: Yes No If yes, with whom, how often, are the visits supervised, how does the child respond after the visits?: _____

If the child is not yet adopted, is there a plan for this to happen?: Yes No If yes, what is the time frame?: _____

How has the child adjusted to foster care/adoption?: _____

List all family members/residents that reside in the house with the child:

Name	Age	Gender M/F	Relationship	Highest Grade Completed

If any brothers or sisters live outside the home, list their names, ages, where they are living, and why they are no longer in the home: _____

Are parents separated?: Yes No Divorced?: Yes No

When did you separate or divorce?: _____

Who has physical custody of the child?: _____

Who has legal custody of the child?: _____

Does the other parent see the child?: Yes No If yes, how often?: _____

Have there been any major changes within the family life or child's living situation that may have affected your child's development (i.e., deaths; moves; divorce; loss of job; natural disaster, etc.)?: Yes No

If yes, please describe:

Event	Date	Child's Age

DEVELOPMENT

Did mother receive prenatal care during the pregnancy? Yes No If yes, starting in which month?: _____

Number of the following the child's mother has had (including the current child being evaluated):

Pregnancies _____ Miscarriages _____ Premature Births _____

Did mother have any of the following during or immediately before/after the pregnancy (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Emotional stress | <input type="checkbox"/> Infections (cold, flu) | <input type="checkbox"/> Preterm labor/bed rest |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Abnormal weight gain |
| <input type="checkbox"/> Excessive swelling (edema) | <input type="checkbox"/> Measles/German measles | <input type="checkbox"/> Excessive vomiting |
| <input type="checkbox"/> Flu | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Vaginal bleeding-when? _____ | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Threatened miscarriage |
| <input type="checkbox"/> Epilepsy/seizure | <input type="checkbox"/> X-ray studies | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Other (Rh incompatibility, etc.) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other virus |
| <input type="checkbox"/> Maternal injury. Describe: _____ | | |
| <input type="checkbox"/> Operation/hospitalization during pregnancy. Reason: _____ | | |

Were any of the following used during mother's pregnancy? (check all that apply)

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Prescribed medications. (Please specify): _____ | For: _____ | |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Methamphetamines |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Heroin | <input type="checkbox"/> Methadone |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Other (specify) _____ |

BIRTH HISTORY

Age of mother at birth? _____ Age of father at birth? _____

Was infant born full term? Yes No Number of weeks gestation _____

Birth weight: _____ lbs. _____ oz. APGARS (if remembered) _____ at 1 min _____ at 5 min.

Type of Labor Onset: Induced Spontaneous

Type of Birth: Vaginal C/Section (Planned? Yes No Emergency? Yes No)
 Vaginal Birth after C/Section (VBAC) With Instruments (forceps)

Type of Anesthesia: Gas Spinal Local None

Baby's Presentation: Breech Head Transverse (sideways)

Please check the following problems that may have occurred during labor:

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Toxemia/eclampsia Fetal distress
Maternal fever Medications used (please specify):

Length of active labor: _____ hours. Describe any complications during delivery: _____

POST-DELIVERY PERIOD

Check which of the following problems may have occurred after the child's birth, if known:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Cord around the neck (# of times ____)	<input type="checkbox"/>	<input type="checkbox"/>	Poor feeding
<input type="checkbox"/>	<input type="checkbox"/>	Knot in cord	<input type="checkbox"/>	<input type="checkbox"/>	Did you nurse? How long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Required a blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhage (bleeding) in head	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting / reflux
<input type="checkbox"/>	<input type="checkbox"/>	Hydrocephalus (water on the brain)	<input type="checkbox"/>	<input type="checkbox"/>	Floppy muscle tone
<input type="checkbox"/>	<input type="checkbox"/>	Cyanosis (turned blue)	<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Need for ventilation	<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Incubator care	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Did the infant require x-ray/CT scan? Yes No Was the infant placed in NICU? Yes No If yes, how long? _____

Length of stay in the hospital: Mother: _____ days Child: _____ days

Were any of the following present in the child during the first few years of life? If so, please explain on the back of the page.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Did not enjoy cuddling	<input type="checkbox"/>	<input type="checkbox"/>	Was not calmed by being held or stroked
<input type="checkbox"/>	<input type="checkbox"/>	Difficult to comfort	<input type="checkbox"/>	<input type="checkbox"/>	Excessive restlessness
<input type="checkbox"/>	<input type="checkbox"/>	Excessive irritability	<input type="checkbox"/>	<input type="checkbox"/>	Frequent head banging
<input type="checkbox"/>	<input type="checkbox"/>	Difficult feeding	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Extremely passive	<input type="checkbox"/>	<input type="checkbox"/>	Early learning problems
<input type="checkbox"/>	<input type="checkbox"/>	Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawn behaviors
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Poor eye contact
<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>	Unable to separate from parent
<input type="checkbox"/>	<input type="checkbox"/>	Destructive behavior	<input type="checkbox"/>	<input type="checkbox"/>	Failure to thrive/poor weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Other:

Was your child adaptable, easy to please and easy to discipline as an infant and toddler? Yes No If no, please describe: _____

As an infant, was your child interested in social contact (i.e., eye contact, sharing, etc.)? Yes No If no, please describe: _____

Describe your child regarding his/her ease of self-regulation (i.e., ability to settle down at night, calm self when upset, etc.): _____

Please list the approximate age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A. If unsure, please write DK for "I don't know."

<u>Age</u>	<u>Skill</u>	<u>Age</u>	<u>Skill</u>
_____	Smile in response (social smile)	_____	Knew primary colors
_____	Sit independently	_____	Say the letters of the alphabet
_____	Crawl independently	_____	Print first and last name
_____	Walk independently	_____	Tie shoes
_____	Say "mama" or "dada" specifically	_____	Snap, zip, button clothing
_____	Say 1 st word other than "mama" or "dada"	_____	Began to read
_____	Put two words together	_____	Toilet trained (urine)
_____	Put 4-5 sentences together to relate an experience	_____	Toilet trained (bowel)
_____	You understood 100% of what child said		

Were there any concerns about toilet training? Yes No If yes, please explain: _____

Has your child ever lost skills that he/she was able to perform at one time? Yes No If yes, please explain: _____

MEDICAL/HEALTH HISTORY

Physician: _____ Phone: _____

Address: _____

Date of last physical exam: _____

Vision problem? Yes No Date of last vision exam: _____

Hearing problem? Yes No Date of last hearing exam: _____

Appetite concerns? Normal Picky Eat too much Weight loss/gain

Oral-motor concerns? None Difficulty swallowing Drooling Gagging

Where does your child sleep? Own bedroom Bedroom parent(s) sleep in Shared bedroom with:

Does your child have problems falling asleep? Yes No If yes, how long does it take? _____

Does your child wake up in the middle of the night? Yes No If yes, how many times per night? _____

If yes, why? _____ How long does it take for them to go back to sleep? _____

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for Discontinuing

Has your child been given a specific diagnosis?

- | | | |
|--|--|---|
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Language disorder | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Attention Deficit Disorder (ADHD) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Oppositional Defiant Disorder (ODD) | <input type="checkbox"/> Tourette's Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Autism/ Asperger's/ PDD | <input type="checkbox"/> Fragile X | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Genetic Disorder | |

Surgeries – (Age/Reason): _____

Hospitalizations – (Age/Reason): _____

Major accidents or injuries – (Age/Details): _____

Has your child ever been unconscious? Yes No If yes, please explain: _____

Does your child have current problems with:

	Yes	No	?		Yes	No	?
Ears (specify) R L Both				Appetite, digestion, stomach problems			
Poor hearing				Frequent stomach aches			
Chronic earaches/infections				Poor eating habits			
Draining ears				Frequent vomiting			
				Soiling or daytime accidents			
Eyes (specify) R L Both				Constipation			
Poor vision				Problems with weight			
Crossed eyes							
Wears glasses				Hematology (Blood)			
				Anemia			
Endocrine				Excessive bleeding or bruising			
Thyroid problems				Leukemia			
Diabetes				Sickle cell disease			
Hypo/Hyperpituitarism				Other:			
Growth problems							
Other:							
				Excretory System			
				Urine and/or bladder problems			
Nervous System				Bedwetting			
Frequent and/or severe headaches				Daytime wetting and/or accidents			
Seizures or convulsions				Urinary tract infections			
Tremors or twitches							
Coordination problems				Respiratory System			
Balance problems				Wheezing and/or asthma			
Frequent dizziness				Other:			
Other:							
Cancer				HIV/AIDS			

Has your child had any of the following?

- | | | | |
|--------------------------------|------------------------------|-----------------------------|---|
| Ear Tubes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, number of tube placements _____ |
| Encephalitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Meningitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Poisoning or drug intoxication | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Coma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, what was the cause? _____ |
| Staring spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Immune system disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Other significant illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

If yes to any of the above, please provide additional details: _____

Has your child had any of the following tests or treatments?

	Yes	No	Date (month/year)	Where	Results
Neurologic Evaluation					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
CT Scan of head					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
MRI of head					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
EEG					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
Genetic Testing					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
Chemotherapy					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
Radiation Therapy					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
Other					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know
					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Don't know

Has your child ever had: Traumatic Brain Injury Seizure CVA/Stroke Aneurysm Heart Attack

If yes, please provide the details for each on the back side of this page:

Date: _____ Loss of Consciousness: Yes No If yes, how long? _____

PERSONAL/SOCIAL INFORMATION

What are your child's main hobbies and interests?: _____

What about your child makes you most proud?: _____

What does your child dislike doing most?: _____

How many **close** friends does your child have?: _____ Does your child have a best friend?: Yes No

If yes, how old is he/she?: _____ How long have they been friends?: _____

How easily does your child make friends?: Worse than average Average Better than average

Does your child have problems keeping friends?: Yes No

How well does your child get along with friends?: Worse than average Average Better than average

If worse than average, please explain: _____

Does your child get along best with: Older children Children of the same age Younger children

Social Activities: _____

Hobbies: _____

Amount of Social/Leisure Time/Week: _____

FAMILY MEDICAL HISTORY

Father's health, learning, mental health problems (please specify): _____

Child's siblings' health, learning, mental health problems (please specify): _____

Have any of the child's family members had the following problems/disorders? Please specify the family member's relationship to the child and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

Family Member(s) Relation

Family Member(s) Relation

- | | |
|--|--|
| <input type="checkbox"/> Birth Defect _____ | <input type="checkbox"/> Reading Problem(s) _____ |
| <input type="checkbox"/> Genetic Disorder _____ | <input type="checkbox"/> Other Learning Disability _____ |
| <input type="checkbox"/> Cerebral Palsy _____ | <input type="checkbox"/> Speech/Language Delay _____ |
| <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Intellectual Disability _____ |
| <input type="checkbox"/> Multiple Sclerosis _____ | <input type="checkbox"/> Autism/Asperger's _____ |
| <input type="checkbox"/> Physical Handicap _____ | <input type="checkbox"/> ADHD _____ |
| <input type="checkbox"/> Huntington's Chorea _____ | <input type="checkbox"/> Oppositional Behaviors _____ |
| <input type="checkbox"/> Muscular Dystrophy _____ | <input type="checkbox"/> Antisocial Behavior _____ |
| <input type="checkbox"/> Sickle Cell Anemia _____ | <input type="checkbox"/> Aggression _____ |
| <input type="checkbox"/> Seizures/Epilepsy _____ | <input type="checkbox"/> Tics/Tourette's Disorder _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Anxiety/Nervousness _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Obsessive-Compulsive _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Alcohol Abuse _____ | <input type="checkbox"/> Bipolar Disorder _____ |
| <input type="checkbox"/> Drug Abuse _____ | <input type="checkbox"/> Schizophrenia _____ |
| <input type="checkbox"/> Physical Abuse _____ | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Sexual Abuse _____ | <input type="checkbox"/> _____ |

Have any maternal family members ever received extra help in school, early intervention, or special education services? Yes No If yes, who and why?: _____

EDUCATIONAL HISTORY

Has your child ever received Early Childhood Intervention services?: Yes No If yes, please explain:

Did your child attend preschool?: Yes No If yes, at what age?: _____

Name of preschool: _____

Were there any adjustment problems?: Yes No If yes, please explain: _____

Were you concerned about your child's ability to succeed in preschool?: Yes No If yes, please explain:

Name of your child's current school: _____

School District: _____

Address of school: _____

Phone number: _____ Grade: _____ Teacher: _____

Has your child ever been retained?: Yes No What grade(s)?: _____ Why?: _____

How often is your child absent from school?: Often Seldom Never

Usual reason for absence: _____

If your child is in school, please comment on the areas below:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance					
Reading					
Writing					
Mathematics					
Relationship with teachers					
Relationship with peers					
Participation in organized activities					

Has testing been completed by the school?: Yes No Date: _____ *(Please provide a copy)*

By whom?: _____

Present class placement: Regular Education class Special Education class (specify): _____
 Bilingual/ESL class Gifted and Talented

Does your child have an IEP (Individualized Education Plan)?: Yes No

Does your child have a 504 plan?: Yes No

Is your child currently participating in Response to Intervention (RTI)?: Yes No If yes, what Tier?: _____

Please provide copies of any plans/documents.

Special Education Categories: Please check all that apply (specify since what grade child has been in this placement):

- | <u>Category</u> | <u>Grade</u> |
|--|--------------|
| <input type="checkbox"/> Autism Spectrum Disorder (ASD) | _____ |
| <input type="checkbox"/> Communication Disorder | _____ |
| <input type="checkbox"/> Deaf – Blind | _____ |
| <input type="checkbox"/> Developmental Delay | _____ |
| <input type="checkbox"/> Emotional Disability (ED) | _____ |
| <input type="checkbox"/> Hearing Impairment | _____ |
| <input type="checkbox"/> Intellectually Disabled (ID) | _____ |
| <input type="checkbox"/> Learning Disability (LD) Specify: | _____ |
| <input type="checkbox"/> Multiple Disabilities | _____ |
| <input type="checkbox"/> Orthopedic Impairment | _____ |
| <input type="checkbox"/> Other Health Impaired (OHI) | _____ |
| <input type="checkbox"/> Traumatic Brain Injury (TBI) | _____ |
| <input type="checkbox"/> Visual Impairment | _____ |
| <input type="checkbox"/> Other Specify: | _____ |

Have any of the following instructional modifications been attempted?:

- | | |
|--|---|
| <input type="checkbox"/> Oral tests | <input type="checkbox"/> Study sheets |
| <input type="checkbox"/> Additional instructions | <input type="checkbox"/> Control of distractions |
| <input type="checkbox"/> Manipulatives in math | <input type="checkbox"/> Behavior modification program |
| <input type="checkbox"/> Preferential seating | <input type="checkbox"/> Instructional technology |
| <input type="checkbox"/> Peer teaching | <input type="checkbox"/> Outlines |
| <input type="checkbox"/> Reduced paper and pencil work | <input type="checkbox"/> Positive reinforcers |
| <input type="checkbox"/> Repeated review | <input type="checkbox"/> Behavior check cards/charts |
| <input type="checkbox"/> Study carrel | <input type="checkbox"/> Predictable routines and classroom rules |
| <input type="checkbox"/> Extended time to complete assignments | <input type="checkbox"/> Increased positive feedback |
| <input type="checkbox"/> Shortened or modified assignments | <input type="checkbox"/> Other: |

How successful have the above interventions been?: _____

Curriculum Materials

What are the names of your child's current textbooks and publishers (curricular materials)? Please note, you may have to ask your child's teacher(s).

English/Language Arts Curriculum: _____

Math Curriculum: _____

Science Curriculum: _____

Social Studies Curriculum: _____

History Curriculum: _____

Other Curricula: _____

BEHAVIOR AND DISCIPLINE

Please describe briefly any behavioral problems at school: _____

Has your child ever been assigned: Out of school suspension Yes No Number: _____

In school suspension Yes No Number: _____

Expulsions Yes No Number: _____

Please describe briefly any behavioral problems at home: _____

Types of discipline you use with your child:

Rewards

Verbal reprimands/demands

Time out

Removal of privileges

Ignoring behavior

Physical punishment

Giving in to child

Other (please specify): _____

Which form(s) of discipline has proven most effective?: _____

Which form(s) of discipline has proven least effective?: _____

Any other behavioral concerns or other comments: _____

SYMPTOM SURVEY

Below is a list of items and behaviors that commonly describe people. Please check all behaviors that your child currently exhibits or has exhibited in the past. Please add any helpful comments next to the items.

PROBLEM SOLVING

- | Current | Past | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty figuring out how to do new things |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty making decisions |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty planning ahead |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty solving problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Disorganized in his/her approach to problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty understanding explanations |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty doing things in the right order (sequencing) |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty verbally describing the steps involved in doing something |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty completing an activity in a reasonable period of time |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty changing a plan or activity when necessary |
| <input type="checkbox"/> | <input type="checkbox"/> | Is slow to learn new things |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty switching from one activity to another activity |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily frustrated |
| <input type="checkbox"/> | <input type="checkbox"/> | Other problem solving difficulties: |

SPEECH, LANGUAGE, AND MATH SKILLS

- | Current | Past | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty speaking clearly |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty finding the right word to say |
| <input type="checkbox"/> | <input type="checkbox"/> | Not talking |
| <input type="checkbox"/> | <input type="checkbox"/> | Rambles on and on without saying much |
| <input type="checkbox"/> | <input type="checkbox"/> | Jumps from topic to topic |
| <input type="checkbox"/> | <input type="checkbox"/> | Odd or unusual language or vocal sounds |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty understanding what others are saying |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty understanding what you are reading |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty writing letters or words |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty reading letters or words |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with math |
| <input type="checkbox"/> | <input type="checkbox"/> | Other speech, language, or math problems: |

SPATIAL SKILLS

- | Current | Past | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion telling right from left |
| <input type="checkbox"/> | <input type="checkbox"/> | Has difficulty with puzzles, or assembling items from diagrams |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems drawing or copying |
| <input type="checkbox"/> | <input type="checkbox"/> | Don't know your colors |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty dressing (not due to physical difficulty) |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems finding way around places he/she has been to before |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty recognizing objects |
| <input type="checkbox"/> | <input type="checkbox"/> | Seem unable to recognize facial or body expressions of disapproval or emotions |
| <input type="checkbox"/> | <input type="checkbox"/> | Gets lost easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Other spatial problems: |

AWARENESS AND CONCENTRATION

- | Current | Past | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Easily distracted by: Sounds <input type="checkbox"/> Sights <input type="checkbox"/> Physical sensations <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Mind appears to go blank at times |
| <input type="checkbox"/> | <input type="checkbox"/> | Loses train of thought |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty concentrating on what others say, but can sit in front of a TV for long periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Attention starts out OK but can't keep it up |
| <input type="checkbox"/> | <input type="checkbox"/> | Other attention or concentration problems: |

MEMORY

- | Current | Past | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Forget where he/she leaves things |
| <input type="checkbox"/> | <input type="checkbox"/> | Forget things that happened recently (e.g., last meal) |
| <input type="checkbox"/> | <input type="checkbox"/> | Forget things that happened days/weeks ago |
| <input type="checkbox"/> | <input type="checkbox"/> | Forget what he/she is supposed to be doing |
| <input type="checkbox"/> | <input type="checkbox"/> | Forget names more than most people do |
| <input type="checkbox"/> | <input type="checkbox"/> | Forget school assignments |
| <input type="checkbox"/> | <input type="checkbox"/> | Forget instructions |
| <input type="checkbox"/> | <input type="checkbox"/> | Other memory problems: |
| <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | |

PHYSICAL

- | Current | Past | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequently complain of headaches or nausea How often? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have dizzy spells How often? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have pains in joints Where? |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive tiredness When? |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination or drinking |
| <input type="checkbox"/> | <input type="checkbox"/> | Other physical problems: |

MOTOR AND COORDINATION

Current	Past
---------	------

- | | | | | | |
|--------------------------|--------------------------|--|---------------|---------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fine motor control problems (using a pen/pencil) | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Clumsy | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremor | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscles are tight or spastic | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Odd movements (posturing, peculiar hand movements, etc.) | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Drop things more than most people | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Have an unusual walk | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Balance problems | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other motor or coordination problems: | | | |

SENSORY

Current	Past
---------	------

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Needs to squint or move closer to page to read | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems seeing objects | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of feeling | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems hearing sounds | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty telling hot from cold | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty smelling odors | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty tasting food | R side | L side | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Overly sensitive to: | <input type="checkbox"/> Touch | <input type="checkbox"/> Light | <input type="checkbox"/> Noise |
| <input type="checkbox"/> | <input type="checkbox"/> | Other sensory problems: | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | |

BEHAVIOR

Current	Past
---------	------

- | | | |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aggressive |
| <input type="checkbox"/> | <input type="checkbox"/> | Attached to things, not people |
| <input type="checkbox"/> | <input type="checkbox"/> | Toileting Accidents (day / night) |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual behavior |
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel movements in underwear |
| <input type="checkbox"/> | <input type="checkbox"/> | Dependent |
| <input type="checkbox"/> | <input type="checkbox"/> | Depressed |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating habits are poor |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional |
| <input type="checkbox"/> | <input type="checkbox"/> | Fearful |
| <input type="checkbox"/> | <input type="checkbox"/> | Immature |

Current	Past
---------	------

- | | | |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous |
| <input type="checkbox"/> | <input type="checkbox"/> | Nightmares, night terrors, sleepwalks |
| <input type="checkbox"/> | <input type="checkbox"/> | Quiet |
| <input type="checkbox"/> | <input type="checkbox"/> | Resists change |
| <input type="checkbox"/> | <input type="checkbox"/> | Risk-taking |
| <input type="checkbox"/> | <input type="checkbox"/> | Self-mutilates |
| <input type="checkbox"/> | <input type="checkbox"/> | Self-stimulates |
| <input type="checkbox"/> | <input type="checkbox"/> | Shy and withdrawn |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleeping habits are poor |
| <input type="checkbox"/> | <input type="checkbox"/> | Swears a lot |
| <input type="checkbox"/> | <input type="checkbox"/> | Unmotivated |

Does your child currently (within the past 6 months) display any of the following behaviors frequently?

These behaviors should occur more frequently than in others the same age

- | | | |
|--|--|---|
| <input type="checkbox"/> Fainting, falling | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Obsessive-compulsive behaviors |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Short attention span | <input type="checkbox"/> Stereotyped/repetitive behaviors |
| <input type="checkbox"/> Shy, timid | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> Physical aggression |
| <input type="checkbox"/> Lack of confidence | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Use of profanity |
| <input type="checkbox"/> Crying episodes | <input type="checkbox"/> Attention seeking | <input type="checkbox"/> Skipping work |
| <input type="checkbox"/> Unhappiness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Concern with weight | <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Destructiveness |
| <input type="checkbox"/> Sleep problem | <input type="checkbox"/> Oppositional behavior | <input type="checkbox"/> Cruelty to animals |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Noncompliance | <input type="checkbox"/> Gang Involvement |
| <input type="checkbox"/> Unusual fears | <input type="checkbox"/> Defiance | <input type="checkbox"/> Cigarette use |
| <input type="checkbox"/> Avoidance | <input type="checkbox"/> Lying | <input type="checkbox"/> Alcohol / Substance use |
| <input type="checkbox"/> Laziness | | |
| <input type="checkbox"/> Other: | | |

Overall these symptoms have developed: Slowly Quickly

The symptoms occur: Occasionally Often

Over the past six (6) months, the symptoms have: stayed about the same worsened

SERVICES/INTERVENTIONS PREVIOUSLY SOUGHT

- | | | |
|--|--|---|
| <input type="checkbox"/> Medical Evaluation | <input type="checkbox"/> Neurological Exam/Evaluation | <input type="checkbox"/> Psychiatric Exam/Evaluation |
| <input type="checkbox"/> Neuropsychological Evaluation | <input type="checkbox"/> Speech/Language Evaluation/Therapy | <input type="checkbox"/> Psychological Evaluation/Treatment |
| <input type="checkbox"/> Occupational Evaluation/Treatment | <input type="checkbox"/> Physical Therapy Evaluation/Treatment | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Other: | | |

Has your child had any of the following forms of psychological treatment? If so, how long did it last?

- | | | | |
|--------------------------|------------------------------|-----------------------------|------------------------|
| Individual psychotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Duration of therapy? |
| Group psychotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Duration of therapy? |
| Parenting classes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Duration of classes? |
| Residential treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Duration of placement? |



Powers Ferry Psychological Associates, L.L.C.

The Offices of:

Gerald S. Drose, Ph.D.
Dina M. Zeckhausen, Ph.D.
Steven Perlow, Ph.D.

David M. Schwartz, Ph.D., ABPdN
Abby L. Friedman, Ph.D.
Kimberly Smiley, Psy.D.
Jennifer Spring, Ph.D.

And the Offices of:

Martin Fleet, Ph.D.
Susan Berel, Ph.D.
Elaine Eassa, Ph.D.
Keith Helmken, LCSW

Jennifer Swales, Ph.D.
Rachel Scheinfeld, Ph.D.
Brian Smith, Psy.D.
Katherine Higgins, Ph.D.

Consent for Evaluation

I, _____, hereby authorize and request that David M. Schwartz, Ph.D. evaluate me, based on his professional opinion.

I understand that I have no obligation whatsoever to grant this permission and that I may revoke this consent at any time by informing David M. Schwartz, Ph.D. in writing. I further understand that this authorization is valid until I revoke this privilege in writing.

I also acknowledge, with my signature, that David M. Schwartz, Ph.D. has explained to me the nature, purpose, and basic procedures of this evaluation.

In consideration of this consent, I hereby release David M. Schwartz, Ph.D. from any legal liability resulting from this evaluation.

Signature: _____ Date: _____

or

Signature: _____ Date: _____
(Parent, Guardian, or Legal Representative)

Marietta/East Cobb

1827 Powers Ferry Rd., Bldg. 22
Atlanta, GA 30339
Office: 770.953.4744 / Fax: 770.953.4640

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Release of Information

I hereby authorize _____

to: release receive exchange

any and all information concerning _____ (Name of Patient, DOB)

to from with **David M. Schwartz, Ph.D., ABPdN**

I understand that such disclosure will be made for the following purposes:

- | | | |
|--|---|--|
| <input type="checkbox"/> Neuropsychological Evaluation | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Child Custody/Visitation |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Social History | <input type="checkbox"/> Competency to stand trial |
| <input type="checkbox"/> Medical Treatment | <input type="checkbox"/> Treatment Progress | <input type="checkbox"/> Treatment Summary |
| <input type="checkbox"/> Academic Placement | <input type="checkbox"/> Other _____ | |

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein, and if not earlier revoked, it shall terminate 365 days from date of signature without revocation.

I understand that disclosures may not be subject to confidentiality if Dr. Schwartz becomes aware of any suicidal or homicidal thoughts or plans, or any form of abuse or neglect.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read or had read to me, the above information and understand the contents.

_____ I authorize this information to be faxed or emailed to the party indicated above and understand
Initial the limits of confidentiality which doing so creates.

Signature: _____ Date: _____

or

Signature: _____ Date: _____
(Parent, Guardian, or Legal Representative)