Client Information and Agreement

Welcome to my practice. This document contains important information about how I like to work with my clients. Please read it carefully and jot down any questions you might have so that we can discuss them when we meet.

Psychological Services

Psychotherapy varies depending on the personalities of the psychologist and client, and the particular problems you bring forward. To help you, I may use many different methods, including Cognitive-Behavioral Therapy (CBT), solution-focused therapy, family therapy, and others. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

While psychotherapy has been shown to have significant benefits for most people who apply themselves to it, no outcome is guaranteed, and it can be unpleasant, difficult work. Because it often involves discussing troublesome aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.

Our first few sessions will be an evaluation of how best to meet your needs. By the end of the evaluation, I will be able to offer you an assessment of your situation and a plan for moving forward. You should evaluate this information along with your own sense of how comfortable you feel working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. Most clients have questions about the process of therapy, and I encourage you to raise those so we can discuss them when they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Contacting Me / What to do in an Emergency

I am often not immediately available by telephone. I check voicemail daily, except weekends and holidays, and will make every effort to return your call as soon as I get it. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, the nearest emergency room, or Crisis Support Services at 1 (800) 309-2131. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Arriving Late

If you are going to be more than 10-15 minutes late, please call me to let me know, or I may not be available when you arrive.

Ted G. Obbard
Licensed Clinical Psychologist
License #PSY 21799

5480 College Avenue
Oakland, CA 94618 • (510) 652-5253
email: DrTedObbard@Gmail.com

Fees

I charge $180 for a 50-minute session. I give a $5 discount for payment by cash or check. I prefer that you pay at the time of the session. If you would like to set up a different arrangement, please let me know. Once we schedule an appointment, you will be expected to pay for it unless you provide 48 (weekday) hours advance notice of cancellation.

I charge my regular fee for other professional services, including phone calls lasting longer than 10 minutes, emails, assessment, report writing, attendance at meetings with other professionals you have authorized, etc. I generally raise my rate $5-10 each January 1st. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $350 per hour for preparation and attendance at any legal proceeding.

Confidentiality

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

- If I believe that a child, elderly person, or disabled person is being abused, I am required to file a report with the appropriate state agency.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- If a client presents a threat of bodily harm to another, I am required to notify the potential victim and contact the police. I also may need to seek hospitalization for the client.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

In most legal proceedings, you have the right to prevent me from providing information about your treatment. In proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

If you pay for any part of our sessions through insurance, your insurance company and related companies, such as billing companies, will gain access to some of your private information.

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 at our next meeting. I will be happy to discuss these issues with you.

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Electronic Communication

If you provide me with your email address or mobile phone number, I will assume that you consent to my communicating with you by email and text, respectively. Because email and text cannot be guaranteed to be secure, please let me know if there are types of information that you would like kept out of such communications. If you need an immediate response, please contact me by phone.

If you would like to use videoconferencing (e.g. via Doxy.me), please let me know. You are by no means required to do so. If we do, I will not record our sessions, and all of your regular confidentiality protections and HIPAA rights (see below) remain in full force. In addition, you can decide at any time that you do not want to use videoconferencing and I will work with you to find other ways to continue the therapy. Be aware that while videoconferencing has benefits (e.g. less travel, remote sessions), some of the benefits of psychotherapy may be lost. For example, it may be harder for me to know how to be helpful to you, and there is more potential for misunderstanding. In addition, our session may get interrupted if there is an electrical or internet outage.

Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have.

Insurance

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a PPO health insurance policy, it will usually provide some coverage for mental health treatment. I will give you a bill for my services that you can submit to your insurance carrier for reimbursement. In addition, I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

For you to receive reimbursement, most insurance companies require me to provide them with information about you and about our sessions such as: when we met, for how long, what kind of treatment I am providing, and a clinical diagnosis. Your signature below indicates that you agree to my sharing such information with these companies. This information will become part of their files and will probably be stored in a computer. Though all such companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

Videotaping

To help me improve our therapy, I may videotape sessions. In using these recordings, I adhere to all ethical standards of professional confidentiality for licensed psychologists. If you agree to my taping our sessions, please sign in the box below. The videos will not be kept as part of your clinical record.

Consent for Videotaping

I understand that my therapy sessions may be recorded and that these recordings may be used privately and in consultation with colleagues to improve the quality of my therapy.

I understand that I will not receive financial compensation for the use of these recordings. I understand that my participation is fully voluntary and that, should I wish it at any time, these recordings will be destroyed at my written request.

_____ _____

Signature of patient or parent/guardian Date

_____ _____

Signature of patient or parent/guardian Date

Access to Records

As outlined in the accompanying HIPAA Notice of Privacy Practices, you have certain rights to your Health Insurance Portability and Accountability Act (HIPAA) – defined Protected Health Information. In addition, you are entitled to review or receive any other records that I keep, unless I believe that seeing them would be emotionally damaging. I generally recommend that we review records together. Alternately, I may be able to prepare a summary for you or to send them to a mental health professional of your choice who can review them with you.

Your signature below indicates that you have read and agree to the information in this document.

_____ _____

Signature Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date

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Collateral Agreement

This document informs you of your rights, responsibilities, and risks as a 'collateral' participant in therapy.

The Role of Collaterals

A collateral is usually a parent, spouse, or friend who participates in therapy to assist the person, couple, or family receiving therapy. The collateral is not considered to be a patient and is not the subject of the treatment. Psychologists have certain legal and ethical responsibilities to patients, and the privacy of the relationship is given legal protection. Collaterals have less privacy protection. A collateral might attend only one session, either alone or with the patient, or a collateral might attend all of the patient's therapy sessions. We will discuss your specific role in treatment at our first meeting and at other appropriate times.

Benefits and Risks

Psychotherapy often engenders intense emotional experiences, and your participation may engender strong anxiety or emotional distress. It may also expose or create tension in your relationship with the patient or others. While your participation can result in better understanding of the patient or an improved relationship, or may even help in your own growth and development, there is no guarantee that this will be the case. Psychotherapy is a positive experience for many, but it is not helpful to all people.

Medical Records

No record or chart will be maintained on you in your role as a collateral. Notes about you may be entered into the patient's chart. The patient has a right to access the chart and the material contained therein. You have no right to access that chart without the written consent of the patient. You will not carry a diagnosis, and there will be no individualized treatment plan for you.

Fees

As a collateral, you are not responsible for paying for my professional services unless you are financially responsible for the patient.

Confidentiality

The confidentiality of the information in the patient's chart, including the information that you provide me, is protected by both federal and state law. It can only be released if the patient specifically authorizes me to do so. There are some exceptions to this general rule.

If there is reasonable suspicion of child or elder abuse, I am will file a report with the appropriate agency.

If you are a danger to yourself, or if you threaten serious bodily harm to another person, I will take action to protect you and/or the other(s), even if I must reveal your identity to do so.

If you, or the patient, is involved in a lawsuit, and a court requires that I submit information or testify, I will have to comply.

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If insurance is used to pay for treatment, the client's insurance company may require me to submit information about the treatment for claims processing or utilization review.

Do Collaterals Ever Become Patients?

Collaterals may discuss their own problems in therapy, especially problems that interact with issues of the patient. As appropriate, I may recommend therapy or other services for the collateral. In these situations, I usually refer the collateral to another clinician for therapy. This allows me to keep my focus on my initial patient and avoid any dual role or confusion about goals and treatment plans. Sometimes, however, I will see both patients, especially when a family therapy approach can be effectively and ethically used to treat all members of the family or couple.

Release of Information

The patient is not required to sign an authorization to release information to the collateral when a collateral participates in therapy. The presence of the collateral with the consent of the patient implies the patient's consent to release information to the collateral.

Parents as Collaterals

Clinicians specializing in the treatment of children have long recognized the need to treat children in the context of the family. Participation of parents, siblings, and sometimes extended family members, is common and often recommended. Parents participating as collaterals in the treatment of their minor child have more rights and responsibilities than other collaterals do.
In treatment involving children and their parents, access to information is an important and sometimes contentious topic. Particularly for older children, trust and privacy are crucial to treatment success. At the same time, parents also need to know certain information about the treatment. For this reason, we need to discuss and agree about what of the information the child reveals in therapy will be shared with the parent and what will remain private. In general, I believe that parents should be informed about the goals of treatment, whether the child is coming to his or her appointments, and generally how the treatment is going. In addition, I will always inform parents if I think their minor child is in significant danger.

Summary

If you have questions about therapy, my procedures, or your role in this process, please discuss them with me. The best way to assure quality, ethical treatment is to keep our communication open and direct.

Your signature below indicates that you have read and agree to the information in this document.

_____ _____

Signature Date

Ted G. Obbard
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License #PSY 21799

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Notice of Privacy Practices

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

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. In addition, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website.

III. HOW I MAY USE AND DISCLOSE YOUR PHI
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, any other licensed health care providers who provide you with health care services or are involved in your care. For example, if you are being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. For health care operations. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountants, attorneys, consultants, and others to make sure that I am complying with applicable laws.
4. Other disclosures. I may also disclose your PHI to others without your consent in certain situations. For example, your consent is not required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but your are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by law; judicial or administrative proceedings; or law enforcement. For example, I may make a disclosure to applicable officials with a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
3. For workers' compensation purposes. I may provide PHI in order to comply with workers' compensation laws.
4. For public health activities. For example, I may have to report information about you to the county coroner.
5. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a healthcare provider or organization.
6. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
7. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
8. Appointment reminders and health related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

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C. You Have the Right to Object to Disclosures to Family, Friends, or Others Involved in Your Care. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

IV: RIGHTS YOU HAVE REGARDING YOUR PHI

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I send PHI to You. You have the right to ask that I send information to you at an alternate address or by alternate means. I must agree to your request so long as I can easily provide the PHI to you in the format you request.

C. The Right to see and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 per page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and the cost in advance.

D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances over the previous six years in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made directly to you, or to your family, or for treatment, payment, or health care operations. The list also will not include uses and disclosures made for national security purposes, or to corrections or law enforcement personnel.

E. The Right to Request Corrections or Updates to Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI.

F. The Right to Get this Notice by Email. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES. If you think that I may have violated your privacy rights, or you disagree with a decision I make about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES. If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Dr. Ted Obbard, 2801 Piedmont Avenue, Berkeley, CA 94705, (510) 495-5080; DrTedObbard@Gmail.com

This notice went into effect on January 1, 2008.

I have received, reviewed, and agree to the above Notice of Privacy Practices:

Name: _____

Signature: _____ Date: _____

Confidential Information Sheet – Child, Adolescent, and Family

(to be filled out by parent or guardian)

Child's Name: _____ Today's Date: _____

Address: _____ Phone (Home): _____

Child's Birthday: _____Age: _____

School: _____ School District: _____ Grade: _____

Religion / Spirituality (if any): _____ Ethnicity: _____

Pediatrician: _____

Date of Last Medical Check-Up: _____ Referred by: _____

Name of Person Completing Form: _____ Relationship to Child: _____

Parents are: □ Married □ Divorced □ Separated □ Unmarried

If divorced, who has legal custody : _____

Mother's name: _____ Hm Ph#: _____ Cell/Wk Ph#: _____

Father's name: _____ Hm Ph#: _____ Cell/Wk Ph#: _____

Emergency Contact: _____ Day time Ph#: _____

Guardian's name, if different: _____ Day time Ph#: _____

Consent for Treatment

I am the legal guardian of _____, I have full legal authority to consent to treatment, and I consent to mental health evaluation and treatment of him/her by Dr. Ted Obbard.

_____ _____

Signature of Parent / Guardian Date

_____ _____

Signature of Patient (12 and older), if applicable Date

Child's Main Problem / Main reason(s) for seeking help: _____

_____

_____

_____

Other Behavior or Emotional Problems: _____

_____

_____

Impact on the Family of these Problems: _____

_____

_____

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Your Child's Unique Qualities and Strengths _____

_____

_____

What have you tried to do to deal with your child's main problem? _____

_____

_____

Have you tied counseling previously for your child? If so, for what? _____

_____

_____

How are you hoping therapy will help you and your child? _____

_____

How long are you hoping it will take? _____

Has there been any abuse of the child?	Physical	□ Yes	□ No
	Sexual	□ Yes	□ No
	Emotional	□ Yes	□ No
	Neglect	□ Yes	□ No

If yes, please describe briefly _____

_____

_____

Is there any legal action pending? If yes, please describe: _____

_____

Is there any history of legal action? If yes, please describe: _____

_____

Custody	□ Yes	□ No
Visitation	□ Yes	□ No
Probation	□ Yes	□ No
Child Protection	□ Yes	□ No
Adoption	□ Yes	□ No

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Behavior Checklist: Please check any of the following behaviors that concern you:

	Now	Past		Now	Past		Now	Past
Sadness, crying, depression			Temper outbursts			Worries more than others		
Loss of enjoyment of usual activities			Irritable, angry			Unusual fears or phobias		
Expressing a wish to die			Argues a lot			Panics		
Bedtime fears, won't sleep			Disobeys			Anxious, nervous		
Has threatened or attempted suicide			Does things that annoy other people			Repeats an act over and over that is unnecessary (e.g. washing, checking doors, counting, lining things up)		
Sleepwalking			Blames others for own mistakes			Is overly concerned about things (e.g. germs, safety, or their health)		
Withdrawn			Easily annoyed by others			Has rituals, habits, superstitions		
Nightmares, night terrors			Swears and uses obscene language			Twitches or unusual movements		
Low self-esteem						Eats little or fasts to lose weight		
Low motivation level			Wanting to run away			Gorges on food		
Tiredness, fatigue			Sneaks out at night			Injures self		
Daydreams, fantasizes			Stealing			Hallucinations (hears or sees things that aren't there)		
Poor appetite			Lying			Vomits intentionally		
Under or overweight			Hurts animals			Strange or unusual behavior		
Trouble going to sleep			Hurts people			Disorientation (confused about the time, who he/she is and where he/she is)		
Sleeps too much			Destroys property			Bedwetting/daytime wetting		
Easily Distracted			Drug use			Soiling (pooping) in pants		
Over activity			Alcohol use			Waking up very early and unable to go back to sleep		
Frequently acts without thinking			Cigarette use			Restless sleep, wakes up frequently		
Doesn't finish things			Sexual problems			Has been arrested and/or on probation		
Disruptive			Problems with authority					
Short attention span			Problems with the law					

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Check items that describe your child's relationship development (present or past):

- ☐ Prefers to be alone
- ☐ Is alone a lot, but is lonely
- ☐ Is shy
- ☐ Has few friends
- ☐ Has many friends
- ☐ Plays with "problem kids"
- ☐ Is picked on a lot
- ☐ Poor relationship with teacher(s)
- ☐ Is oversensitive
- ☐ Is demanding and bossy
- ☐ Fights with others
- ☐ Bullies others
- ☐ Teases a lot
- ☐ Plays with younger kids
- ☐ Plays with older kids
- ☐ Poor relationship with peers
- ☐ Has difficulty getting along with sibling(s)
- ☐ Conflict with parents or step-parents

Forms of discipline used:

- ☐ Time out
- ☐ Loss of privileges
- ☐ Grounding
- ☐ Physical punishment
- ☐ Extra chores
- ☐ Rewards/incentives
- ☐ Other: _____

_____

School:

Check any area of concern:

- ☐ Dislikes school
- ☐ Works hard, but does not do well
- ☐ Unmotivated, refuses to complete work
- ☐ Learning problems
- ☐ Missed many school days
- ☐ Repeated a grade
- ☐ Discipline referrals / detention
- ☐ Expulsions. How many? _____

School Environment

- ☐ Resource classes / special education
- ☐ Gifted program
- ☐ Speech therapy
- ☐ Continuation School
- ☐ Home Study
- ☐ Independent Study

Family Stresses

Now or in the past, have there been:

- ☐ Marital problems
- ☐ Marital separation
- ☐ Divorce
- ☐ Custody disputes
- ☐ Financial problems
- ☐ Housing problems
- ☐ Death of a friend
- ☐ Death of a relative
- ☐ Death of a pet
- ☐ Parents using drugs or alcohol
- ☐ Job loss
- ☐ Family Illness. Days missed of work _____
- ☐ Legal stress. What kind? _____

☐ Other: _____

Developmental History

During pregnancy, did you: ☐ Drink ☐ Smoke ☐ Drugs ☐ Accident ☐ Illness

Did you have any problems with pregnancy, labor, or delivery? ☐ Yes ☐ No

If yes, please describe: _____

_____

Do you remember if your child doing any of the following earlier or later than other children?

Hold Head up / Turn over / Crawl / Sit up / Sleep through the night / Stop breastfeeding / Feed self / Walk on own / Use single words / Use sentences / Toilet train

If yes, please describe how your child was different: _____

_____

My child as a baby (check all that apply):

☐ Ate poorly
☐ Was colicky
☐ Was clumsy
☐ Had head banging
☐ Had rocking behavior
☐ Was hard to soothe
☐ Had wild, risky behavior
☐ Wanted to be left alone
☐ Was more interested in things than people
☐ Was hard to get to sleep or eat normally
☐ Had trouble changing situations (getting in car, sitting down to eat, leaving the park)

Medical History

Indicate if your child had or has any of the following

	Yes	No	Age	Explain
Serious infection				
Convulsions				
Head injuries				
Other injuries				
Hospitalizations				
Operations				
Poisonings				
Alcoholism				
Drug use				
Sexual problems				

Does your child have other medical conditions? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does your child frequently complain of bodily aches and pains? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does your child miss school because of his/her physical complaints? ☐ Yes ☐ No

If yes, please describe: _____

_____

Does your child have any allergies to medications / drugs? ☐ Yes ☐ No

If yes, please describe: _____

_____

List any medications your child is taking, when it was started, and the dosage.

_____

_____

_____

Family Information

List all the people who live with the child now

Name	Age	Relationship	Occupation / School Grade

Other important people in your child's life

Name	Age	Relationship	Occupation / School Grade

Ted G. Obbard
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Family Information (continued)

	Father		Mother		Sibling		Other _____		Other _____	
	Now	Past (When)	Now	Past (When)	Now	Past (When)	Now	Past (When)	Now	Past (When)
Problems with attention, activity, impulse control										
Learning disabilities										
Did not graduate High School										
Alcohol Abuse										
Drug Use										
Problems with aggressive behavior										
Jail arrests / legal problems / probation										
Abuse victim										
Abusive to others										
Depression										
Nervous disorder										
Mental retardation										
Serious illness/operation										
Physical handicaps										
Tics or unusual movements										
Other mental problems										

What are your family supports? (for example, church, friends, clubs)? _____

_____

_____

What are your family strengths? _____

_____

_____

Anything else I should know about your child or your family? _____

_____

_____

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