INTAKE FORM/SOCIAL HISTORY QUESTIONNAIRE (Child)
（please print all information）

Today's Date: _____

Child's Name: _____ Date of birth: _____Age:____

Address: _____

How long have you been in this address? _____

Phone: _____Cell: _____

Parent's email: _____

May we send Dr. Zhang's free email newsletter providing simple instructions on how to parent and better manage and enjoy life? Yes____ No____

Who referred you to us? Or how did you hear about us? _____

Name of the School: _____Present Grade:_____

YOUR CHILD'S FAMILY HISTORY

	Name	Education	Workplace	Work number	Age
Mother					
Father					

Brothers and sisters

Name	Age	Sex	Occupation	Highest grade achieved

List the hobbies or interests that your child has:

_____

_____

_____

EDUCAITON INFORMATION (check highest level)

Was your child ever enrolled in special education classes? Yes_____ No_____

Please give details, if Yes:_____

PHYSICAL HEALTH INFORMATION

Family physician: _____ Phone: _____

Last physical:

Date: _____Reason: _____Result: _____

Last Doctor visit:

Date: _____Reason: _____Result: _____

Last Dental visit:

Date: _____Reason: _____Result:___ _____

Have you noticed any recent changes in your child's

Sleep patterns	Yes or No	Behavior	Yes or No
Eating patterns	Yes or No	Energy	Yes or No
Physical Activity	Yes or No	Weight	Yes or No
Increased Tension	Yes or No	Disposition	Yes or No

If yes to any of the above, describe:

_____

_____

_____

MEDICAL INFORMAITON: past or present (please check any)

	No	Past	Present
Allergy			
Asthma			

Ulcer			
Chronic stomachache			
Heart disease			
Seizure/epilepsy			
Fainting/dizzy			
Hallucination			
High/low blood pressure			
High/blood sugar			
Thyroid problems			
Liver Disease			
Vision problems			
Hearing problems			
Broken bones			
Major injuries			
Ob/gyn problems			
Diabetes			
Communicable disease			
Nutritional problems			
Other problems			

CURRENT MEDICATION AND DRUG USED: (include all drugs)

Prescribing physician(s) _____

Name of drug	Prescribed?	Dosage	Frequency

Previous medication and/or drug usages (prescription and non-prescription)

Name of drug	Dosage	Reason of stoppage

Has your child ever overdosed on a drug or medication? Yes: _____ No: _____

If yes, describe: _____

RELATIONSHIP

Please briefly describe how you get along with (filled by the child):

Friends: _____

Parents: _____

Siblings: _____

PREVIOUS COUSELLING /TREATMENT INFORMATION:

Has your child ever received prior counseling, drug, or psychiatric services? Yes_____No_____

When and Where? _____

Why are you seeking psychological services for your child at this time? Current problems, issues, etc.)

_____

_____

How do you feel counseling will assist your child in the areas noted above?

_____

_____

ALCOHOL/SUBSTANCE USE:

Does your child use alcohol regularly? Yes_____ No_____

If yes, how old was your child when they had their first drink? _____

How old was your child when they first started to use alcohol regularly?_____

Do you use other substances? Yes_____ No_____

If yes, please specify:

_____

_____

Have members of your child's family experienced difficulty with alcohol or substances? Yes____ No___

If yes, please describe_____

CHILD-DEVELOPMENTAL PROFILE

EARLY DEVELOPMENTAL HISTORY

1. The age of the natural father when the child was born?_____
2. The age of the natural mother when the child was born? _____
3. What was the mother's attitude while pregnant with the child? _____
4. Did the mother receive medical care while pregnant? _____
5. Describe any complications with the mother while pregnant: _____
6. Describe any problems with the birth of the child_____
7. What was the child's approximate birth weight when born? _____
8. Who cared for the child before the age of two?_____
9. Describe the child's mood before the age of two. _____
10. From birth to the age of two how was the child's development of physical skills?
    _____
11. At what age did the child walk? _____
12. At what age did the child talk? _____
13. At what age was the child toilet trained? _____
14. Describe any problems with the toilet training._____
15. Who was the caregiver from the age of two to five? _____
16. Describe any problems in the child's motor development between the age of two and five (i.e., throwing, etc.)_____
17. Describe the child's language development from age two to five (i.e., talking in sentences)_____
18. What was the social development of the child between the age of two to five? (i.e., how did s/he getting along with others) _____
19. Describe the child's mental development from age two to five_____
20. Describe the child's temperament from the age of two to five_____

KINDERGARTEN

21. Describe any difficulties when starting kindergarten:_____
22. At what age did s/he start kindergarten? _____
23. Did the child enjoy kindergarten? _____
24. How did the child get along with other children? _____
25. Describe the child's academic performance in kindergarten. _____

GRADE ONE

26. At what age did s/he start? _____
27. Describe any problems_____
28. How did the child get along with other children? _____
29. Describe the child's academic performance_____

OTHER GRADES

30. Describe the child's school experiences since the first grade_____
31. What are the child's current subject strengths in school? _____
32. What are the child's current subject weaknesses in school? _____
33. Describe the child's current skill strengths. (i.e., spelling, concentration, organization, understanding concepts, reading, intelligence, behaving, etc.)_____
34. Describe the child's current skill weaknesses (i.e., the above) _____
35. Does the child currently complete homework assignments on time? _____
36. Is there any additional academic support to the child presently? _____
37. Does the child skip school or class? _____
38. How often is the child excused from school (for illness, etc)_____
39. Are there currently any behavior problems in the classroom? _____
40. Explain any problems with attention and concentration that the child is now experiencing: _____

ATTENTION DEFICIT DISORDER (A.D.D) SERVERITY SCALE

Choose the number that best describe your child's attention or behavior difficulties (1-10)

1. Often fidgets or squirms in seat.
2. Has difficulty remaining seated.
3. Is easily distracted.
4. Difficulty waiting for his/her turn.
5. Often blurts out answers to questions.
6. Has difficulty following instructions.
7. Has difficulty keeping attention to task.
8. Often shifts from one uncompleted task to another

9. Often loses things needed for tasks.
10. Often engages in physically dangerous activities without considering consequences.

Choose the number that best describes your child's behavior or attention difficulties at home.

1. While playing with other children
2. Mealtimes.
3. Getting dressed.
4. When visitors are in your home.
5. When you are visiting someone else.
6. At church or Sunday school.
7. In supermarkets, stores, restaurants, or other public places.
8. When asked to do chores at home.
9. While in the car.
10. When asked to do homework.

Supplemental Information

Is there anything else you consider important for us to know about yourself or your child?

_____

_____

_____

Person completing the form: _____(print) Relationship_____

Signature: _____Date: _____

Reviewing staff: _____Credential: _____

Consent and Service Agreement

Dr. Zhang is a licensed psychologist who with the other psychologists or psychological associates supervise the staff of the Neuro Wellness. Therapists, other than social workers (who are registered with their own college), work under the direct supervision of Dr. Zhang or the other psychologists.

Dr. Zhang or our other Psychologists will review each session and co-sign each written addition to the file, including treatment planning and other assessment information. Our staff's qualifications and training are listed in the waiting area of our office, but unless otherwise indicated, Dr. Zhang is the Licensed Psychologist supervising their work.

At times, sessions may be conducted via telephone or video conferencing, when therapists are unavailable at a particular office. Notification will be provided prior to booking.

If you are working with a therapist or psychological assistant, you may ask our front desk to schedule an appointment with Dr. Zhang directly or other psychologists or psychological associates working at our offices.

Should you experience a **QEEG Assessment**, the results will be interpreted by Dr. Zhang or other qualified professionals such as Dr. Robert Thatcher and his staff may analyze the results at their offices in St. Petersburgh, Florida (extra fee of $500 will be charged if his services is requested).

The number of sessions required will depend on progress within treatment. It is understood that all information discussed within therapy will be kept confidential unless circumvented by legal authority, expressed written consent of the patient, or where harm to others or the patient may result when information is not disclosed to a third party.

Payment of Fees
Payment is required for each session without exception. For those with insurance coverage, the receipt issued after payment should be sent to your insurance company to receive reimbursement for your claim. The fee charged for each 45 minute session with each associate ranges from $140-$200. Phone consultations are charged at the same rate as seeing a therapist. Reports and letters are charged at a rate of $30 per page. Fees for other services will be provided as scheduled. All overdue accounts are subject to a fee of 2% per month on any unpaid balance.

Missed Appointments – we request a 24 hours notice of cancellation or a full fee will be charged. Any unpaid portion is subject to a charge of 2% per month.

When payment is not made, this office may utilize legal means to collect overdue accounts. It is your responsibility to gather information regarding insurance reimbursement for therapy. The office personnel will assist in the completion of forms if needed, however, the final responsibility of ensuring completion of such documentation and securing of funds rests with you.

Health Insurance Portability and Accountability Act (HIPPA)
For the purposes of this Act, Dr. Zhang is both the *health information custodian* and the HIPAA Information Officer. You may contact Dr. Zhang directly by telephone (519.490.8920) or by e-mail (hzhang@neurowellness.ca) or by asking the front desk staff at any of our offices.

I consent to the possibility of receiving a three month post discharge follow up survey by phone or mail.
[ ] Yes [ ] No

Client's name (please print)	Client's social security Number	Client's Birthdate	Date
Signature of client (or parent/guardian)	SSN of Parent/Guardian	Relationship to client	Date
Parent/Guardian's Name (please print)	Parent/Guardian's Birthdate	Signature of Witness/provider	Date