Serenity Therapeutics LLC
753 North Main St, Suite B5, Cottonwood AZ 86326
928-899-0723 info@SerenityTherapeuticsLLC.com

Pediatric Intake Form

(5 year old-17 year old)

Today's Date _____

Child's Name _____ Age _____ Birth Date _____

Child's Address _____

_____

City State Zip

Accompanying Parent's Name _____ Relationship to Child _____

Parents Marital Status _____ If divorced, who has custody of the child? _____

Child's Primary Care Physician _____ Phone _____

Consent to contact Primary Care Physician if needed: **Y** or **N**

Signature: _____ Date: _____

Accompanying Parent's Information:

Parent Name _____

Address_____

_____

City State Zip

Best Number to Call _____

Occupation _____ Employer _____

E-mail _____

Person to contact in case of emergency: _____Phone _____

Whom may we thank for referring you? _____

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Has child been recently diagnosed with disorder: **Y** or **N** Date of diagnosis _____

Person who diagnosed: _____Place (City/State): _____

Diagnosis: _____

Reason for evaluation_____

Has child been previously treated with Neurofeedback? _____ If yes, where/when/location? _____

_____

Number of sessions _____ Reason for stopping treatment _____

Does anyone else in the family have a problem similar to your child's? _____ Relationship _____

Describe child's strengths _____

Describe child's weaknesses _____

Child is: biological _____ adopted (at age) _____ foster _____

List siblings (names, ages) _____

Educational History

Is child in child care? **Y** or **N** How many hours/day? _____

Potty trained? **Y** or **N** Learning? **Y** or **N** Can he/she feel sensation to go? **Y** or **N**

What does child eat there? _____

Issues at child care with peers/teachers/others? _____

School _____ Grade _____Public/Private/Charter How many hours/day? _____

Placement: Gifted Regular Resource Special Education IEP/504 Plan

Toilet trained? **Y** or **N** Pull-ups? **Y** or **N** Can he/she feel sensation to go? **Y** or **N**

What does child eat at school? _____

Issues at school with peers/teachers/others/subjects? _____+_____

_____

Does child rotate classes? **Y** or **N** If yes, does he/she like, why or why not? _____

_____

_____

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Teachers report problems in:

Reading Spelling Arithmetic Writing Attention Behavior Social Adjustment
Hyperactivity Impulsivity Easily Distracted Other_____

Please describe the above noted problem(s) _____

_____

How much outside time does child get per day? _____ activities he/she enjoys outside? _____

Inside activities? (e.g., puzzles, games, dress-up, toys, etc.) _____

How much tv/computer/IPad/etc. does child get per day? _____

Does child have sensory issues? (e.g., food, texture, hot/cold, wet, sticky, etc.)_____

_____

Describe your child's typical day during school days: _____

_____

_____

Describe your child's typical day during weekend: _____

_____

_____

Has your child experienced (circle all that apply)

Death of a loved one separation from a loved one emotional trauma sexual abuse

Family conflict marital conflict physical abuse emotional abuse

Please explain _____

Pregnancy and Birth History

Known health problems of mother during pregnancy (circle all that apply)

Toxemia Hypertension Gestational Diabetes Trauma Fever
Allergies Smoking Alcohol Use Drug Use Antibiotics
Depression Anxiety Injury Accidents Mental Illness
Emotional Abuse Physical Abuse Sexual Abuse
Sexually Trans. Disease Blood Incompatibility
Fertility Used? _____ Other: _____
Drug Use? _____ Other: _____

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Delivery: Vaginal or Cesarean? If Cesarean, reason: _____

Baby: Full Term or Premature? If Premature, gestational weeks _____

Birth Weight _____ lbs. _____ oz.

Circle any birth complications:

Feet first Cord around neck Meconium staining Lacking oxygen

Jaundice Not breathing Other: _____

Apgar scores (if known) _____

Please explain complications and interventions: _____

_____

Please explain any medical problems after discharge and interventions: _____

_____

Any problems during the first few months? _____

Did you experience postpartum (after birth) depression? **Y** or **N**

Developmental History

Motor:

Age sat alone _____ crawled _____ stood alone _____ walked alone _____

Was your child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball)? **Y** or **N** _____

Handedness: Right Left Ambidextrous (both)

Family history of left-handedness (list relatives)? _____

Please list any physical or occupational therapy services your child has received: _____

_____

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Speech/Language:

Child's first language _____ Age spoke first word _____

Put 2-3 words together _____

Circle all that apply:

Speech delays	Stuttering	Hard to understand	Late drooling
Poor Sucking	Poor chewing	Articulation problems	Slow to learn alphabet
Slow to learn colors	Slow to learn counting	Feeding	Sensory Issues

Other:_____ Other:_____ Other:_____
Other:_____

Please list any speech therapy services your child has received_____

Duration _____

Toileting:

Age when toilet trained _____

Problems with : Bedwetting Urinating Soiling Explain: _____

Any current problems? _____

Social Behavior:

My Child (circle all that apply)

Gets along with peers	Gets along with older children	Has a sense of humor	Gets along with adults
Keeps friends	Understands others' feelings	Understands social cues	Bullies others
Initiates play	Has problems with peer pressure	Is "bossy"	Is bullied by others
Is teased at school	Gets along with siblings	Initiates bad behavior	Has empathy for others

Please explain any pertinent issues regarding your child's social behavior: _____

_____

_____

_____

_____

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Medical History

Has vision been checked? _____ Any problems? _____

Has hearing been checked? _____ Any problems? _____

CT _____ MRI _____ EEG _____ If yes, results?

_____

Other tests and results: _____

List serious illnesses/injuries/hospitalizations/surgeries:

Date Incident (explain)

_____ _____

_____ _____

_____ _____

Circle all that apply to child:

Failure to thrive	Febrile seizures	Lead poisoning/toxic	Sleep walking or talking
Eating difficulties	Encephalitis	Ear infections	Diabetes
Abdominal pains	Sleep difficulties	Vomiting	Headaches
Asthma	Epilepsy	Staring spells	Allergies
Meningitis	Loss of consciousness	Facial or other tics	Temper tantrums
Eating disorder	Impulsivity	Repetitive movements	Nail biting
Head banging	Self-injurious behavior	Physical injuries	Head injuries
Anxiety	Depression	Mood Swings	Fears
Frustration	Anger	Obsessive worries	Low self-esteem
Sense of direction	Memory issues	Attention	Distractibility
Ability to organize time/space		Over-active	under-active
Coordination	Accident prone	Sense of self in space	Motor tics
Vocal tics	Uncooperative	Manipulative	Insensitive to others
Oppositional defiant	Aggressive	Lying	Cheating
Stealing	Not knowing right from wrong		No guilt feelings
Food cravings	Bedwetting	Nightmares or night terrors	

Soiling Teeth grinding Sugar craving or reaction

Salt craving or reaction Compulsions Frequent illness Stomachaches

Chronic constipation Pain Fainting Seizures

Hearing problems Vision problems Colic Poisoning

Stroke Drug usage Alcohol usage CNS infection

Thyroid disorder (Hyper/Hypo) PTSD OCD

Other: _____ Other: _____ Other: _____ Other: _____

Please explain the age of occurrence, relevant information, and interventions of any conditions circled above:

_____

_____

_____

Current Medications:

Medication	For Condition	Dose	How long been on

Current Supplements:

Supplement	For Condition	Dose	How long been on

Maternal (Mother) Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning difficulties Mental illness Neurological illness Seizures Thyroid (Hyper/Hypo)

Psychiatric disorder Schizophrenia Depression Bipolar disorder Migraine Anxiety

Suicide Alcoholism Drug abuse Sleep problems Legal problems Arrests

Obsessive-compulsive disorder Personality disorder

Motor or Vocal Tics Addictions Speech problems Attention problems Asthma

Hyperactivity Learning problems Conduct problems or criminal behavior

Autism spectrum Autoimmune disorders: Type 1, Type 2 Diabetes, Rheumatoid Arthritis, Lupus,

MS, Scleroderma, etc. (please list if any): _____

Other: _____ Other: _____ Other: _____

Please explain: _____

_____

Does anyone else in the family have an issue similar to your child's? _____

_____

Paternal (Father) Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

Learning difficulties Mental illness Neurological illness Seizures Thyroid (Hyper/Hypo)

Psychiatric disorder Schizophrenia Depression Bipolar disorder Migraine Anxiety

Suicide Alcoholism Drug abuse Sleep problems

Legal problems Arrests Obsessive-compulsive disorder Personality disorder

Motor or Vocal Tics Addictions Speech problems Attention problems Asthma

Hyperactivity Learning problems Conduct problems or criminal behavior

Autism spectrum Autoimmune disorders: Type 1, Type 2 Diabetes, Rheumatoid Arthritis, Lupus

MS, Scleroderma, etc. (please list if any): _____

Other: _____ Other: _____ Other: _____

Please explain: _____

_____

_____

Does anyone else in the family have an issue similar to your child's? _____

_____

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Prior Psychological and Treatment History

Please include psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/Occupation Dates Seen For What? Describe Progress

_____

_____

_____

_____

Please add any additional information you would like us to know in the space below: _____

_____

_____

_____

_____

_____

_____

The information given is correct to the best of my knowledge.

Signature: _____ **Date:** _____

Print Name: _____ **Relationship to Client:** _____

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CHILD CHECKLIST OF CHARACTERISTICS

Please check all that may apply
You may add notes where necessary

	ADD/ADHD, hyper-active
	Allegries/Asthma
	Anxiety, depression, manic depression, mood swings, fears, frustration, obsessive worries
	Arthritis, Fibromyalgia, Rheumatoid arthritis, joint pain, muscle aches, tenderness, growth pain
	Affectionate
	Argues “talks back”, smart-alecky, defiant
	Autism, Asperger’s Syndrome
	Autoimmune Disorders: Type I/II Diabetes, Lupes, MS
	Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
	Cerebral Palsy
	Cheats, lying, stealing, not know right from wrong, no guilt feelings
	Cruel to animals
	Concern for others
	Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
	Complains
	Cries easily, feelings are easily hurt
	Dawdles, procrastinates, wastes time
	Difficulties with parents’ love interest/new marriage/new family
	Dependent, immature
	Developmental delays
	Disrupts family activities
	Disobedient, uncooperative, refuses, noncompliant, doesn’t follow rules
	Distractible, inattentive, poor concentration, daydreams, slow to respond, reduced attention span
	Down Syndrome
	Dropping out of school
	Drug or alcohol use, poison
	Eating: poor manners, refuses, appetite increase or decrease, odd combinations, overeats, eats feces, dirt or other materials, sugar craving or reaction, food cravings, food sensitivities, compulsions
	Exercise problems, fatigue, poor muscle tone, over-active/under-active, coordination
	Extracurricular activities interfere with academics
	Failure in school
	Fearful
	Fighting, hitting, violent, aggressive, hostile, threatens, destructive
	Fire setting
	Friendly, outgoing, social

	Health: frequent illness, stomachaches, chronic constipation, chronic pain, vision problems
	Headaches, tension/migraine, seizures, epilepsy, light headed, dizzy spells, fainting
	Hearing difficulties, tinnitus, ear aches, sensitive to noise, sound sensitive
	Heart: heart problems, surgeries, murmur, heart disease
	Hypochondriac, frequently complains of feeling sick
	Immature, “clowns around”, has only younger playmates
	Imaginary playmates, fantasy
	Independent
	Interrupts, talks out, yells
	Lacks organization, unprepared, forgetful
	Lacks respect for authority, insults, dares, provokes, manipulates
	Learning disability, problems with logical thinking, trouble with abstract concepts, impaired comprehension, impaired memory, reading disorder
	Legal difficulties-truancy, loitering, drinking, vandalism, stealing, fighting, drug sales
	Likes to be alone, withdraws, isolates
	Lying, uncooperative, inflexible, unpredictable, manipulative, insensitive to others, oppositional, defiant, aggressive
	Loss of parent, loss of family member, loss of animal
	Low frustration tolerance, irritability, strong willed
	Mental retardation
	Moody
	Motor: sense of self in space, accident prone, motor tics, vocal tics, coordination
	Mute, refuses to speak
	Nail biting
	Nervous
	Nightmares, difficulty going to bed, waking up, restless sleep, talking in sleep, sleep walking, night terrors, bed wetting or soiling, vivid dreaming, sleeps too much, sleep apnea, Bruxism (teeth grinding), night sweats, naps a lot, not napping
	Need for high degree of supervision at home over play/chores/schedule
	Obedient
	Obesity
	Overactive, restless, hyperactive, overactive, out-of-seat behaviors, fidgety, noisiness
	Oppositional, resists, refuses, does not comply, negativism
	Prejudiced, bigoted, insulting, name calling, intolerant
	Pouts
	Recent move, new school, loss of friends
	Relationships with brothers/sisters or friends/peers are poor-competition, fights, teasing/provoking, assaults
	Responsible
	Rocking or other repetitive movements
	Runs away
	Sad, unhappy

	School: teacher complaints, problems with other students, homework, work load, academics, friends-many/lack of
	Self-harming behaviors-biting or hitting self, head banging, scratching self
	Senses: To taste/touch/smell/sound/textures
	Spina Bifida
	Speech difficulties
	Sexual-sexual preoccupation, public masturbation, inappropriate sexual behaviors
	Shy, timid
	Stubborn
	Suicide talk or attempt
	Swearing, bathroom language, foul language
	Temper tantrums
	Thumb sucking, finger sucking, hair chewing
	Thyroid Disorder: Hypothyroidism, Hyperthyroidism
	Tics-involuntary rapid movements, noises, or word productions
	Teased, picked on, victimized, bullied
	Truant, school avoiding
	Uncoordinated, accident-prone
	Wetting or soiling the bed or clothes
	Work problems, employment, workaholic/overworking, can't keep a job

Any other characteristics: _____

_____

_____

_____

Please look over the concerns you have checked off and choose the one that you most want help with for your child. Which is it? _____

*Some concerns may be treated together, others may need to be treated separately.

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Agreement to Pay for Professional Services

I request professional services to be provided to:

_____

Please initial each line to acknowledge and agree to the following:

____ I am responsible for the charges for services provided **at the time of service**. I agree to cancel or change appointments with **at least 2 business days' notice.** I am responsible for full payment of any missed appointments. It is considered a missed appointment to cancel with less than 2 full business days' notice.

____ I am responsible for filing insurance claims on my behalf and obtaining any prior authorization or pre-certification from my insurance company if I seek reimbursement. The Serenity Therapeutics, LLC. contractors are out-of-network providers and I may request a monthly superbill with services for submittal.

____ If I am late, my appointment will end at the scheduled time. If my appointment starts late due to my therapist, my appointment will last for the full appointment time. In rare cases, if my therapist is late and cannot accommodate this, I will receive an extended session.

____ If I miss a payment or if a payment is returned due to insufficient funds, my credit card will be charged for the services immediately. I agree to pay any assessed bank fees.

____ I authorize charges associated for treatment or assessment to be charged to the credit card on file.

____ Payments not made within 30 days are subject to a 5% late fee and every 30 days that will continue to accrue until payment is made. Late payments may be sent to a collection agency after 60 days, although I will be notified beforehand and will have an opportunity to pay for services at that time.

_____ _____

Signature of Client (or person acting for client) Printed Name

_____ _____ _____

Relationship to Client Date Time

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ARIZONA STATE LAW

I acknowledge that Arizona State Law requires (must) and designates all Behavioral Health Counselors, Case Managers, Clinicians, or Technicians, to report any suspected or reason to suspect cases of **domestic violence, abuse, neglect to include all ages (child or adult)**, to the proper authorities as deemed necessary in behalf of the interested persons to protect their legal rights.

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION PRIVACY INFORMATION

This form is an agreement between you and Serenity Therapeutics, LLC. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his/her name here

_____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls Protected Healthcare Information (PHI) about you. This information is needed to decide which treatment should be provided to you in your best interests. We may also share this information with others who provide treatment to you or to those who need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to permit us to use your information here and to send it to others as detailed below.

Serenity Therapeutics, LLC. is fully compliant with the Health Insurance Portability and Accountability Act of 1966 (HIPAA) regulations to protect the confidentiality of your information. You have a right to fully informed consent regarding handling of your privileged information. In general, unless you sign a written release of information, your information will not be released to a third party.

Exceptions are:

- Serenity Therapeutics, LLC. may be required to release your information if the withholding of this information could result in harm to either you or another person. This may apply if, for example, you indicate you intent to harm yourself or another person, or in cases of abuse or neglect of a child or a vulnerable adult.
- Serenity Therapeutics, LLC. may be required to release your information by court order or subpoena. An example would be if you were party to litigation and a judge decided this information was needed.
- Serenity Therapeutics, LLC. may be required to release your information to emergency treatment personnel or to your emergency contact if you require immediate medical attention while in session.
- Serenity Therapeutics, LLC. may release your information to another health care provider if you initiate contact with that provider. Your information may be released with your verbal consent to facilitate a referral. In most cases, a written release of information will be requested for this purpose.
- Serenity Therapeutics, LLC. may release your information to a consultant or supervisor for the purpose of insurance reimbursement, and to provide you with optimal care.
- Serenity Therapeutics, LLC. may release your information anonymously if brief consultation with professional colleagues is necessary to provide you with optimal care. An example might be a description of your situation (without identifying you by name) and asking a colleague for resources to provide you to assist you with your treatment.

- Serenity Therapeutics, LLC. generally will request a written release of information from you whenever possible. Your rights include: access to your records upon request, the safeguarding of your records at all times, and the keeping of accurate financial and clinical records.

If you do not sign this consent form agreeing to what is in this notice of privacy practices, we cannot treat you.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. Requests must be in writing and although we will try to respect your wishes, Serenity Therapeutics, LLC. is not required by law to agree to these limitations.

I, _____ have read and understand the above information.

All of my questions have been adequately addressed.

_____

Patient or Guardian Signature Date

Relationship to Patient: _____

I have discussed the issues contained herein with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Witness Signature Date

_____

Signature of Practice Representative Date

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INFORMED CONSENT FOR TREATMENT

Treatment of emotional, behavioral and mental health disorders such as Attention Deficit Hyperactivity Disorder, depression and anxiety involves the active participation of the patient (and their family in most cases). There are many different approaches to treatment including counseling, behavior modification, family therapy, medication, skill training and EEG (biofeedback) neurofeedback. At Serenity Therapeutics, LLC. we will work with you to plan the treatment program that will best meet your needs.

If you choose to use EEG neurofeedback as part of your treatment, you need to be aware that there has been over 30 years of research since this was first developed. Although no guarantees or promises can be made that it will be effective, experienced clinicians are usually reporting 80% to 90% improvement rates. Many patients have been found to no longer require medication for their disorder. However, in 10% to 20% of cases people are unable to change their brainwave patterns in desired directions sufficiently to bring about adequate improvements.

Counseling and EEG neurofeedback can sometimes bring up painful memories. This can be part of the growth and healing process, however, it can, at times, be emotionally painful. Although side effects from neurofeedback are rare, they can occur. If they do occur they are usually redeemable relatively quickly.

QEEG Topographic Brain Maps are not intended to diagnose neurological disorders. If you suspect a seizure disorder or any other neurological disorder you are strongly encouraged to see a neurologist. EEG neurofeedback is usually a helpful adjunctive treatment for many neurological disorders (stroke, closed head injury, seizure disorders, Tourettes syndrome, etc.).

It is uncommon, but if following treatment session you feel confused, disoriented or light headed, please inform a staff member and rest here until you feel normal again. Do not drive a vehicle until fully recovered.

I have read the above “Informed Consent for Treatment”. I understand that there are usually significant improvements but that some people do not improve, become worse before they become better, or may even, in very rare cases, find their problems have worsened. I hereby release Serenity Therapeutic, LLC. from any liability related to my treatment and to hold its staff harmless from any effects caused directly or indirectly from counseling or EEG neurofeedback.

_____

Patient or Responsible Party Signature Date