



Dr. Daniel Chorney & Associates

Psychological Services

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Child Developmental History

(All information is kept strictly confidential and will not be released to anyone without your permission)

Child's Full Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____ Postal Code: _____

Phone (H): _____ Cell/Work: _____

Email Address (of Parent/Guardian): _____

School: _____ Grade: _____ Today's date: _____

Name of person completing this form: _____ Relation to child: _____

Referral Information:

How did you hear about our practice? Please provide additional information where indicated:

Word of mouth: _____ Teacher/Guidance Counselor: _____

Physician: _____ Professional Directory: _____

Web Search: _____ Public Talk/Presentation: _____

Other Practice: _____ Other: _____

Family Information:

Parent /Caregiver Name: _____ Age: _____ Education: _____ Occupation: _____

Parent /Caregiver Name: _____ Age: _____ Education: _____ Occupation: _____

Parent/Caregiver Marital or Relationship Status: _____

If separated/divorced, please describe the **custody** arrangement*: _____

**Please note you may be asked to provide legal documentation to verify the above arrangement.*

Child's Siblings:	<u>Name</u>	<u>Age</u>	<u>Living where?</u>
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Other individuals living in the home (name, age, relation): _____

Pets? _____

Child's Medical History:

Current Medical Problems/Conditions/Disorders (including allergies):

Current medications (include dosage):

All previous psychiatric medications if any (include dosages):

History of other significant health **AND/OR** mental health problems or surgeries:

Any history of: Concussion: **Yes / No** Seizures: **Yes / No** Strokes: **Yes / No** Brain Injury: **Yes / No**

Family Doctor Name & Location/Clinic: _____

Pediatrician Name & Location/Clinic: _____

Sleep History:

Bed Time (most days): _____ Time (min) To Fall Asleep: _____

Wake-up time (most days): _____

Difficulty Falling Asleep? Yes / No Snoring/Breathing issues? Yes / No

Difficulty Staying Asleep? Yes / No Fatigue during the day? Yes / No

Any naps? Yes / No Sleepwalking/talking? Yes / No

Child's Prior Psychological/Psychiatric History:

Name of Provider: _____ When: _____

Reason: _____ Why stopped? _____

Name of Provider: _____ When: _____

Reason: _____ Why stopped? _____

Birth History (please circle one):

Child: Biological / Adopted / Foster Delivery: Vaginal / Caesarian-Section

Length of Pregnancy: Full Term / Premature (How early? _____)

Medical problems/complications at delivery: _____

Developmental History/Milestones (circle one):

Sitting alone: Early / On Time / Late Language development: Early / On Time / Late

Walking alone: Early / On Time / Late Toilet Training: Early / On Time / Late

First words: Early / On Time / Late Social Skills: Early / On Time / Late

Did your child require or have any history of:

Speech therapy: Yes / No Occupational therapy: Yes / No

Physical therapy: Yes / No Sleep problems: Yes / No

Fine motor problems: Yes / No Lacking eye contact: Yes / No

Gross motor problems: Yes / No Excessive crying: Yes / No

Self-injurious behavior: Yes / No Head-banging: Yes / No

Eating problems: Yes / No Separation difficulties: Yes / No

Hair pulling: Yes / No Skin picking: Yes / No

Repetitive behaviors: Yes / No Social difficulties: Yes / No

Aggressive behavior: Yes / No Tics (verbal or motor): Yes / No

Trauma history: Yes / No Significant loss/death: Yes / No

If you would like to provide further detail about anything circled "Yes" please do so here:

If there are any other behaviors that you, your family/friends, or your child's doctor were concerned about during your child's development, please list them below:

Child's Temperament (Check all time frames that apply):

	First Year of Life	This Past Year	Ongoing Issue Over All Years
Difficult to comfort/soothe:	_____	_____	_____
Sleep difficulties:	_____	_____	_____
Fussy/irritable:	_____	_____	_____
Frequent sadness/unhappy:	_____	_____	_____
Lack of affection:	_____	_____	_____
Excessive energy:	_____	_____	_____
Very shy/cautious:	_____	_____	_____
Obsessive or rigid:	_____	_____	_____

Child's Social Development:

Please describe your child's social behavior at **school** (e.g., numerous friends, birthday parties, fights, etc?)

Please describe your child's social behavior **at home** and/or with siblings (e.g., Respectful? Aggressive?):

Please describe your child's social behavior **in public**:

What activities does your child enjoy (e.g., games, sports, hobbies, people, places, things, etc)

Religion (if applicable): _____ Actively involved? _____

Please describe your child's strengths below:

Child's Academic History: *(Please note that no contact is made by me with school staff without your signed consent)*

Teacher/staff most familiar with your child's behavior or learning ability: _____

Name of guidance counselor (if applicable): _____

Coursework/Progress:

(Circle One)

English/Language Arts	Delayed / On Target / Advanced
Mathematics	Delayed / On Target / Advanced
Spelling	Delayed / On Target / Advanced
Writing Ability	Delayed / On Target / Advanced
Any grades repeated?	Yes / No
Special education classes?	Yes / No
Tutoring?	Yes / No

Does your child have any academic or behavioral adaptations at school? _____

Does your child have an Individualized Education Plan (IEP/IPP) at school? _____

Has your child has a previous Psychoeducational Assessment completed? _____

*(if you answered **YES** to any of the above, please bring a **copy** to the initial evaluation to provide to your clinician)

Please use the space below to describe any current or past problems described by teachers/instructors (this can include any issues with behavior and/or learning difficulties):

What are your main reasons/goals for seeking treatment for your child/family at this time? What would you like to see changed?

1.

2.

3.

Is there a specific question you are hoping to have answered during your first appointment? If yes, please describe below:

Family History:

A review of family history is often extremely helpful in understanding both the biological and environmental causes of certain behavioral problems. Please think about parents, siblings, grandparents, aunts/uncles, and cousins as you fill in the table below:

Family Mental Health History

Please check the item (middle column) if you suspect or know that a family member has or had any of the following. Please indicate the relation to the child in the final column.

Illness or Problem	X	Relation to Child
Attention Problems (e.g. "ADD")		
Hyperactivity (e.g., "ADHD")		
Significant anger management difficulties		
Learning Disability		
Tics or Tourette's Disorder		
Special Education services		
Developmental Disability/Cognitive delay		
Autism Spectrum Disorder (ASD)		
Depression		
Bipolar Disorder (e.g., "Manic Depression")		
Schizophrenia		
Suicide or Suicide Attempts		
Deliberate self-harm		
Psychiatric Hospitalization		
Obsessive-Compulsive Disorder		
Severe Anxiety/Phobias/Fears		
Panic Attacks/Panic Disorder		
Eating Disorder (Anorexia/Bulimia/Bingeing)		
Alcoholism		
Drug/Substance Abuse		
Victim of Abuse		
Post-Traumatic Stress Disorder		
Legal Problems/Law-breaking behaviors		
Other (please write in below):		



Cancellation/Late/No-Show Policy

Appointment times are reserved exclusively for you, and without sufficient notice we can not provide that time to other individuals and families who may benefit from that time. Our online booking software can send reminder emails and text messages that allow for multiple opportunities to cancel or reschedule your appointment if necessary.

1. We require **48hrs of notice** for no administrative fees to be charged for cancelled/missed appointments.
2. Appointments cancelled with **less than 48 hours notice** will be charged 50% of the session rate of the time reserved for you (regardless of reason for cancellation).
3. Appointments cancelled with **less than 24 hours** of notice or "no-show" appointments will be charged the full session fee (\$210 for recurring appointments, \$315 for initial appointment).
4. Any receipt issued for a missed appointment will clearly indicate "Missed Appointment" as many insurance providers will not provide coverage for missed appointments.
5. I understand that in order to remember my appointment time(s), I can do any of the following:
 - a. Ask for an appointment reminder card to be filled out for me at clinic visits
 - b. Call (902) 444-1160 and ask my provider when my next appointment is
 - c. Email my clinician directly (emails are found on www.chorneyandassociates.com) to inquire about my next appointment time

I have read and agree to the above cancellation policy.

(Initials)

(Clients Signature)

(Client's Printed Name)

(Date)



Client Information and Consent to Services

Services

Psychologists at Chorney & Associates provide a range of psychological services which may be customized to meet your specific needs or the needs of your family. We provide services to children, adolescents, adults, and families. Please note that no psychologist at this practice specializes in custody evaluations, parental alienation concerns, or parental capacity assessments. To provide the best quality of care to our clients, parents in legal/divorce/custody proceedings should be aware that we would not provide any legal opinions about the capabilities of either parent unless required by law. Emergency psychological services are not provided and should be addressed by your local emergency department or by calling police/ambulance/emergency services (e.g., 9-1-1).

Fees

Psychological services are billed at the rate of \$210.00 per therapy hour (50 minute session, with 10 minutes devoted to chart review and progress notes). Additional time and other services pertinent to your care are charged on a prorated basis. Examples of this include longer session times (e.g., if 1.5hrs is needed or desired), report writing, attendance at meetings or school visits, extended correspondence via email, and/or phone calls in excess of 15 minutes. The Initial Evaluation is typically 1.5 hours in length (\$315) given the time to review your records and background, review confidentiality and consent, discuss your current situation in detail, and establish goals for treatment. All payments are processed using our online practice management software ("JANE") using credit card (VISA or Mastercard). Cheques are currently not accepted. Upon payment prior to your session, a receipt will be provided to you for reimbursement/tax purposes.

Insurance

Psychologist's fees are not covered under the Nova Scotia's MSI Plan. Many private extended health care plans cover part, or a significant portion of psychological services. Please talk to your insurance provider directly to see what your specific plan covers. At this time we do **not** offer direct billing to insurance companies, therefore, regardless of third-party coverage we require payment in full prior to beginning each session.

Cancellation/Late/No-Show Policy

Appointment times are reserved exclusively for you, and without sufficient notice we can not provide that time to other individuals and families who may benefit from that time. Our online booking software can send reminder emails and text messages that allow for multiple opportunities to cancel or reschedule your appointment if necessary. We require **48hrs of notice** for no administrative fees to be charged for cancelled/missed appointments.

Appointments cancelled with **less than 48 hours notice** will be charged 50% of the session rate of the time reserved for you (regardless of reason for cancellation). Appointments cancelled with **less than 24 hours** of notice or "no-show" appointments will be charged the full session fee (\$210 for recurring appointments, \$315 for initial appointment). Receipts issued for missed appointments will state "Missed Appointment."

Confidentiality and Privacy

Please note that the use of our online practice management, charting, and scheduling software (Jane | janeapp.com) results in your treatment chart and Personally Identifiable Information/Protected Health Information (PII/PHI) being stored in secured Canadian based data storage servers.

All discussions with a psychologist are strictly confidential and your privacy is important to us. No information will be released to third parties without your explicit consent, except where required by law or in situations where the psychologist is ethically and legally required to disclose information to others without your consent. The following are examples of when your information may be released **without** written consent:

1. When an individual poses potential or **threatened harm to themselves OR to others** (in this circumstance the psychologist will act to protect the person(s) in danger by informing police, medical personnel, parents/caregivers, or other relevant individuals who may assist).
2. Suspicion of or risk of **child abuse** (psychologists are mandated reporters and required to report relevant information the Department of Children's Services).
3. Suspicion of **adult/elder abuse** (physical, sexual, and/or mental cruelty to anyone over 16 at risk of being abused due to physical or mental disability that impedes their ability to care for themselves).
4. In the event your information is **subpoenaed by a judge** or court of law in the case of legal proceedings.
5. If services are **being paid by a third-party** (e.g., insurance), certain information may be disclosed (e.g. dates/time of service, who was present, fees charged).
6. Internal **consultation** amongst psychologists within Chorney & Associates Psychological Services.

Consent to Treatment

In order to voluntarily provide consent to treatment, an individual should understand **1)** the nature of the assessment and treatment, **2)** the potential benefits, risks, and side effects of treatment, and **3)** any reasonable alternatives to treatment (including refusal). It is important to note that consent is an ongoing process and you have the right at any time to ask questions about your treatment or terminate your treatment at this clinic.

Adolescents. In the case the individual consenting to treatment is an adolescent, consent to treatment is obtained on a case-by-case basis and the consent/signature of a legal guardian or parent may be required depending on the ability of the adolescent to understand the points listed above. In most cases, privacy is protected to ensure the adolescent feels able to share confidential information (including drug use, lying, or sexual behavior) and this information will remain confidential unless a significant risk of harm to themselves or to others is revealed.

By signing below, I agree that I have read (or had read to me) and agree to all items with the Client Information & Consent form. I have discussed and asked questions about any portion of the form I find unclear or unacceptable, and have had my questions, if any, answered. I agree to act in accordance with the points and information listed above, and by signing I consent to taking part in both assessment and treatment with the provider named below.

(Client Signature)

(Client Printed Name)

(Clinician Signature)

(Clinician Printed Name)

(Date)