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: Name Age Living where?

Name	Age	Living where?
____________	____	____________
____________	____	____________
____________	____	____________

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:

<u>Child's Academic History</u>: *(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):____

<u>Coursework/Progress</u>:

	(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 **<u>copy</u>** 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 if 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/Asperger's		
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):		

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Cancellation and Late Fee Policy

When you reserve an appointment time, the hour is yours and unavailable to anyone else. Appointment changes and cancellations make it difficult to provide timely service to everyone who needs it, and delays our work together.

1. I understand that in some cases, appointments changes must be made due to unforeseen circumstances. Given this, **one** missed ***or*** cancelled appointment within 24 hours of the appointment time will **not be** charged to me.

2. All further appointments cancelled with **less than 24 hours notice** will be charged the full fee of $170/hr. An invoice will be sent to my home address outlining the charge and payment methods.

3. For cancelled appointments due to illness a medical note is required in order for the cancellation fee to be waived. I understand that fees are **only waived if a medical note is presented.** Without a medical note, I will be charged for the missed appointment as stated above ($170 for 24hrs or less notice).

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)

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Client Information and Consent to Services

Services

Psychologists at Chorney & Associates may provide the following services, which may be customized to meet your specific needs or the needs of your family: individual therapy and/or assessment, group therapy, family therapy, couples counseling, and psychoeducational assessments. We provide services to children, adolescents, adults, and families. Please note that no psychologist at this practice specializes in custody evaluations 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 will **not** provide any legal opinions about the capabilities of either parent unless required by law. Emergency psychological services 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 $170.00 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 ($255) given the time to review your records and background, review confidentiality and consent, discuss your current situation in detail, and establish goals for treatment. We accept a variety of payment options, including: Interac/debit, VISA, MasterCard, and cash payments. 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. Appointments cancelled with less than 24 hours' notice by phone (902-444-1160) or email to your provider will be charged the full session rate of the time reserved for you unless a medical note is presented. Given emergencies/unforeseen circumstances do arise, **<u>one</u>** missed **or** cancelled appointment within 24hrs will **not** be charged to you. Following this, the charge will apply regardless of the reason for missing the appointment unless a medical note is presented or at least 24hrs notice is given. Whenever possible, please try to give at least one week's notice if you know you may not be able to make your appointment and we will be happy to provide you with another appointment time.

Confidentiality and Privacy

Please note that the use of our online scheduling software (Full Slate) and Google Calendar results in a limited amount of Personally Identifiable Information (PII) being stored on U.S. based data storage servers and may be accessible to law enforcement and national security authorities of that jurisdiction/country. This includes your name, email address, telephone number(s), and appointment dates.

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 circumstances constitute 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 rare 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. Clinical case discussion is a standard practice within psychology and ensures you are receiving optimal care.

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), the Client Information & Consent form. I have discussed and asked questions about any portion of the form I find unclear or unacceptable, and I 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 psychologist/clinician named below.

______________________	______________________	__________
(Clients Signature)	(Client's Printed Name)	(Date)
______________________	______________________	__________
(Clinician Signature)	(Clinician Printed Name)	(Date)