

Information, Policies, and Consent

We are very honored that you have selected Woodlands Family Institute to provide counseling or psychological services. All of us wish to do our best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more satisfying.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be as safe and secure as possible so that we concentrate exclusively on your concerns. You are best served by experiencing me in my professional role. If at any time you are dissatisfied with my services, please let me know.

Children can be joyful and energetic, but with respect to the concerns which brought you to us, we request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you.

Office Policies

Psychotherapy

This document contains important information about my professional services and business policies. Your signature in reference to this form will indicate that you have received this information, have read it, that you understand it, and that you agree to it.

If you have concerns or questions, please feel free to ask me about them.

Sessions

Therapy sessions are scheduled for 50 minutes, unless otherwise planned in advance. I make every effort to start appointments on time. The session time that we have scheduled is reserved for you. If you are not able to keep an appointment, I ask you to give me 24 hour notice. Sessions not cancelled with 24 hour notice will be charged. See below.

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Standard Rate

\$170.00 per 50 minute session. Charges for other professional services are prorated on the basis of \$170.00 per hour. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is charged at the rate of \$170.00 per hour, portal to portal.

Forensic Rates

\$500.00 per hour (portal to portal) for court testimony or deposition. Payment is due 24 hours prior to service provided.

Payment Policy

Payment is due in full at time of service. Please make out your check before the session begins. Visa and MasterCard are also accepted. It is not our policy to carry balances forward. We expect balances for “forgotten checkbooks” or “forgotten appointments” to be made up promptly or by the next regularly scheduled appointment. If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a \$10.00 rebilling for every statement sent out after the first billing. There is also a \$15.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and will impact your credit rating.

Insurance

Your health insurance policy is a contract between you and your insurance company. I am not a party to that contract. Although I am not listed as a provider on any network panels, benefits are often available for services rendered by “out-of-network” providers. I advise that you contact your insurance company to determine how your insurance company will reimburse you. If you elect to seek reimbursement by an insurance carrier for services rendered, I will provide you with a receipt to assist you in completing your insurance claim. We will consult your third-party payer only at your direction with such consultations billed to your account. Some insurance companies reimburse clients for services and some do not. The client remains responsible for payment in full.

Cancellations

Since the scheduling of an appointment involves the reservation of time specifically for you, 24 hour advance notice for any cancelled appointments will not be charged. If you are unable to meet this time schedule, but we are able to assign your appointment time to another client, you will not be charged.

Office Hours

My office hours are from 8 am to 6 pm on Tuesdays and Wednesdays.

Emergencies

In the event that an emergency occurs, leave a message with the answering service, making sure to state that your call is an emergency. I will respond to your call as promptly as possible. Routine calls will be returned during normal office hours. The office phone is (281) 363-4220 or (713) 866-4494. If you are experiencing a life threatening emergency please call 911.

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. I will make every effort to return your call on the same day that you make it, with the exception of weekends and holidays. If you are unable to reach me and it is an emergency, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

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Confidentiality

The law protects the privacy of all communications between a client and psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by federal and state law. There are other situations that require only that you provide written, advance consent. Your signature on our Acknowledgment form provides consent for those activities, as follows.

You should be aware that we practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professional consulted is also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions unless it seems important to our work together. If you would prefer to handle this differently, please let me know. All administrative staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

We also have contracts with some business services, such as the answering service, electronic claims processing services, and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available on request.

I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else; b) I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose abuse or neglect of children, the elderly, or disabled persons; e) the need to release information to other professionals involved in your treatment; f) in proceedings in which a claim is made about one's physical, emotional, or mental condition; g) when disclosure is relevant in any suit affecting the parent-child relationship; h) where otherwise legally required. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties.

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Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally I understand that there can be not absolute guarantee of cure in the practice of psychotherapy.

CLIENT'S SIGNATURE

DATE

Client Information Statement

The Texas Boards of Examiners of Licensed Psychologists, Marriage and Family Therapists, Licensed Social Workers and Licensed Professional Counselors were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of psychology, family therapy, and counseling. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

After reading the agreements, please ask about any part of the agreement that you do not understand.

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PERSONAL DATA RECORD

Client Name _____ Date of Birth _____
Address _____
City/State/Zip _____
SSN _____ TXDL _____
Employer/School/Address _____

May we leave a message at any of the following?

Cell phone (circle one) _____ Yes No
Work phone (circle one) _____ Yes No
Unencrypted email address _____ Yes No

*** Please do not cancel appointments via email. You must contact the office directly.**

If you would like to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other _____

CONSENT FOR TREATMENT

Client Name _____ Date of Birth _____

I give full consent for *myself, my child/adolescent or dependent* due to legal guardianship to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

Authorized Signature

Date

REQUIRED: We require that a credit card be provided for after-hours appointments, missed sessions, and late cancellations. You may also designate the use of this card for regularly scheduled sessions.

Cardholder's Name _____ Relationship _____

MC/VISA/DISC No. _____ Exp. Date _____

Signature of Authorized User _____

Use for **regular** sessions, after hours, missed or late cancel sessions

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Financial Responsibility

Name of person(s) financially responsible for this account _____

Address/phone if different from client _____

Signature(s) _____

Relationship to client _____

Emergency Contact

Name _____ Phone _____

Alternate phone _____ Address _____

Relationship to client _____

Referred to our office by _____

May we send a **thank you** to the person who referred you? (circle one) Yes No

May we mention your **name** in that thank you? (circle one) Yes No

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Appointment Reminders

As a courtesy, you will receive an appointment reminder to your email address or your cell phone (via text message or computer generated voice mail message), the day before your scheduled appointments.

Your name: (Please print): _____

Your email address: _____

Your cell number: _____

Where would you like to receive appointment reminders? (Check one)

_____ Via text message on my cell phone (normal text message rates will apply)

_____ Via email message to the address listed above

_____ Via automated voice mail message on my cell phone

****Missed appointment fees will still apply. 24 hour cancellation policy still applies. Please call the office if you need to cancel an appointment.****

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature

Date

{Please refer to pages 8-9 of this document}

I acknowledge that I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies**. I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

Client or Authorized Representative Signature

Date

_____ Refuse to Sign _____ Unable to Sign (specify reason) _____

Signature of Person Documenting Refusal or Inability to Sign

Date

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute (WFI) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your general consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.
Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within WFI such as utilizing information that identifies you.
- “Disclosure” applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

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- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Client's Rights and Our Professional Duties

Client's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

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CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY

Identifying Information/Presenting Problem:

Child's Name _____ DOB: _____ Age: _____

Education (grade): _____ Present School: _____

Guardian(s): _____

Who referred your child for services: _____

Primary Reason for Services: _____

How long have these problems occurred? (weeks, months, years)

What happened that makes you seek help at this time? _____

Problems perceived to be: _____ very serious _____ serious _____ not serious

What changes would you like to see in your child? _____

What changes would you like to see in yourself? _____

What changes would you like to see in your family? _____

Developmental History:

Prenatal:

Normal pregnancy? _____ Yes _____ No Was prenatal care received: _____ Yes _____ No

Medications, smoking, drugs, or alcohol taken during pregnancy (amount and frequency):

Complications during pregnancy: _____

If mother ill or upset during pregnancy, please explain: _____

Family/Partner reaction to pregnancy: (explain) _____

Father's age at birth _____ Mother's age at birth _____

Length of active labor: _____ hrs. _____ Easy _____ Difficult

Full term: _____ Yes _____ No; Number of weeks _____

Birth weight: _____ lbs. _____ oz. Birth length: _____

Any complications for mother or infant during or after birth? Please explain _____

Number of days in hospital: _____ Postpartum blues or depression? _____

Newborn: Breast or bottle fed? Breast feeding difficulties? _____

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Any difficulties connecting to baby? _____

Please check any of these that occurred during the first 12 months:

- | | |
|---|---|
| <input type="checkbox"/> Difficult to put on a schedule | <input type="checkbox"/> Sociable |
| <input type="checkbox"/> Alert | <input type="checkbox"/> Easy to comfort |
| <input type="checkbox"/> Difficult to feed | <input type="checkbox"/> Difficult to keep busy |
| <input type="checkbox"/> Difficult to get to sleep | <input type="checkbox"/> Overactive, in constant motion |
| <input type="checkbox"/> Colicky | <input type="checkbox"/> Very stubborn, challenging |
| <input type="checkbox"/> Cheerful | <input type="checkbox"/> Affectionate |

At approximately what age did your child first accomplish the following:

- | | |
|-----------------------|--------------------------------|
| Rolled over: _____ | Sat Up: _____ |
| Crawled: _____ | First steps: _____ |
| First word: _____ | Put 2 words together: _____ |
| Toilet trained: _____ | Began daycare/preschool: _____ |

Where there any delays in development? _____

Does your child have any speech difficulties?: _____

Motor difficulties (e.g. clumsiness)?: _____

Does your child have difficulties with hygiene? _____

Please describe any other developmental concerns: _____

Medical History:

Has your child ever been hospitalized, had a seizure, head injury, surgery, or major illnesses?:

Yes (Explain below) No

Age	How Long	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has child ever been seen by a medical specialist? Yes No

Age	How Long	Reason
_____	_____	_____

Child Health Information: Note all health problems the child has had or has now.

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Weight problems |
| <input type="checkbox"/> Flu | <input type="checkbox"/> Allergies | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Unconsciousness | <input type="checkbox"/> Stomach | <input type="checkbox"/> Concussions | <input type="checkbox"/> Accident-prone |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Tonsils out | <input type="checkbox"/> Heart | <input type="checkbox"/> Vision |

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Hearing Earaches Infectious diseases
Other illnesses (explain) _____

What medications does your child currently take? (include over-the-counter and supplements)

Name	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Name and Phone number of Pediatrician: _____

Date and results of last vision screen: _____

Date and results of last hearing screen: _____

Describe child's appetite _____ Any weight concerns? _____

Circle and describe any Feeding Challenges: Pickiness/ Overeating/ Stuffing/ Gagging/ Choking/ Vomiting _____

Describe the child's sleeping patterns: _____

(include problems falling asleep, staying asleep, not enough sleep, oversleeping and sleepwalking) Bedtime: _____

Approximate Number of Hours of Sleep Per Night: _____

Is there a history of nightmares or night terrors? _____ (Describe):

Is there a history of bedwetting? (Describe): _____

Mental Health History:

Has the child received therapy services or counseling in the past? Yes No

Current Services: _____

Past Services:

Name of provider: _____ Dates: _____ Type of Service _____

Name of provider: _____ Dates: _____ Type of Service _____

Is your child seeing a psychiatrist for medication? Or in the past? Yes No

Name of Psychiatrist: _____ Dates of treatment: _____

Medication the Psychiatrist Prescribed: _____

Has your child ever received psychological testing in the past? Yes No

Date/s: _____ Who conducted the testing? _____

Do you have a copy of the report? _____

Results of testing: _____

List any previous mental health diagnoses: _____

Is there a history of self-harm or suicidal thoughts, threats, or attempts? _____

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Explain: _____

List any mental health medications that family members are taking or have taken in the past (who): _____ Has anyone in the family received mental health services?

(Describe): _____

Family

Mother: Relationship to child ___ natural parent ___ relative ___ stepparent ___ adopted

Occupation: _____ Education: _____

Religion: _____ Birthplace: _____ Age: _____

Father: Relationship to child- ___ natural parent ___ relative ___ stepparent ___ adopted

Occupation: _____ Education: _____ Religion: _____

_____ Birthplace: _____ Age: _____

Are parents: Married ___ Yes ___ No
Separated ___ Yes ___ No
Divorces ___ Yes ___ No

Current Members of the Household:

Name	Age	Relationship	How do they get along
1 _____			
2 _____			
3 _____			
4 _____			
5 _____			
6 _____			

Siblings or other immediate family members NOT in the home:

Name	Age	Relationship	How do they get along
1 _____			
2 _____			

If father is not actively involved, have there been other father figures? (e.g. stepfather, boyfriend, relatives) Explain: _____

Describe how everyone typically gets along in your home:
___ Calm, No Conflict ___ Distant, not much interaction ___ Parent Conflicts ___ A lot of Arguing/Conflict ___ Very Close ___ Conflict Only Regarding Child

Explain: _____

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Has the child or the family been involved with the Child Protective Services? _____

Dates: _____ Reason for Involvement: _____

If child is adopted:

Adoption source: _____

Reason and circumstances: _____

Age when child first in home: _____ Date of legal adoption: _____

What has the child been told? _____

Living Arrangements:

Places

Dates

Number of moves in child's life

Present Home: renting own

house apartment

Does the child share a room with anyone else? Yes No

If yes, with whom? _____ Was

the child ever placed, boarded, or lived away from the family? Yes No

Explain: _____

What are the major family stresses at the present time, if any? _____

What are the sources of family income? _____

Has the child been exposed to any of the following:

(Please put an X next to all that apply and explain below):

() Physical Abuse: _____

() Emotional or Verbal Abuse: _____

() Sexual Abuse: _____

() Domestic or Family Violence: _____

() Substance Use or Abuse: _____

() Neglect or Abandonment: _____

() Separation from Parent: _____

Child's reaction to divorce/separation: _____

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

Allergies

Deafness

Muscular Dystrophy

Anemia

Diabetes

Anxiety

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Asthma Glandular problems Autism
 Bleeding tendency Heart diseases Mental Retardation
 Depression High blood pressure Seizures
 Cancer Kidney disease Cerebral Palsy
 Mental illness Alcohol/Drug Problem Migraines
 Suicide Learning Problems Other (specify):
Comments re: Family Health: _____

Education History:

Does/did your child receive early intervention? Behavioral/Speech/OT/PT
Other _____ Did your child attend daycare/preschool? _____
How old was child when began school? _____ Where did they attend? _____
Name of Current School: _____ District: _____
Grades/classes repeated or failed: _____ Reason: _____
Typical Grades: _____
Circle Classroom Type: Mainstream Class Special Education Class
Resource Assistance Other: _____
ARD/IEP Primary Eligibility: MD Mild MD Mod MD Sev MD Prof Autism OHI
ARD/IEP Secondary Eligibility: _____

Has your child had educational/developmental testing? (If yes, Where, When, Results?) _____

Number of schools the child has attended & reason for changes?

Describe any history of learning problems the child has: _____

Any History of Attendance Problems (truancy)? Describe: _____

Describe any behavior problems reported by the school: _____

Has the child ever been suspended or expelled? _____ Number of suspensions in last two years? _____ Reason for suspensions/expulsions? _____

Favorite class or classes: _____ Least favorite: _____

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Social/Emotional Functioning:

Describe the child's personality: _____

What behaviors are concerning to you? _____

How does he/she deal with frustration or anger ? (Mark those that apply and explain):

No Issues Physical Aggressiveness Destruction of Property Self-Harm

Crying/Sadness Withdrawal Verbal Aggressiveness

Explain: _____

What are your child's strengths? _____

What are your child's weaknesses? _____

What is the child afraid of (fears)? _____

Are there any concerns about: Low Self-Esteem Sadness/Depression Worry
or Nervousness Crying _____

Describe your child's relationships with other children or peers:

Does your child have a Boyfriend/Girlfriend? _____

Is your child sexually active? _____

How does the child spend his/her free time? _____

How do you discipline the child? Physical: _____ Time Out Take Away
Privileges No Discipline

What event/change(s) have impacted the child? _____

At what age did you first notice any behavioral or emotional issues? _____

What did you do about it at that time? _____

Legal & Substance Abuse History:

Has the child been involved with the court currently or in the past? _____

(Date/s): _____

(Describe) _____

Current Probation? yes no

Probation Officer: _____ Phone #: _____

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Has the child ever used or abused drugs or alcohol? (Circle): Yes No Not Sure

What Substance(s)? _____

(include nicotine and excessive caffeine use)

Age of First Use? _____ Frequency of Use? _____

Any Consequences of Substance Use? _____

Symptom Checklist

Please check all that apply: (Please write any symptoms not listed at the bottom)

- | | |
|---|---|
| <input type="checkbox"/> Low Intelligence | <input type="checkbox"/> Depressed Mood |
| <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Lack of Pleasure in Activities |
| <input type="checkbox"/> Motor Delays | <input type="checkbox"/> Weight Loss or Gain |
| <input type="checkbox"/> Language Delays | <input type="checkbox"/> Insomnia or Oversleeping |
| <input type="checkbox"/> Stuttering | <input type="checkbox"/> Feeling Restless or Slowed Down |
| <input type="checkbox"/> Refusing to Speak | <input type="checkbox"/> Loss of Energy |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Feeling Worthless or Guilty |
| <input type="checkbox"/> Urinating in Pants | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> Soiling Pants | <input type="checkbox"/> Thoughts of Death |
| <input type="checkbox"/> Smearing Feces | <input type="checkbox"/> Eating Non-Edible Things |
| <input type="checkbox"/> Increased Self Esteem | <input type="checkbox"/> Less Need for Sleep |
| <input type="checkbox"/> Repetitive Movements | <input type="checkbox"/> More Talkative than Usual |
| <input type="checkbox"/> Poor Social Skills | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Lack of Eye Contact | <input type="checkbox"/> Increased Pleasurable Activities |
| <input type="checkbox"/> Obsessed with Specific Objects/Topics (e.g. sex, shopping, etc.) | |
| <input type="checkbox"/> Inattention | <input type="checkbox"/> Repetitive Behaviors |
| <input type="checkbox"/> Does Not Listen | <input type="checkbox"/> History of Trauma |
| <input type="checkbox"/> Problems with Organization | <input type="checkbox"/> Shaking or Trembling |
| <input type="checkbox"/> Loses Things Easily | <input type="checkbox"/> Avoids Situations |
| <input type="checkbox"/> Damages Property | <input type="checkbox"/> Problems Separating from Parents |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Nausea and/or Stomachaches |
| <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Blurts Out/ Talks without Thinking | <input type="checkbox"/> Feeling Like Going Crazy |
| <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Fear of Dying |
| <input type="checkbox"/> Excessive Talking | <input type="checkbox"/> Chills or Hot Flashes |
| <input type="checkbox"/> Interrupts Others | <input type="checkbox"/> Fear of Leaving the House |
| <input type="checkbox"/> Fear of Social Situations | <input type="checkbox"/> Bullies/Threatens Others |
| <input type="checkbox"/> Gets into Physical Fights | <input type="checkbox"/> Recurrent Thoughts or Images |

Woodlands Family Institute, P.C.
Lesley Stabinsky Compton, PhD

{Your clinician will discuss the following items with you upon your initial session, and periodically thereafter as needed.}

Treatment Plan

Diagnostic Impression:

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

Treatment Goals:

1. Reduce frequency and intensity of:
2. Increase frequency and intensity of:
3. Eliminate:

Treatment Methods and Duration:

____ Individual sessions weekly bi-weekly monthly
____ Couple/family sessions weekly bi-weekly monthly

Recommendations for Adjunctive Treatment/Assessment:

Plan Review/Revision:

Lesley Stabinsky Compton, PhD

Date

Client Signature

Date