ADHD FAMILY COUNSELING CENTER OF CENTRAL NEW JERSEY

Irv Finkelstein, LCSW

Licensed Clinical Social Worker

220 St. Paul Street
Westfield, NJ 07090

Introductory Information

1. Name of Child _____
2. Child's Birthplace_____ Age_____
3. Date form filed out _____
4. Family Address

   _____

   _____
5. Home Telephone Number _____
6. Father's Name_____ Mother's Name_____
7. Business Number (Father)_____
8. Business Number (Mother)_____
9. Please provide the following information on each person (adults and children) living in your home (including child being evaluated or treated).

Name	Date of Birth	Place of Birth	Highest Grade or Degree Reached

10. Are there any other "extended family members" or important persons in the child's life who are not living in the home?

11. Please fill in the following information:

	Father	Mother
Number of brothers	_____	_____
Number of Sisters	_____	_____
Which child were you	_____	_____
Occupation of Father	_____	_____
Occupation of Mother	_____	_____

12. Date of your marriage _____

13. Please fill in the following information concerning family employment:

	Father	Mother
Type of Work	_____	_____
Place of Work	_____	_____
Address of Work	_____	_____
	_____	_____
Hours of Work	_____	_____

PRESENTING PROBLEMS

14. Who referred you to this office? (name, address)?

_____

_____

_____

15. What concerns you about your child?

16. How long have you been concerned about the above problem(s)?

17. When and how do you feel these difficulties developed?

18. Do you feel that your child is aware of his/her problem? If yes, how much?

19. What concerns if any do you feel your child's school system has about your child?

CHILD'S MEDICAL HISTORY

20. Who is your child's physician? (name and address)

21. Has he/she had any major illnesses? (Type and when)

22. Has she/he ever been hospitalized? (If yes , please include when, why, how long, where)

23. Have you ever taken your child to any specialist for consultation? (If yes, why, who, where and dates)

24. Is your child currently on medication? If yes, please give the name, dosage, reason, and the prescribing doctor.

25. Was she/he ever on medication for an extended period of time? If yes, explain.

_____

_____

_____

26. Do you feel that a child you had emotional problems or learning disabilities?

Mother:_____

_____

Father:_____

_____

27. Do you feel that any of your other children have emotional problems or learning disabilities?

_____

_____

_____

28. Were there any problems with the pregnancy or birth of child?

_____

_____

_____

29. Were there any problems with feeding or sleeping as a baby?

_____

_____

_____

30. Any concerns regarding your child's developmental milestones (sitting, walking, toilet training etc.)?

_____

_____

_____

31. Do you feel that your child has a speech or hearing or language problem? Has he/she ever been tested?

If so, by whom? Recommendations?

_____

_____

_____

Academic History

32. Please fill out the following information:

Current school placement (grade, type of class): _____

Name of school: _____

School Address: _____

_____

Principal: _____

Teacher's Name: _____

Child Study Team members (if known) _____

_____

_____

33. For each program give age he/she began and describe the experience (positive, negative, problems).

Nursery School: _____

_____

_____

Kindergarten: _____

_____

_____

First-Third : _____

_____

_____

Fourth-Fifth : _____

_____

_____

Middle School: _____

_____

_____

_____

High School : _____

_____

_____

_____

College: _____

_____

_____

_____

34. At this time, at what grade level do you feel your child is functioning in:

Reading: _____

Writing: _____

Arithmetic: _____

School Adjustment: _____

SOCIAL AND PSYCHOLOGICAL DEVELOPMENT

35. To the best you remember, at what age did your child:

Comfortably separate from mother _____

Give up bottle or breast completely _____

Feed himself/herself independently _____

Become bladder trained _____

Become bowel trained _____

36. Since age 3.5 has your child had or still have a problem with bed-wetting? If yes, has he/she been evaluated by your family doctor? _____

_____

37. Does your child sleep through the night? _____

_____

_____

_____

38. Does he/she now have or ever had a problem with:

Nightmares _____

Eating _____

Stealing _____

Fire setting _____

Sneaking/hoarding food _____

Temper tantrums _____

39. Has he/she had or now have any fears?

_____

_____

_____

40. Does he/she get along reasonably with brothers and sisters? If no, please elaborate.

_____

_____

_____

41. Has he/she ever had emotional problems? If yes, was your child ever evaluated? By whom?

Recommendations? Has he/she ever been in psychotherapy before? When? With whom?

_____

_____

_____

42. Has he/she ever had psychological testing? If yes, when and by whom?

_____

_____

_____

43. At what age did your child begin to:

Show sexual curiosity _____

Show modesty _____

Does he/she prefer privacy in the bathroom? Bedroom? _____

_____

_____

_____

44. Do you feel that your child has any excessive concerns or difficulties in the area of sex?

_____

_____

_____

CURRENT STATUS

45. Does your child at home:

Have chores? If yes, what?

_____

_____

_____

Get an allowance? If yes, how much? _____

Get dressed by themselves? If no, how much can they do?

_____

_____

_____

46. At what time does your child usually:

Go to sleep: _____

Fall asleep: _____

Wake up: _____

47. Does your child go to religious school? If yes, please elaborate.

_____

_____

_____

48. Is your child a discipline problem? If yes, please explain.

_____

_____

_____

49. How does your child get along with babysitters? Please elaborate.

_____

_____

_____

50. Does your child get along with other children the same age? If no, please elaborate.

_____

_____

_____

51. Concerning his/her play:

What age group does he/she prefer? _____

_____

What type of play is preferred? (Active, sedentary, formal sports, team sports, fantasy, alone)

Are there neighborhood children or do you need to schedule playmates? _____

52. Does your child have any special interests or hobbies? Please elaborate.

53. Does your child belong to any clubs or organizations (scouts, religious, little league, etc.)? If yes, does he/she enjoy it? How does he/she get along with the other children?

54. Does your child play well with others? If no, please elaborate.

55. Do other children tend to reject him/her or pick on them? If yes, please elaborate.

THE FUTURE

56. What future plans or goals do you have for your child?

_____

_____

_____

57. If your child is an adolescent:

How does your child get along with others of the same sex and age?

_____

_____

_____

Does your child have difficulty accepting limits?

_____

_____

_____

Does your child have difficulty with authority figures?

_____

_____

_____

58. Has your child begun to develop:

Adult sexual characteristics: _____

_____

If girl, begun to menstruate? If yes, when? Any difficulties? _____

_____

Concern about his/her appearance? _____

HOME

59. Housing

Do you live in a house or apartment? _____

Do you rent or own your home? _____

How long have you lived at your present location? _____

How many places have you lived during this child's lifetime? _____

Does he/she have his or her own room? If no, whom do they share with? _____

60. Are there any problems related to your neighborhood?

_____

_____

_____

61. Please share any other information not yet discussed.

_____

_____

_____

_____

_____

_____

ADHD FAMILY COUNSELING CENTER OF CENTRAL NEW JERSEY
Irv Finkelstein, LCSW
Licensed Clinical Social Worker
***Tel.#* (908) 389-0683**
Fax: (908) 389-0218

220 St. Paul Street
Westfield, NJ 07090

Patient-Clinician Authorizations and Agreements

Authorizations and agreements with Irv Finkelstein, LCSW.

Please read carefully and sign. The paragraphs below contain several agreements.

For _____

1. Medical Insurance. I authorize the medical insurance company to pay directly for the above clinical services. I, however, understand that the person who signs below are responsible for all my fees, including any fees not paid by the insurance company. I understand that if I have not provided Irv Finkelstein, LCSW with adequate information in order to allow for the verification of my insurance coverage, that I will be fully responsible for all fees incurred. Also, that as a result, I may not be eligible for reimbursement from my insurance company.

2. It is also understood that it is my responsibility to update Irv Finkelstein, LCSW with any changes in insurance coverage that may occur during treatment with this office.

Release of Information: I authorize Irv Finkelstein, LCSW to release information about me to the medical insurance company and the referring physician. This authorization will end if I give written instructions to Irv Finkelstein, LCSW to that effect, which I may do at any time.

Financial Responsibility*: We, the undersigned; understand and agree that each of us is responsible for the patient's fees to Irv Finkelstein, LCSW including fees not paid by medical insurance; that if the account is not paid when due, reasonable collection costs will be paid by the undersigned; that interest at the rate of 1% per month will be charged on any balance outstanding after 90 days; that we are responsible for full therapy fees resulting from appointments not kept or canceled without a 24-hour notice; that fees for out patient services must be paid at the time services are rendered; and that the patient is responsible for filing for insurance reimbursement.*

I understand that if I have not provided Irv Finkelstein, LCSW with adequate information in order to allow for the verification of my insurance coverage, that I will be fully responsible for all fees incurred. Also, that as a result, I may not be eligible for reimbursement from my insurance company.

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DISCLAIMER

In an attempt to provide quality customer service to our patients any verification of your insurance is only an estimate and is not a guarantee of payment by your insurance company. Any insurance approval implied or otherwise is subject provisions in force at the time services are rendered. As a result, **you the patient will be held responsible for all fees incurred.**

Patient or Parent's signature: _____ Date: _____

Relationship to patient (If patient is a minor) _____

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Consent to Release Confidential Information

I hereby authorize and request,

Irv Finkelstein, LCSW

ADHD Family Counseling Center of Central New Jersey

to release confidential information, including personal, psychological, psychiatric, drug/alcohol, medical records and opinions, resulting from my contacts with the above to:

Name

Title/Functions:

Address:

Disclosure shall be limited to the following specific types of information:

Use of this information shall be limited to the following purpose(s):

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

This authorization shall remain valid until:

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information

Signature _____ **Date** _____

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CREDIT CARD AUTHORIZATION FORM

CREDIT CARD TYPE ☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER**

CREDIT CARD NUMBER _____

EXPIRATION DATE _____ **Card Code (on back)** _____

CARD HOLDER NAME _____

BILLING ADDRESS _____

CITY/STATE/ZIP _____

PHONE _____

AMOUNT **Only to pay for professional services**

I, _____, authorize the use of the above listed credit card to pay the fees for **Irv Finkelstein, LCSW**. I understand that the credit card will be used at my request to pay for session fees**. I also give authorization to use the card to pay for any outstanding fees that are over 90 days overdue. I also authorize the card to be used to cover the cost for any fees occurred for missed sessions or sessions canceled with less than the 24 hours notice required. I understand that these transactions will occur without additional notice.** I understand that fee payment deadlines, and/or late fees are my responsibility. I further understand that I may be charged a penalty fee if the credit card company denies my credit card. I understand that a facsimile or photocopy of this form with my signature on it is the same as an original. A copy of the transaction will be mailed for your personal record. Please ensure that you complete this form in its entirety.

Signature Date

Phone: 908 389-0682 *Fax: 908 389-0218*

Email: irv@adhd911.com