



66 Park Street, Suite 105
Montclair, NJ 07042
www.evolve-ps.com

(917) 723-9986

Biographical Information

Child/Adolescent Information:

Name: _____
Address: _____
Home #: _____
Mobile #: _____
Email: _____
School: _____
Grade: _____

DOB: _____ Age: _____
Gender: _____
Ethnicity: _____
Religion: _____
Language(s): _____

Guardian Information:

Guardian #1: _____
Relationship: _____
Address: _____
Home #: _____
Work #: _____
Mobile #: _____
Email: _____

Guardian #2: _____
Relationship: _____
Address: _____
Home #: _____
Work #: _____
Mobile #: _____
Email: _____

Primary Insurance:

Insurance Company: _____
Plan Name: _____
Insured ID#: _____

Cardholder Name: _____
Employer: _____
DOB: _____

Referral Source:

Mental Health Provider: _____
 Friend or Family Member
 www.nicolegarciaphd.com
 Other: _____

Primary Care Doctor: _____
 Internet (google, yahoo, bing, etc): _____
 www.psychologytoday.com

Forms of Communication:

Can psychologist leave messages on the mobile phone(s) provided above? Yes No
Can psychologist leave messages on the home phone(s) provided above? Yes No
Can psychologist communicate with me via text message (for non-clinical matters)? Yes No
Can psychologist communicate with me via the email (for non-clinical matters)? Yes No

Parent/Guardian Signature

Date

Evolve Psychological Services, LLC

Psychological Testing Background Information

Name: _____

Date: _____

Reason for Referral:
Briefly describe your reason(s) for seeking psychological and/or psychoeducational testing for your child/teen.
How long has your child/teen had the problem(s)?
Are there any kinds of support that make the problem(s) better, such as support from family, teachers, others?
Are there any kinds of stressors that make the problem(s) worse, such as anxiety, peer relationships, etc?
Briefly describe any significant event(s) and/or change(s) that have occurred within the last year.
Why did you decide to seek psychological and/or psychoeducational testing for your child/teen now?
What kinds of help do you think would be most helpful for your child/teen at this time?

Psychological and/or Psychoeducational Testing History:
Has your child/teen previously undergone psychological and/or psychoeducational testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes: How many evaluations have been conducted in total?
When and where was the most recent evaluation conducted?
What was the reason for the evaluation?
What was the outcome of the evaluation?
What were the recommendations made, if any?
If more than one evaluation has been conducted:
When and where was the first evaluation conducted?
What was the reason for the evaluation?
What was the outcome of the evaluation?
What were the recommendations made, if any?

Please check any of the following behaviors/symptoms that apply to your child/teen:	
<input type="checkbox"/> Thoughts of suicide	<input type="checkbox"/> Thoughts of harming others
<input type="checkbox"/> Trouble getting to sleep	<input type="checkbox"/> History of attempts to kill him/herself
<input type="checkbox"/> Waking during the night	<input type="checkbox"/> Cutting or self-injurious behavior
<input type="checkbox"/> Waking early every day	<input type="checkbox"/> Feelings of hopelessness
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Inability to make decisions
<input type="checkbox"/> Excessive guilt	<input type="checkbox"/> Trouble controlling temper
<input type="checkbox"/> Decreased motivation	<input type="checkbox"/> Large weight gain or loss
<input type="checkbox"/> Excessive energy	<input type="checkbox"/> Seeing things others do not
<input type="checkbox"/> Fidgets or squirms in seat	<input type="checkbox"/> Hearing voices
<input type="checkbox"/> Disorganized, loses things often	<input type="checkbox"/> Violence toward others
<input type="checkbox"/> Daydreams or “zones out” often	<input type="checkbox"/> Cruelty to animals
<input type="checkbox"/> Trouble concentrating	<input type="checkbox"/> Tingling or numbness
<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Flashbacks
<input type="checkbox"/> Always worrying about something	<input type="checkbox"/> Depressed mood
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Frustrated easily
<input type="checkbox"/> Obsessional thoughts	<input type="checkbox"/> Irritability
<input type="checkbox"/> Compulsive behaviors	<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Steals or lies	<input type="checkbox"/> Expansive/Elevated mood
<input type="checkbox"/> Disorganized/Disruptive thoughts	<input type="checkbox"/> Anorectic/Bulimic behavior
<input type="checkbox"/> Paranoid thoughts	<input type="checkbox"/> Appears to have low self-esteem
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Prefers to be alone
<input type="checkbox"/> Phobias	<input type="checkbox"/> Complains of aches and pains
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Learning problems
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Problems at school
<input type="checkbox"/> History of physical abuse	<input type="checkbox"/> Frequent peer conflicts
<input type="checkbox"/> History of sexual abuse	<input type="checkbox"/> Frequent family conflicts
<input type="checkbox"/> Financial problems	<input type="checkbox"/> Legal problems
<input type="checkbox"/> Health problems	<input type="checkbox"/> Alcohol/substance abuse problems
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Please check any of the following settings/situations where your child/teen has difficulty:			
<input type="checkbox"/> When getting ready for school	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When separating at morning school drop-off	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When at school	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When transitioning into the home after school	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When doing homework	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When eating at the dinner table	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When playing by him/herself	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When playing with siblings	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When playing with friends/peers	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When engaging in physical activity/sports	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When with a babysitter/other caregiver	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When in public places	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When in the car	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When told to do something he/she doesn't like	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When watching TV	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> When playing a video game	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> Other:	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
<input type="checkbox"/> Other:	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently

Please describe your child's/teens strengths and talents (artistic, musical, athletic, etc):

Mental Health Treatment History:

Is your child/teen currently under the care of a psychiatrist? Yes No

If yes: What is the name of the psychiatrist?
 What are the diagnoses?
 What medications, if any, are currently prescribed?
 Does your child/teen consistently take the medication prescribed?
 What are the positive and/or negative effects of the medication?

Has your child/teen ever received outpatient mental health treatment? Yes No

If yes: For what reasons did your child/teen need help?
 Did it help?
 With whom was your child/teen in treatment?
 How long was your child/teen in treatment?
 Was your child/teen prescribed any medication?

Has your child/teen ever received inpatient mental health treatment? Yes No

If yes: For what reasons did your child/teen need help?
 Did it help?
 In what hospital did your child/teen receive treatment?
 How long was your child/teen in treatment?
 Was your child/teen prescribed any medication?

Alcohol and Drug Use History (please check any of the following substances that your child/teen is currently using and provide information regarding usage):

Substance	Age first used	Weekday use	Weekend use	Monthly use	Last used
<input type="checkbox"/> Beer					
<input type="checkbox"/> Liquor					
<input type="checkbox"/> Wine					
<input type="checkbox"/> Marijuana					
<input type="checkbox"/> Cocaine/Crack					
<input type="checkbox"/> Methamphetamine					
<input type="checkbox"/> Heroin					
<input type="checkbox"/> Barbituates (downers)					
<input type="checkbox"/> PCP, LSD (hallucinogens)					
<input type="checkbox"/> Tobacco (any form)					
<input type="checkbox"/> Other:					

Has your child/teen ever felt like he/she should cut down on his/her use? Yes No

Has a friend or relative expressed concern about his/her use? Yes No

Has your child/teen ever felt guilty about his/her drinking or drug use? Yes No

Is your child/teen in recovery from abusing alcohol or drugs? Yes No

Is there a history of problems with drug or alcohol use in your family? Yes No

Evolve Psychological Services, LLC

Developmental History

Name: _____

Date: _____

Current Household Composition:		
Name	Relationship	Age

Developmental History:
Is child your: <input type="checkbox"/> biological child <input type="checkbox"/> adopted child <input type="checkbox"/> foster child <input type="checkbox"/> other:
Are parents of child/teen currently: <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> never married
If separated or divorced: Who has legal custody? What is the visitation agreement? How has your child/teen feel adjusted to the separation/divorce? Does your child/teen spend time with any other person not in the home?
Were there any complications with pregnancy or child birth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Length of pregnancy (in weeks):
Child's birth weight (pounds, ounces):
During infancy, please describe your child's temperament:

During the first few years of life, please check off any of the following behaviors that were present to a significant degree:	
<input type="checkbox"/> did not enjoy cuddling <input type="checkbox"/> was not easily calmed by being held <input type="checkbox"/> difficult to comfort <input type="checkbox"/> colicky <input type="checkbox"/> excessive irritability <input type="checkbox"/> diminished sleep	<input type="checkbox"/> difficult nursing <input type="checkbox"/> poor eye contact/did not turn toward caregivers <input type="checkbox"/> did not respond to name or speech of caregivers <input type="checkbox"/> fascination with certain objects <input type="checkbox"/> constantly into everything <input type="checkbox"/> frequent head banging

Please indicate the age or age range when your child performed the following milestones:							
Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years
Sat up without help							
Crawled							
Walked alone							
Walked up stairs							
Spoke first words							
Spoke first phrases							
Spoke sentences							
Fully bladder trained							
Fully bowel trained							
Stayed dry all night							

Educational History (please list schools attended and describe your child's/teen's academic and behavioral performance):

Preschool/Daycare:

Elementary School:

Middle School:

High School:

Description of current functioning at school:

How does your child/teen feel about school?

How does your child/teen interact with his/her friends/peers?

How motivated is your child/teen to learn?

How much time does your child/teen spend on homework each night, on average?

How much of a struggle is homework?

What types of grades does your child/teen earn, on average?

What subjects are easier for your child/teen?

What subjects are harder for your child/teen?
Does your child/teen receive special school services (IEP, 504, Gifted/Talented)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Does your child/teen receive any tutoring/extra help outside of school? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:

Description of current functioning at home:
What is your child's/teen's personality/basic mood at home?
How does your child/teen get along with his/her brothers/sisters?
Which adult would your child/teen prefer to talk with about a problem?
Which family member does your child/teen feel closest to?
Who is primarily responsible for discipline at home?
What are the methods of discipline used for dealing with your child's/teen's misbehavior?
How does your child/teen respond to discipline?
What are your child's/teen's responsibilities at home?
On a school night, how many hours of sleep does your child/teen get on average? On a non-school night?
Does your child/teen eat regularly? What are your child's/teen's preferred foods?

On a school night, how much time does your child/teen spend:	On a non-school night, how much time does your child/teen spend:
watching TV? playing video/computer games? texting? on social media? other:	watching TV? playing video/computer games? texting? on social media? other:

Medical History:
What is the state of your child's/teen's current health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Is your child/teen currently under the care of a primary care physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes: What is the name of his/her physician? What are the diagnoses? What medications, if any, are currently prescribed? Is your child/teen consistently taking the medication prescribed? What are the positive and/or negative effects of the medication?
List any medical or physical problems and when they were diagnosed:
List any vision or hearing problems:
List any major surgeries your child/teen has had to date:
List any serious illness or injuries including any seizures or head injuries:
List any allergies to foods or drugs:
Date of last physical examination:

Family History (please check any of the following problems and indicate the biological family members with the history):
<input type="checkbox"/> Emotional problems:
<input type="checkbox"/> Learning difficulties:
<input type="checkbox"/> Speech or language difficulties:
<input type="checkbox"/> Developmental delays:
<input type="checkbox"/> Medical problems:
<input type="checkbox"/> Genetic disorders:
<input type="checkbox"/> School failure:
<input type="checkbox"/> Alcohol or drug addiction:
<input type="checkbox"/> Other:
<input type="checkbox"/> Other:

Thank you for providing this important information about your child/teen!

Evolve Psychological Services, LLC

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the American Psychological Association Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse, neglect, or abandonment; the reporting of the abuse, neglect, or exploitation of an elderly or disabled person; or mandatory government agency audits or investigations (such as the psychology licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer: Nicole Garcia, PhD, Evolve Psychological Services, 66 Park Street, Suite 105, Montclair, NJ 07042.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. This right includes medical records and billing records but does not include psychotherapy notes. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer: Nicole Garcia, PhD, Evolve Psychological Services, 66 Park Street, Suite 105, Montclair, NJ 07042, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is April 14, 2008.

Evolve Psychological Services, LLC

Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Name: _____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Evolve Psychological Services' Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Dr. Garcia, Owner, Evolve Psychological Services at the address and/or phone number below:

66 Park Street, Suite 105
Montclair, NJ 07042
(917) 723-9986.

Parent/Guardian Signature

Relationship

Date

Evolve Psychological Services, LLC

Informed Consent for Child/Adolescent Psychological Testing

This form documents that I _____ (*Name of Guardian*) hereby give our consent to _____ (*Name of Psychologist*) to conduct psychological testing with my child/adolescent _____ (*Name of Child/Adolescent*).

I have fully discussed with the psychologist what is involved in psychological testing and we have agreed to the policies about scheduling, fees, missed appointments, third party payments and other matters outlined below. Our discussions have included the initial intake session, the referral questions and purpose of the evaluation, the types of testing materials utilized, the approximate length and frequency of testing sessions, the nature and purpose of the written report, the feedback session of testing results and recommendations and the guidelines for confidentiality and record keeping. I have been informed and understand the goals of psychological testing as well as the foreseeable benefits and risks. In addition, the psychologist has discussed how to reach the psychologist in emergency situations.

I understand that personal information is kept confidential and will not be revealed to others without written consent. Some exceptions are:

1. The psychologist is required by law to report suspected child abuse or neglect or suspected abuse of an elderly person to the authorities.
2. In the event that I or my child/adolescent intends to harm another person or ourselves and there is immediate danger present the psychologist may be required to take steps to warn or protect the person at risk by informing that person, designated family members, the police or other health care providers.
3. If my health insurance or managed care plan will be reimbursing the client/family for services rendered, it may require that we waive confidentiality and the psychologist to provide them with information about the services.

I understand that the evaluation sessions will be occurring at agreed upon dates and times and fee, \$_____, and that I will be responsible for payment at the time of the first session. Unless the psychologist receives 24 hours' notice of canceling the appointment, I am responsible for the payment of that missed session at the fee of \$250/hour based on the number of hours allotted for the session that particular day. Additional clinical face-to-face time will be prorated in 15-minute increments according to the fee above. This additional time may include the administration of additional, more specialized tests of phonological processing, oral reading, written language and personality functioning that are deemed appropriate based on the scores obtained from the standard protocol, and will only be administered with the expressed consent of the guardian. I also understand that I am responsible for the payment of other services that we may request including telephone consultations with other mental health providers, teachers, etc., preparation of records, and time spent performing any other service, and that such services will be prorated in 15-minute increments according to the hourly fee above.

By signing below I am attesting to the fact that I have read, discussed, and understood this form and give my consent for psychological testing.

Guardian Signature

Date

Evolve Psychological Services, LLC

Consent for Release of Information

Client Name: _____ Date: _____
Address: _____ Home #: _____
_____ Mobile #: _____

Nature of information to be disclosed: Emotional, Behavioral, Medical and/or Academic Functioning

Purpose for release of information: Psychological Testing/Care Coordination

Information of professional providing information:

Name: _____ Office #: _____
Institution: _____ Fax #: _____

Information of psychologist receiving information:

Name: _____ Office #: _____
Institution: Evolve Psychological Services Fax #: _____

I hereby authorize the periodic release of the above information to the person identified above as often as necessary to plan for treatment or testing. I understand that I have the right to cancel my permission to release information at any time.

My consent to release information from the Person/Facility identified above will expire when I am no longer receiving services or one year from this date whichever occurs first.

Signature of Client/Person Acting for Client

Relationship

Date