



Dear Friend:

We are grateful you have selected the Rice - Lewis Clinic for your health care needs and look forward to meeting you.

Visits are by appointment only and appointment times vary according to individual therapists or psychiatrist. Clinic staff are available from 8:15 a.m. until 4:45 p.m. Monday through Thursday and 8:15 a.m. until 12:00 p.m. on Friday to answer your phone calls. In the event of an emergency your calls will be answered by our answering service and one of our professionals will get back to you as soon as possible.

Please feel free to contact us at anytime during office hours if you have any questions or require further information. We want to assist you in any manner possible. Enclosed, you will find an appointment card for your first appointment. Please note that our cancellation policy requires 24-hour advance notice in order to avoid being billed for a missed appointment.

Also enclosed you will find a clinic brochure, a Life History Questionnaire, and a registration form. Please complete these forms and return to the Clinic at the time of your first appointment. Plan to arrive twenty minutes early for your first appointment for you will need to complete a little more paper work.

Thanks in advance and again thanks for choosing us, it means a lot.

Sincerely,

A handwritten signature in black ink that reads "Robert Rice, M.D." in a cursive style.

Robert Rice, M.D. and Staff

PARENT FORM

Date form completed: _____

CHILD'S NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____

HOME PHONE: _____ GRADE: ____ SCHOOL: _____ TEACHER: _____

FATHER'S NAME: _____ AGE: _____ OCCUPATION: _____

MOTHER'S NAME: _____ AGE: _____ OCCUPATION: _____

MARITAL STATUS (check one): Married Separated Divorced Never Married

CUSTODY STATUS (check one): Joint Mother Father Other: _____

STEP-FATHER: _____ AGE: _____ DATE MARRIED: _____

STEP-MOTHER: _____ AGE: _____ DATE MARRIED: _____

List siblings' name, age, relationship (e.g., full, half, step) and whether they live in the home with the child.

NAME	AGE	RELATIONSHIP	LIVE IN HOME
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY (Please indicate at which age your child has had or been diagnosed with the following conditions or illnesses. Leave blank ones that do not apply. For headaches, also note frequency in a one-month period of time.)

Primary Care Physician: _____ **City:** _____

Chicken Pox	Measles	Mumps
Flu	Asthma	High Fever
Seizure(s)	Meningitis	Encephalitis
Migraine Headaches	Sinus Headaches	Stress Headaches
Heart Problems	Anemia	Cancer

(Medical History continued)

Does your child suffer from allergies or sinus infections? ___ Yes ___ No

Describe: _____

Has your child ever received an injury to the head? ___ Yes ___ No Loss of consciousness? _____

Generally describe what happened: _____

Medical Treatments/Hospitalization: _____

Has your child been hospitalized for anything other than a head injury? Yes No Explain: _____

Is your child currently taking any medications? ___ Yes ___ No Medication and Dosage: _____

DEVELOPMENTAL HISTORY (Indicate the category that best describes when your child met the following developmental milestone categories):

SPEECH: ___ Within Normal Limits ___ Delayed (circle one: slightly severely) ___ Advanced

MOTOR: ___ Within Normal Limits ___ Delayed (circle one: slightly severely) ___ Advanced

SOCIAL: ___ Within Normal Limits ___ Delayed (circle one: slightly severely) ___ Advanced

SELF-CARE: ___ Within Normal Limits ___ Delayed (circle one: slightly severely) ___ Advanced

FAMILY MEDICAL/PSYCHIATRIC HISTORY: In your family was there a history of the following:

Seizures or Epilepsy? _____ Heart disease? _____ Respiratory disease? _____ Cancer? _____ Asthma? _____

Alcoholism? _____ Substance abuse? _____ Prolonged/chronic physical illness? _____

Depression? _____ Manic/Depression (or Bipolar Disorder)? _____ Anxiety? _____ Obsessive/Compulsive? _____

Schizophrenia? _____ Attention Deficit Hyperactivity Disorder? _____ Other? _____

MOTHER'S PREGNANCY: Under Doctor's Care? ___ Yes ___ No

If you experienced any of the following problems, please **indicate the month of pregnancy** in which they occurred:

Bleeding	Injury (Describe)
Threatened Miscarriage	Early Contractions
Toxemia	Anemia
Measles	Other Serious Illness

List any medications you took: _____ Activity level of baby? _____

Did you smoke? _____ Drink Alcohol? _____ Use Drugs? _____ Which Months? _____

BIRTH HISTORY:

Type of delivery: Vaginal _____ Cesarean _____ Emergency? ___ Yes ___ No Induced or Elective: _____

Forceps Used? ___ Yes ___ No Natural Childbirth? ___ Yes ___ No Premature? _____ Twins? _____

Hospital Stay: _____ Complications: _____ Oxygen used? _____

Condition at Birth: Good Fair Poor Birth weight: _____ Color: Normal Blue Yellow

Tell about any problems with feeding, breathing, etc., which occurred soon after birth: _____

If adopted, at what age? _____ Do you have information about biological parents? _____

REASON FOR REFERRAL: Tell your main concerns with your child, when and how they began, frequency and intensity, and what goal(s) you hope to accomplish by coming here.

FAMILY PROBLEMS: Tell about marital problems, psychiatric illness or emotional problems, alcoholism, drug abuse, or other major upsetting events in the family.

CHARACTERISTICS OF CHILD:

How would you describe your child's personality? _____

Does your child get along well with father? _____ mother? _____ brother(s)? _____ sisters(s)? _____

Who is your child very close to? _____

How does your child get along with other children? _____

What kinds of discipline techniques work best with your child? _____

LEGAL ISSUES:

Custody Issues? ___ Yes ___ No Charges pending against child? ___ Yes ___ No
 Child on probation? ___ Yes ___ No Probation Officer: _____
 Parent or other family member incarcerated? ___ Yes ___ No Explain: _____

SOCIAL SKILLS ASSESSMENT: Below, you will see a list of five social skills categories. Within each category are five pairs of opposite characteristics. Please check the statement in each pair that best describes your child.

PEER RELATIONS

Compliments peers	Poor peer relations
Offers help or assistance	Likes to be alone
Invites peers to interact	Is teased/picked on
Participates in discussions	Prefers Younger companions
Stands up for fights of peers	Is shy, timid

COOPERATION

Follows instructions	Argues with adults
Follows rules	Defies rules
Uses free time appropriately	Deliberately annoys others
Shares belongings	Is touchy or easily annoyed
Responds appropriately to criticism	Blames others for his/her mistakes

SELF MANAGEMENT

Remains calm	Temper tantrums
Follows rules & limits	Refuses directions
Will compromise	Dominates or bullies
Accepts criticism	Impertinent or "smart"
Appropriately responds to teasing	Fighting

ASSERTION

Initiates conversations	Won't talk
Acknowledges compliments	Shy, timid
Invites others to interact	Withdrawn
Is self-confident	Cold, unresponsive
Makes friends	Likes to be alone

ACADEMIC

Independently accomplishes tasks	Passive or lazy
Completes assignments	Fails to finish tasks
Follows teacher directions	Inattentive or distractible
Produces work of acceptable quality	Clumsy
Uses free time appropriately	Daydreaming

Please use the space below to write any additional comments or information you would like to provide.

I have read all of the information in this packet and certify that the information I have provided is true and correct to the best of my knowledge. I will notify you of any changes in the information contained herein.

Signature of person completing form/Date

Relationship to child

CHILD SYMPTOM CHECKLIST-IV

Child: _____ Date: _____

Age: _____ Rater: _____

Instructions: Check (☑) which rating best describes the child's overall behavior. Answer each question to the best of your ability.

Section 1a	Never	Some-times	Often	Very Often
1. Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
2. Has difficulty maintaining attention in tasks or play activities				
3. Does not seem to listen when spoken to direct				
4. Does not follow through on instructions and fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions)				
5. Has difficulty organizing tasks and activities				
6. Avoids, dislikes, or is reluctant to engage in tasks that require continued mental effort (such as schoolwork or homework)				
7. Loses things necessary for tasks or activities (for example, toys, school assignments, pencils, books, or tools)				
8. Is easily distracted by other things going on				
9. Is forgetful in daily activities				

Section 1b				
1. Fidget with hands or feet or squirms in seat				
2. Leaves seat in classroom or in other situations in which remaining seated is expected				
3. Runs about or climbs too much in situations in which it is inappropriate				
4. Has difficulty playing quietly				
5. Is "on the go" or acts as if "driven by a motor"				
6. Talks too much				
7. Blurts out answers before questions have been completed				
8. Has difficulty awaiting turn				
9. Interrupts or intrudes on others (for example, butts into conversations or games)				

OVER PLEASE!

Section 2	Never	Some- times	Often	Very Often
1. Loses temper				
2. Argues with adults				
3. Active defies or refuses to mind adults' requests or rules				
4. Deliberately annoys people				
5. Blames others for his or her mistakes or misbehavior				
6. Is touchy or easily annoyed by others				
7. Is angry and resentful				
8. Is spiteful or vindictive (for example, takes anger out on others or tries to get even)				

Section3				
1. Bullies, threatens, or intimidates others				
2. Starts physical fights				
3. Lies to obtain goods or favors or to avoid obligations (that is, "cons" others)				
4. Stays out at night despite parental not allowing him or her to do so				
5. Is truant from school				
<i>For the items below, circle No or Yes</i>				
6. Has used a weapon that can cause serious physical harm to others (for example, a bat, brick, broken bottle, knife, gun)	No	Yes		
7. Has been physically cruel to people	No	Yes		
8. Has been physically cruel to animals	No	Yes		
9. Has stolen while confronting a victim (for example, mugging, purse snatching, extortion, armed robbery)	No	Yes		
10. Has forced someone into sexual activity	No	Yes		
11. Has deliberately engaged in fire setting with the intention of causing serious damage	No	Yes		
12. Has deliberately destroyed others' property (other than by fire setting)	No	Yes		
13. Has broken into someone else's house, building, or car	No	Yes		
14. Has stolen items of nontrivial value without confronting a victim (for example, shoplifting, but without breaking or entering; forgery)	No	Yes		
15. Has run away from home overnight at least twice while living at home (or once without returning for a lengthy period)	No	Yes		

Thank You!

CHILD/ADOLESCENT REGISTRATION

Child's Name _____ Birth Date _____ Age _____
Address _____ Place of Birth _____
City/Zip Code _____ Length of time at present address _____
Home Phone _____ Child's Social Security # _____
School _____ Grade _____ Teacher's Name _____
How did you hear about our clinic? _____

PRESENT FAMILY INFORMATION (FAMILY CURRENTLY RESPONSIBLE FOR CHILD)

Fathers Name _____ Age _____ Education _____
Mothers Name _____ Age _____ Education _____
Father's Occupation _____ Social Security # _____
Where Employed _____ Business Phone _____
Are the natural parents still Married? Separated? Divorced?
Is either parent a step -- or adoptive parent? YES NO If YES, please specify _____
Physician's Name _____

LIST ALL CHILDREN IN FAMILY:

NAME	AGE	RELATIONSHIP TO PATIENT	SCHOOL GRADE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In Case of Emergency, Whom Shall We Contact (Other Than Spouse or Parents)?

_____ Name _____ Address _____ Phone _____

ALL FEES ARE DUE AT THE TIME OF THE APPOINTMENT. Fees are due for any scheduled appointment unless the appointment is cancelled twenty-four hours in advance. If your insurance will cover our services, it is necessary that you first pay our fees yourself and then collect from your insurance company.

IN CASES OF DIVORCE: The parent who authorizes the child to receive counseling is responsible for payment of the bill.

AUTHORIZATION: I authorize the Rice-Lewis Clinic to release medical information to insurance carriers concerning this illness/accident and to make any necessary appeals in my behalf. I assign claim payments to the Rice-Lewis Clinic if they file a claim in my behalf for services provided. This authorization and assignment may be revoked by me at any time by written notice.

Patient _____ Date _____ Signature _____ Relationship _____

PLEASE SIGN BELOW. I give permission to the Rice-Lewis Clinic to treat the above registered minor.

Signature _____ Date _____

Relationship _____

GUARANTOR OF ACCOUNT

Name _____ Social Security # _____ Home Ph# _____

Address _____
(Street) (City) (State) (zip Code)

Employer _____ Work Ph# _____

INSURANCE

Primary Insurance Carrier _____ Phone # _____

Subscriber's Name _____ Social Security # _____

Relationship to Patient _____

Insurance I.D.# _____ Group Name/Number _____

Secondary Insurance Carrier _____ Phone # _____

Subscriber's Name _____ Social Security # _____

Relationship to Patient _____

Insurance I.D.# _____ Group Name/Number _____