DR.
ROZ
SANDPLAY CONSULTATION
and TRAINING

CHILD OVER 6 OR TEEN PORTFOLIO

CHILD INFORMATION

Name: _____ **Date:** _____

Age: _____ **Date of Birth:** _____/_____/_____

Address:_____

Occupation: _____ **Employed by:** _____

Occupation: _____**Employed by:** _____

Home Phone #: (_____) _____**Work Phone #:** (_____) _____

Home Phone #: (_____) _____**Work Phone #:** (_____) _____

Cell Phone #: (_____) _____ **Cell Phone #:** (_____) _____

Person Responsible for Payment: _____

Medical Information:

Physician(s):_____**Phone #(s):** _____

Any Medical Problems:

_____

Current Medications:

_____

Referral:

Who referred you to this practice:

_____

What is your reason for consulting specifically with this practice?

DEVELOPMENT QUESTIONNAIRE

GENERAL INFORMATION

Child's Name: _____

Age: _____ **Sex:** _____ **Date of Birth:** _____

Current Grade: _____ **Is your child home schooled?** _____

Does your child attend Public or Private School? _____

Was your child adopted? _____ **If yes, at what age?** _____
(Please provide information on the back of this page and additional pages if needed)

Parent's Name: _____ **Educational Level:** _____

Current Work: _____

Parent's Name: _____ **Educational Level:** _____

Current Work: _____

Brothers/Sisters:

Name	Biological? Yes/No (Explain)	Living at Home? Yes/No	Age	Sex	Grade

Please list all other people living in your child's home:

Name	Age	Relationship to Child	Health/Problems

Please list any other people who care for your child for a significant amount of time (e.g., grandparent, neighbor, etc.):

Please list religious affiliation/spiritual connection(s) of parents/child:

PARENTAL STATUS

If partnered, for how long?: _____If married, on what date?: _____

If separated or divorced, please give date(s) and on the back of this page explain the circumstances, custody & visitation schedule (if any) and communication status between parents. Additionally, please attach a copy of the custody order.

If a parent is deceased, please give the date and explain the circumstances:

If your child was adopted, please give any relevant information about biological parent history:

Briefly describe your child:

BIRTH AND TODDLER HISTORY
(If adopted, please answer to the best of your knowledge)

Were there any illnesses/complications during pregnancy with this child? Explain.

Total number of pregnancies: _____

Were there any miscarriages: _____ Please explain circumstance(s):

How does this child compare with her/his siblings, if any?

During the infant/toddler years, did either parent stay home full or part time?
If so, please elaborate on the circumstances.

At what age did the child go to day care? What type of situation was this? (e.g., home, day care center, etc.) How many hours per week?

Did your child have a toddler or young child history of emotional or behavioral difficulties, such as (please select each behavior that applies):

head banging
obsessive thoughts
breath holding
compulsive need to count things
day soiling
overly aggressive behavior
excessive temper tantrums
irritability
compulsive need to count things
difficulty controlling her/his impulses

Approximately when did any of the above behaviors start, if any?

	Age Began	Still Occurring
Did your child ever…		
Hurt him or herself:	_____	**Yes / No**
Have excessive sleep problems (either getting to sleep, going to sleep, nightmares or night terrors)?	_____	**Yes / No**
Have excessive bedwetting difficulties?	_____	**Yes / No**
Exhibit excessive fears?	_____	**Yes / No**

Exhibit excessive fantasizing? _____ **Yes / No**

Intentionally hurt others? _____ **Yes / No**

Have problems going to school? _____ **Yes / No**

Exhibit difficulty paying attention or concentrating? _____ **Yes / No**

Exhibit frequent mood changes? _____ **Yes / No**

Exhibit motivational problems? _____ **Yes / No**

Have difficulty with substance abuse? _____ **Yes / No**

Other (please explain):

Developmental Milestones

Age at which your child:

Sat up alone _____
Crawled _____
Began saying a few words _____
Began walking _____
Spoke in short sentences _____
Laughed _____
Played alone _____
Began toilet training _____
Ended toilet training _____
Fed him/herself _____

SCHOOL HISTORY (If your child is home schooled please disregard)

Schools Attended:

Elementary: _____

Junior High: _____

High School: _____

Any skipped grades: _____ What grade(s): _____

Any repeated grades: _____ What grade (s): _____

Favorite subjects: _____

Difficult subjects: _____

Has your child attended any gifted and talented classes? Yes / No

If so, please list:

Has your child participated in special education classes? Yes / No

If so, please describe the type of services provided, and what categories your child was placed in:

MEDICAL/MENTAL HEALTH HISTORY

Has your child had any serious accidents/injuries/illnesses involving such things:
If so, please explain.

Convulsions -

High fevers -

Loss of consciousness -

Fainting -

Headaches -

Allergies -

Chronic fatigue -

Head injuries -

Ear problems -

Meningitis -

Did your child ever require hospitalization? If so, please explain:

Current Pediatrician's name: _____

Address and Phone Number: _____

When was your child's last complete physical? _____

Any special physical problems? If so, please list below:

Is your child currently on medication: If so, please explain:

Does your child have any health problems at this time?

Has your child previously seen a therapist? Yes / No

If so, at what age(s)? _____

Whom did s/he see: _____

About how many meetings did the child/family have? _____

Has your child ever been evaluated by a psychologist privately or through the school system?
If so, when, and by whom?

What do you remember of the results/recommendations?

Has any member of your child's immediate family participated in mental health treatment?
If so, please explain. (You may use the extra "Notes" page below if needed).

Has your child ever been molested? Yes / No

If so, when and by whom?

Has your child had any abuse prevention/assertiveness training?

Would you be interested in further information? Yes / No

ABOUT YOUR CHILD

List any significant life traumas:

List any significant life influences:

How would you characterize your child's relationship with her/his siblings(s)?

Whom is the child most like, in your family?

In your family, with whom does your child share secrets, worries, feelings?

What discipline method(s) have you found to be most effective with your child?

What are your child's favorite activities?

Does your child participate in any after-school activities?

Please list any chores or jobs your child has at home (e.g., babysitting, making her/his bed, taking out the garbage, etc.):

How well does your child carry out those chores?

What are your main concerns about your child?

What kind of help do you expect from me in working with your child?

Extra notes:

Name of Person(s) completing this form:

_____

Date: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____,
(Client Name or Parent/Legal Guardian Name)

hereby grant and authorize:

Rosalind L. Heiko, Ph.D.
Sandplay Teaching Member, Sandplay Therapists of America (STA)
International Society for Sandplay Therapists (ISST)

to use all data (including photographs of sandplay images) in her casework with:

▫ _____**Myself**
▫ _____**Minor Child of whom I am the parent or legally appointed guardian**

For the purpose of: (please initial all that apply)
_____ **Research**
_____ **Presentation at professional meetings/conferences/workshops**
_____ **Training**
_____ **Publications**
_____ **CD/DVD publication**
_____ **Electronic publication (utilizing the Internet)**
_____ **Professional Consultation**

I understand that I or my child will be assigned a pseudonym by Dr. Heiko to protect your/their privacy. No last name will be used. This pseudonym will be:
_____

The present authorization will last indefinitely unless I revoke it in writing.

_____
Signature

_____
Printed Name

Address: _____

Signature: _____

Date: _____

AUTHORIZATION REGARDING
CHILD/TEEN CLIENT INFORMATION

I am the parent of _____ and authorize
Print Child/Teen Name Here Please

Pediatric & Family Psychology, P.A. to:

____Exchange Information about my child/teen with
____Release Information about my child/teen to
____Request Information about my child/teen from

_____
Name of Professional & Agency

_____
Agency/Address

_____
Address/Telephone Number(s)

I may revoke this authorization in writing at any time by sending written notification to Pediatric & Family Psychology, P.A. (return receipt requested). I understand that if I do so, information disclosed prior to the written notice cannot be recalled. This authorization may be subject to re-disclosure by the recipient of this request and may no longer be protected by the HIPAA Privacy Rule. This authorization is valid for one year from the date signed.

_____
Parent or Legal Guardian Name

_____
Date

CHILD/ ADOLESCENT FORM
FOR NOTICE & CONSENT

Acknowledgement of Receipt of Notice of Privacy for:

_____
(Child/Teen Name)

I, _____ have received a copy of Pediatric & Family's
(Print Name of Parent/Guardian)
Policies.

_____ _____
Signature **Date**

PSYCHOTHERAPIST- CLIENT AGREEMENT

I, _____ agree to abide by the terms of the
(Print Name of Parent/Guardian)

Psychotherapist-Client Services Agreement Form for the duration of our therapist-client relationship.

_____ _____
Signature **Date**

CONSENT FOR CARETAKERS/STEPPARENTS/RELATIVES TO OBTAIN PSYCHOLOGICAL CARE FOR YOUR CHILD

If someone you have entrusted with the care of your minor child (such as grandparents or child care worker, teenaged children, or other adult relatives), brings your child to the office with your consent, I will act as if you personally consented to treatment for your child. Any PHI that results from this visit will be treated the same as PHI that results from a visit at which you are present. This also means that the caretaker will have access to PHI that results from this visit, and have access to any other PHI that we may need to appropriately care for your child.

I give consent for the following people to bring my child for treatment as well as a Release of PHI to them:

_____
_____

_____ _____
Signature **Date**