



## **CHILD UNDER 6 PORTFOLIO**

**CHILD INFORMATION**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Parent Occupation:** \_\_\_\_\_ **Employed by:** \_\_\_\_\_

**Parent Occupation:** \_\_\_\_\_ **Employed by:** \_\_\_\_\_

**Home Phone #:** (\_\_\_\_) \_\_\_\_\_ **Work Phone #:** (\_\_\_\_) \_\_\_\_\_

**Home Phone #:** (\_\_\_\_) \_\_\_\_\_ **Work Phone #:** (\_\_\_\_) \_\_\_\_\_

**Cell Phone #:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone #;** (\_\_\_\_) \_\_\_\_\_

**Marital/Partnered/Single Status:** \_\_\_\_\_

**Children (names and ages):** \_\_\_\_\_

**Person Responsible for Payment:** \_\_\_\_\_

**Medical Information:**

**Physician(s):** \_\_\_\_\_

**Phone #(s):** \_\_\_\_\_

**Any Medical Problems:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Previous Mental Health Consultations, Evaluations, or Treatment:**

\_\_\_\_\_

**Referral**

**Who referred you to this practice:** \_\_\_\_\_

# EARLY DEVELOPMENT QUESTIONNAIRE

## GENERAL INFORMATION

Child's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Current Grade: \_\_\_\_\_

School: \_\_\_\_\_

Was your child adopted? \_\_\_\_\_

If yes, at what age? \_\_\_\_\_

(Please provide as much information about this adoption process and any relevant information on the back of this page or additional pages, if needed)

Parent's Name: \_\_\_\_\_ Educational Level: \_\_\_\_\_

Work Outside Home: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Educational Level: \_\_\_\_\_

Work Outside Home: \_\_\_\_\_

## Brothers/Sisters:

Name	Biological? Yes/No (Explain)	Living at Home? Yes/No	Age	Sex	Grade
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**Please list all other people living in your child's home:**

<b>Name</b>	<b>Age</b>	<b>Relationship to Child</b>	<b>Health/Problems</b>
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**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 of biological mother: \_\_\_\_\_**

**Were there any miscarriages: \_\_\_\_\_ Please explain circumstance(s) on the back of this page.**

**Which pregnancy was this child?**

**Nature of delivery: \_\_\_\_\_ Full term \_\_\_\_\_ Premature \_\_\_\_\_ Cesarean**

**How would you characterize the experience?**

**Child's birth weight:                      Height:**

**Were there any complications during labor and/or delivery? (circle)**

**breathing problems**

**cord around neck**

**color**

**jaundice**

**other (please explain):**

**Did baby have any complications/problems immediately after birth?**

**Did the baby have colic and/or feeding problems during the first three months?**

**How was the baby fed?**

**Was her/his appetite usually good?**

**Is her/his appetite good now?**

**When was s/he weaned and how did s/he respond to this process?**

**Approximate age:**

**sat alone** \_\_\_\_\_ **stood alone** \_\_\_\_\_ **crawled/crept** \_\_\_\_\_

**walked** \_\_\_\_\_ **pulled to stand** \_\_\_\_\_ **first talked** \_\_\_\_\_

**said 2-3 words** \_\_\_\_\_ **fed self** \_\_\_\_\_ **dressed self** \_\_\_\_\_

**Age at which toilet training began?** \_\_\_\_\_ **Ended?** \_\_\_\_\_

**How did your toddler respond to the training?**

**Favorite Toy**

**Favorite Food**

**Favorite Person**

**As a baby, was your child (circle one):**

**intense, interested in her/his surroundings, friendly with strangers, affectionate, attached to an object, overactive, independent, more interested in people, more interested in objects, a self-starter, other:**

**What is the best family story that characterizes your child as an infant/toddler: (please write on back)**

**Any history of...**

**If so, approximate age began/ended/still occurring?**

**Head banging**

**Stuttering**

**Breath holding**

**Day soiling**

**Temper tantrums**

**Nail biting**

**Excessive Jealousy**

**Hitting**

**Frequent crying**

**Irritability**

**Excessive thumb sucking**

**Excessive masturbation**

**Hurting self**

**Sleep problems**

**Nightmares**

**Bedwetting**

**Excessive fears**



**Excessive fantasizing**

**Intentionally hurting others**

**Problems going to school**

**Problems making friends**

**How does this child compare with her/his siblings?**

**During the infant/toddler years, did either parent stay home full or part time? Please explain.**

**If your child attended day care, at what age? What type of situation was this (e.g., in home, center, etc.)? For how many hours a week?**

**PRESCHOOL/DAYCARE HISTORY**

**School attended:**

**Age**\_\_\_\_\_ **Part-time**\_\_\_\_\_ **Full-time**\_\_\_\_\_

**School attended:**

**Age**\_\_\_\_\_ **Part-time**\_\_\_\_\_ **Full-time**\_\_\_\_\_

**Who was the primary caretaker of the child at home?**

**Any difficulties at preschool?**

**Strengths at preschool:**

**MEDICAL/MENTAL HEALTH HISTORY**

**Has your child had any serious accidents/injuries/illnesses involving such things as (circle); convulsions, high fevers, loss of consciousness, fainting, headaches, chronic fatigue, head injuries, ear problems, meningitis, other:**

**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 allergies?**

**Any special physical problems?**

**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? 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 other member of your child's immediate family participated in mental health treatment? If so, please explain. (Please use back of page if needed)**

**Has your child ever been molested? 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(s) with her/his sibling(s)?**

**What is your child's relationship like with you?**

**Whom is the child most like, in your family?**

**Who are the people your child tells secrets, worries, feelings to, in your family?**

**What discipline methods have you found to be most effective with your child?**

**What are your child's favorite activities?**

**What are your child's least favorite activities?**

**In what after-school activities does s/he participate?**

**Please list any chores or jobs your child has at home (e.g., paper route, babysitting, making her/his bed, etc):**

**How well does your child carry out the above chores?**

**What are your main concerns about your child?**

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

**Any other comments:**

**Name of person(s) completing this form:**

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**Date Completed:**

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**AUTHORIZATION FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, hereby grant and authorize:  
(Client Name or Parent/Legal Guardian Name)

**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

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name

Address: \_\_\_\_\_

**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 Notice of Privacy Practices.

(Print Name of Parent/Guardian)

\_\_\_\_\_  
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/STEPARENTS/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