DR.
ROZ
SANDPLAY CONSULTATION
and TRAINING

ADULT PORTFOLIO

ADULT INFORMATION

Name: _____ **Age:** _____ **Date:** _____

Date of Birth: _____/_____/_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____

Employed by: _____

Home Phone #: (_____) _____

Work 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: _____

What is your reason for consulting specifically with this practice?

ADULT QUESTIONNAIRE

GENERAL INFORMATION

Name: _____
Date: _____
Age: _____ Sex: _____ Date of Birth:_____

Current Working Situation:

If partnered, for how long: _____ If married, since when: _____

If separated, divorced or a partner has died, on the back of this page please explain the circumstances, custody & visitation schedule (if any) and communication status between parents.
Please give a brief history below as to when you and your partner or spouse first met, and any relevant information about your years together (what life crises or challenges or joys you both have experienced).

If you have a child or children, please give the age(s), date(s) of birth, grade level in school, significant health, learning problem or emotional history information below:

If you were adopted, please give any relevant information about biological parent history: (please complete on back of this page)

YOUR FAMILY OF ORIGIN

Mother's Nickname, Country of Origin and Educational Background:

Information about her general health, were there any physical, learning or emotional problems?

Her Religious/Spiritual Affiliation (if any):

Her work experience (if any outside the home):

Father's Nickname, Country of Origin and Educational Background:

Information about his general health, and were there any physical, learning or emotional problems?

His Religious/Spiritual Affiliation (if any):

His work experience (if any outside the home):

Brothers/Sisters:

Name	Biological? Yes/No (Explain)	Married/Partnered? Yes/No	Current Age	M/F	Health Status

Please list anyone else who lived with you or was a memorable caretaker for you as you were growing up:

Name Current Age Relationship to You Health/Problems

DEVELOPMENTAL HISTORY

(If adopted, please answer to the best of your knowledge)

Were there any illnesses/complications during your mother's pregnancy?

Total number of pregnancies: _____

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

How would you compare yourself with your siblings, if you had any?

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

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

As a toddler or young child did you have any history of emotional or behavioral difficulties, such as (please circle):

> **head banging, breath holding, day soiling, excessive temper, tantrums, irritability, obsessive thoughts, a compulsive need to count things or touch them, overly aggressive behavior, or difficulty controlling your impulses?**

If so, approximately when did this start?

Did you ever:	**Age Began**	**Still Occurring**
Hurt yourself in any way (with eating too much or too little, cutting yourself, etc.):	_____	_____
Have excessive sleep problems (either getting to sleep, staying asleep, or with nightmares or night terrors)?	_____	_____
Have excessive bedwetting difficulties?	_____	_____
Exhibit excessive fears?	_____	_____
Exhibit excessive fantasizing?	_____	_____
Intentionally hurt others?	_____	_____
Have problems going to school?	_____	_____
Exhibit difficulty paying attention, concentrating or with distractibility?	_____	_____
Exhibit frequent mood changes?	_____	_____
Exhibit motivational problems?	_____	_____

Have difficulty with substance abuse? _____ _____
(Please explain on the back of this page)
Other (please explain):

SCHOOL HISTORY

Schools Attended

High School:
_____

College(s)/Graduate School Programs and Degrees Held:

Any skipped grades: _____ **Which grade(s):** _____
Any repeated grades: _____ **Which grade(s):** _____

Favorite subjects:
_____

Difficult subjects:
_____

Did you excel at any sports, have special creative music, dance or art talent, etc?

Did you participate in special education or learning resource classes? If so, please describe the type of services provided:

MEDICAL/MENTAL HEALTH HISTORY

Did you have any serious accidents/injuries/illnesses involving such things as (circle): Convulsions, high fevers, loss of consciousness, fainting, headaches, allergies, chronic fatigue, head injuries, ear problems, meningitis? Please explain:

Did you ever require hospitalization or have been treated for serious illness or disease? If so, please explain:

Current Internist/Family Practitioner's name and name of practice:

_____

Address and Phone Number:

When was your last complete physical? _____

Do you currently have any health problems?

Are you currently on any medications, herbs or vitamin regimens? If so, please detail here:

Have you, your partner/spouse or children ever previously seen a therapist? If so, at what age(s)? Whom did you or they see and for what reason? About how many meetings did you have? Was the experience helpful? (Please use the back of this form if needed)

Have you ever been evaluated by a psychologist privately or through the school system? If so, when, and by whom?

If so, what do you remember of the results/recommendations?

Have you ever been molested or physically, emotionally or sexually traumatized? If so, would you give whatever details you believe would be relevant to my understanding of your life?

Please list any significant life traumas:

List any significant and positive life influences:

Who are you most like, in your family?

With whom do you share secrets, worries, or feelings?

How do you best motivate yourself?

What are your hobbies and interests?

What are your main concerns for yourself?

What kind of help do you expect from me in terms of our working together?

AUTHORIZATION REGARDING RELEASE OF ADULT CLIENT INFORMATION

I, _____, hereby authorize

Rosalind L. Heiko, Ph.D.
Pediatric & Family Psychology, P.A. to

____ Exchange Protected Healthcare Information with
____ Release Protected Healthcare Information to
____ Request Protected Healthcare Information from

_____
Name of Professional & Agency

_____
Agency & Address

_____
Address/ Telephone Number(s)

about myself and/or my professional treatment, diagnosis or assessment.

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.

_____
Signature

_____
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, _____ have received a copy of Pediatric
Print Full Client Name

& Family Psychology's Notice of Privacy Practices.

_____
Signature

_____
Date

PSYCHOTHERAPIST-CLIENT AGREEMENT

I, _____ agree to abide by the terms of
Print Full Client Name

the Psychotherapist-Client Services Agreement Form formulated on 4/2003 during our professional relationship.

_____
Signature

_____
Date