Center for Developing Minds
New Patient Intake Questionnaire

Please mail, fax, or email completed forms to (408) 358-1802 or info@devminds.com
Mailing Address: 15951 Los Gatos Blvd. Ste. 6, Los Gatos, CA 95032
Questions? Please call (408) 358-1853

I. GENERAL INFORMATION

DATE COMPLETED:	/ /	NAME OF PERSON COMPLETING FORM		

PATIENT

NAME O Female O Male O Transgender	LAST	FIRST	MI	DOB
PARENT 1 O Mom O Dad O Guardian	LAST	FIRST	PHONE # O Primary?	
PARENT 2 O Mom O Dad O Guardian	LAST	FIRST	PHONE # O Primary?	
ADDRESS O Mom O Dad O Same household	STREET	CITY	STATE	ZIP
EMAIL ADDRESS 1	O Mom O Dad O Guardian			
EMAIL ADDRESS 2	O Mom O Dad O Guardian			

REFERRAL

REFERRED BY:	O Pediatrician O Friend O Teacher O Specialist	O Therapist O Advertisement O Website O Other	**NAME OF REFERRAL:**
REFERRAL CONCERNS:	O Attention (AD/HD) O Anxiety O Autism O Behavioral O Bipolar	O Depression O Developmental O Dyslexia O Learning concerns O Motor delay	O School problems O Social skills O Speech/Language O Tics O Other: ________

Please describe the concerns you have about your child:

What do you hope to gain from visiting our center?

Why do you think your child has these issues? How long have you had these concerns?

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II. MEDICAL HISTORY

NAME OF PATIENT (CHILD'S) PRIMARY PEDIATRICIAN:				
ADDRESS	STREET	CITY	STATE	ZIP
OFFICE PHONE:		OFFICE FAX #:		
OTHER PHYSICIANS/CLINICIANS OR THERAPISTS (leave blank if does not apply)				
○ PSYCHIATRIST		PHONE #:		
○ OTHER:		PHONE #:		
○ OTHER:		PHONE #:		

PREGNANCY/BIRTH HISTORY		YES	NO	IF YES, PLEASE EXPLAIN.
	Bleeding during the pregnancy			
	Gained less than 20 lbs.			
	Gained more than 35 lbs.			
	Too high blood pressure			
	Too high blood sugar/diabetes			
	Physical trauma			
	Maternal infections			
	Maternal alcohol use			
	Maternal tobacco use			
	Exposure to other toxins (e.g. cocaine, marijuana)			
	Previous miscarriages			
	Previous premature births			
	Cesarean section			
	Forceps assisted delivery			
	Length of pregnancy______ weeks Birth weight _______ lbs ______ oz	Twins? Yes No Apgar Scores _____ 1 min _____ 5 min		

NEWBORN HISTORY		YES	NO	IF YES, PLEASE EXPLAIN.
	Newborn jaundice			
	Stayed in the newborn intensive care unit			
	Transfusion			
	Required oxygen			
	Intubation			
	Was infant discharged with mother?			

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PATIENT HEALTH HISTORY

	YES	NO	IF YES, PLEASE EXPLAIN.
Trouble with weight (too little, too much, or major weight changes)			
Trouble with eyes (poor vision, tendency to cross, etc.)			
Trouble with ears or hearing (any specific hearing tests?)			
Ear infections			
Trouble with nose, mouth, or throat (stuffy nose, difficulty swallowing, etc.)			
Heart problems (heart murmurs, ECG or heart tests, etc.)			
Lung problems (asthma or wheezing, tuberculosis, etc.)			
Genital or urinary problems (frequent urination, abnormal genitals, etc.)			
Kidney problems			
Stomach or abdominal problems (vomiting, stomach ache, constipation, etc.)			
Trouble with bones or muscles (weakness, deformities, etc.)			
Skin problems (birthmarks or other skin marks, lumps or bumps, etc.)			
Tics, twitches or makes odd noises			
Headaches			
Loss of consciousness/head injury			
Seizures/Convulsions			
Meningitis/infection of the brain			
Body stiffness			
Body looseness or floppiness			
Wets underwear during day			
Wets bed at night			
Soils underwear/bowel accidents			
Serious illness (in bed and unresponsive for several days)			
Lead poisoning			
Allergies			
Hospitalizations	(If yes, please list dates and purpose)		
Surgeries	(If yes, please list dates and purpose)		

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MEDICATION HISTORY

PAST MEDICATION(S) Name of medications used for a long time in the past:	DOSAGE(S)	DATES
CURRENT MEDICATION(S) **Name of medications currently on:**	**DOSAGE(S)**	**DATES**

SLEEP HISTORY

	YES	NO
Does your child have trouble falling asleep at night?		
Does your child have problems staying asleep?		
Does your child snore or have noisy breathing during sleep?		
Does your child have very heavy sleep?		
Does your child take frequent naps during day?		
Is your child frequently tired during the day?		
How long does it take your child to fall asleep?		min
How much sleep does child get each night?		hrs

DEVELOPMENTAL HISTORY

(PLEASE CHECK APPROPRIATE BOX FOR EACH ROW)

Developmental Milestone	Cannot Recall	0-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	4-5 years	5-6 years
Rolled over									
Sat up without support									
Crawled									
Spoke first words (Mama, Dada, etc.)									
Walked alone (10 steps)									
Walked up stairs									
Put words together (Daddy bye-bye, Mama home, etc.)									
Spoke 2-3 word sentences									
Fully bladder trained									
Fully bowel trained									
Caught a big ball									
Spoke clearly so strangers understood									
Able to dress self									
Able to tie shoelaces									

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SPEECH & LANGUAGE HISTORY

	YES	NO
LISTENING		
Does your child have difficulty with listening?		
Does your child misunderstand spoken directions?		
Does your child confuse speech sounds?		
Does your child misunderstand figures of speech or sarcasm?		
SPEAKING		
Does your child have difficulty with speaking?		
Does your child have slow or labored speech?		
Does your child use grammar incorrectly?		
Does your child jumble up sounds in words?		
Does your child have difficulty telling a story from beginning to end?		

Which languages are spoken at home?	Which is your child's primary language?

BEHAVIOR HISTORY

	YES	NO
EMOTIONAL RESPONSE		
Does your child bang his/her head?		
Does your child have temper tantrums?		
Does your child hold his/her breath when upset?		
Does your child cry easily?		
Is your child physically aggressive toward others?		
Is your child verbally aggressive toward others?		
MOOD		
Does your child appear sad, empty or irritable much of the time?		
Is your child uninterested in participating in many activities?		
Does your child make negative comments about him/herself?		
Is your child overly withdrawn?		
Has your child talked of harming him/herself?		
ANXIETY		
Does your child excessively worry?		
Does your child experience frequent unfounded illness or pain?		
Does your child avoid going to school?		
Does your child have more fears than other children do?		
OBSESSIONS, COMPULSIONS OR PERSEVERATIONS		
Does your child insist upon doing things his/her way?		
Does your child have difficulty making transitions?		
Does your child perform repetitive movements such as rocking or flapping?		
Does your child insist on having things done in a certain way all of the time?		
Does your child line up his/her toys?		
SOCIAL SKILLS		
Does your child have difficulty in conversing with others?		
Does your child have difficulty understanding the body language of others?		
Does your child have problems "acting cool"?		
Does your child have problems taking other people's perspective?		
Does your child have difficulty making friends and acquaintances?		
SENSORY PROCESSING		
Does your child frequently bump into objects, trip or fall?		
Is your child a picky eater?		
Is your child overly sensitive to certain sounds?		
Does your child show an aversion to certain textures or types of clothing?		

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ATTENTION HISTORY		YES	NO
	MENTAL ENERGY		
	Is your child frequently tired during the day?		
	Does your child have highly inconsistent patterns of attention?		
	Does your child have difficulty initiating and/or completing work?		
	Does your child have inconsistent school performance?		
	Does your child tend to work on things that only interest him/her?		
	PROCESSING CONTROLS		
	Do background noises and extraneous activities easily distract your child?		
	Does your child tend to focus on irrelevant information?		
	Do you frequently have to repeat instructions for your child?		
	Does your child have difficulty remembering recently learned information?		
	Does your child frequently daydream and “space out”?		
	Does your child have difficulty concentrating?		
	Does your child miss parts of explanations and information?		
	Does your child have difficulty delaying gratification?		
	PRODUCTION CONTROLS		
	Is your child impulsive?		
	Does your child say and do things in an inappropriate manner?		
	Does your child have difficulty staying on task?		
	Does your child have difficulty recognizing his/her errors?		
	Does your child have difficulty learning from his/her mistakes?		
	Does your child show indifference to punishment and or rewards?		
	Does your child overreact to minor situations?		
	PLANNING AND ORGANIZATION CONTROLS		
	Does your child lose things of value?		
	Is your child’s room frequently messy?		
	Is your child frequently bored?		
	Does your child have difficulty planning?		
	Does your child have difficulty establishing priorities?		
	Does your child procrastinate and dawdle?		

III. EDUCATION INFORMATION

EDUCATION HISTORY

CURRENT SCHOOL & DISTRICT:			GRADE:	
SCHOOL CONTACT & PHONE #:				
SCHOOL ADDRESS:	STREET	CITY	STATE	ZIP

SPECIAL EDUCATION SERVICES		
PLEASE MARK & DESCRIBE ANY SPECIAL EDUCATION SERVICES THAT YOUR CHILD HAS RECEIVED:		YEAR(S) RECEIVED:
○ SPEECH THERAPY		
○ PHYSICAL THERAPY		
○ OCCUPATIONAL THERAPY		
○ SPECIAL EDUC. TEACHER		
○ SMALL CLASSROOM		
○ ABA		
○ COUNSELING		
○ OTHER		

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	YES	NO
Does your child have a 504 plan?		
Does your child have an individualized education plan (IEP)?		
Has your child's school performed a psychoeducational evaluation?		
Is your child receiving educational support outside of school?		
HAS YOUR CHILD HAD DIFFICULTY LEARNING ANY OF THE FOLLOWING:		
Writing the alphabet		
Telling time		
Sounding out words		
Spelling accurately		
Understanding what he/she reads		
Reading fast enough		
Writing neatly		
Drawing pictures		
Performing math calculations		
Understanding math word problems		
Writing reports		
Remembering instructions for an assignment		
Knowing how to study for a test		
Managing his/her homework		

IV. FAMILY INFORMATION

FAMILY BACKGROUND

FAMILY HISTORY OF:	MOTHER	FATHER	BROTHER(S)	SISTER(S)	OTHER RELATIVES
Learning difficulties					
Trouble paying attention					
Hyperactivity					
Autism spectrum disorders					
Cognitive impairment					
Drug or alcohol abuse					
Speech problems					
Depression					
Anxiety/Compulsions					
Manic depression					
Other					

PLEASE LIST FAMILY MEMBER WHO LIVE AT HOME:

NAME	RELATIONSHIP	AGE	OCCUPATION

FAMILY SUPPORTS	YES	NO
Does your child have siblings that are not living at home?		
Is your child adopted?		
Is your child in foster care?		
Are the parents separated?		
Are the parents divorced?		
Who has legal custody of your child?		

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V. ADDITIONAL INFORMATION

INTERESTS & STRENGTHS	
	DESCRIBE YOUR CHILD'S PRIMARY INTERESTS.
	WHAT ARE YOUR CHILD'S STRENGTHS AND TALENTS?
	PLEASE INCLUDE ANY OTHER INFORMATION YOU THINK MIGHT BE VALUABLE.

CONSENT FOR REPORT RELEASE		
	AFTER SEEING A CLINICIAN AT THE CENTER FOR DEVELOPING MINDS, A REPORT IS TYPICALLY DRAFTED. UPON CONSENT LISTED BELOW, PLEASE INDICATE WHETHER YOU WOULD LIKE THE FOLLOWING REPORTS COMPLETED BY THE LISTED PROVIDER SENT TO YOUR CHILD'S PRIMARY PEDIATRICIAN:	
	INITIAL EVALUATION REPORT BY DEVELOPMENTAL/BEHAVIORAL PEDIATRICIAN	PARENTS INITIALS:
	PSYCHOEDUCATIONAL EVALUATION OVERVIEW BY EDUCATIONAL PSYCHOLOGIST	PARENTS INITIALS:
	SPEECH AND LANGUAGE REPORT BY SPEECH AND LANGUAGE PATHOLOGIST	PARENTS INITIALS:
	OCCUPATIONAL THERAPY REPORT BY OCCUPATIONAL THERAPIST	PARENTS INITIALS:

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Center for Developing Minds
Fee Schedule and Billing Policies

Clinician Fees
Charges at the Center for Developing Minds are based on hourly rates. The rate is the same for face-to-face, report-writing, document review, and any other activity that is needed to provide medical, psychological or therapeutic services for the clients. Clinicians at the Center charge at the following rates:

Clinical Service	Hourly Fee
Behavioral and Developmental Pediatrician	$450.00
Behavioral and Developmental Pediatric Nurse Practitioner	$380.00
Psychologist / Psychoeducational Testing	$275.00
Developmental Specialist / In Home Behavioral Consultant	$160.00
Counselors	$175.00
Speech & Language Pathologist	$150.00
Educational Specialist	$150.00
Occupational Therapist	$140.00

A number of tasks can add to the cost of an assessment or counseling session. These may include review of documents, such as prior reports, collateral contacts, such as emails and phone calls (with parents, teachers, therapists, doctors, etc.), and home or school visits. These services, including travel time if necessary, are billed at the standard rate of the clinician who provides the service. **Parent's Initials** ______

In regards to Valley Health Plan (VHP) patients, phone appointments are not permissible under the insurance so in-person appointments must always be made in order to talk to the clinical provider. If supplemental medical reports or letters are requested for the patient to be sent to any third party (i.e. school, organization, or job) there may be a fee associated and the patient will be responsible for paying out-of-pocket. **Parent's Initials** _______

Psychological and Neurodevelopmental Testing
A full psychoeducational assessment involves a review of documents including the New Patient Questionnaire and behavior assessment forms, face-to-face assessment procedures, scoring and interpreting test results, the preparation of a written report, and a follow-up meeting to review findings and recommendations. The face-to face evaluation takes two, three-hour sessions. Test interpretation and report generation take as many or more hours to complete as the time spent face-to-face with the client. Most of the time, services total 16 hours of the psychologist's time, but can take longer if school visits or additional testing is needed.

A deposit of $1,100 is required to schedule psychological testing. This deposit is refundable if testing is cancelled at least two weeks prior to appointment. **Parent's Initials** ______

Counseling & Speech and Language Services
Counseling as well as Speech and Language therapy includes face-to-face time and note taking for the medical record. Each 60-minute counseling session includes 50 minutes of face-to-face time and 10 minutes for recordkeeping, with the client charged for a total of 60 minutes.

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Classes
Payment secures your child's place in a group. Cancellations made two weeks before the first session will receive a reimbursement minus a $25 handling fee. No refunds will be given for cancellations made less than two weeks before the group begins.

Payment Policies
With the exception of VHP patients, the Center for Developing Minds does not accept payment through insurance or any managed-care companies. The inconsistency among insurance plans combined with the very detailed nature of our evaluations makes it cost-prohibitive for us to accept insurance, however, we will provide you with a billing statement that you may send to your insurance company to assist you in the reimbursement process. Please contact your insurance provider for any reimbursement questions.
Parent's Initials ____

For VHP Patients, a prior authorization must be sent to the Center for Developing Minds from the Utilization Management Department to initiate services.

Payment is expected at the time of service. The Center for Developing Minds accepts cash, checks or credit cards. There will be a $25.00 charge for all returned checks. For VHP patients, only co-payments and/or fees associated with any requested medical report(s) are expected at the time of service.

There is a $25 fee for any prescription refills requested via phone or email. VHP patients are required to request prescription refills from their primary care physician, outside of any CDM appointments.

Cancellation Policies
The Center for Developing Minds values your time and we appreciate you valuing ours. We have waiting lists for appointments; therefore, all missed appointments are subject to a charge. If you are unable to keep your appointment, please provide us with at least two business days' notice or you may be charged a cancellation fee of 50% the cost of the office visit. **Parent Initials**______

Fees Schedule and Billing Policies Agreement Statement
I have read and agree with the above fee schedule and billing policies.

____

Signature Date Name of Patient

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NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THE CENTER FOR DEVELOPING MINDS) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

OUR COMMITMENT TO YOUR PRIVACY

The Center for Developing Minds is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

- **Treatment**. Our practice may use your IIHI to treat you (e.g. to write a perscription or order labs). We may also disclose your IIHI to other health care providers for purposes related to your treatment.
- **Payment**. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
- **Health Care Operations**. Our practice may use and disclose your IIHI to operate our business.
- **Appointment Reminders**. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
- **Treatment Options**. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
- **Release of Information to Family/Friends**. Our practice may release your IIHI to a friend or family member that is involved in your care.
- **Disclosures Required By Law**. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

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USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- **Public Health Risks**. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information.
- **Health Oversight Activities**. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law.
- **Lawsuits and Similar Proceedings**. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.
- **Law Enforcement**. We may release IIHI if asked to do so by a law enforcement official.
- **Research**. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances, but only with your written authorization to use your IIHI
- **Serious Threats to Health or Safety**. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- **Military**. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

A. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

- **Confidential Communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location
- **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
- **Inspection and Copies**. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes.
- **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice.
- **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures."
- **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices.
- **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. We, of course, would appreciate any opportunity to correct a mistake prior to such filing.
- **Right to Provide an Authorization for Other Uses and Disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact **Damon Korb, MD, Director of the Center for Developing Minds.**

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, ____, have received a copy of The Center for Developing Minds Notice of Privacy Practices.

______________________________ ________________

Signature of Patient Date

If child is considered a minor:

______________________________ ______________ ___________

Signature of Parent or Guardian Relationship Date

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