Personal Information

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

❒ Male ❒ Female ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

Address: _____ City, State, Zip: _____

Referred by: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Reminder or cancellation messages due to office emergency can be left at:

❒ Home Phone ❒ Work Phone ❒ Email ❒ Cell Phone TEXTING OK? ❒ yes ❒ no

In the event of an emergency with you, whom should we contact:

Name: _____ Relationship: _____ Work # _____ Home # _____

Person Responsible for Services Rendered

Name: _____ Relationship to Patient: _____

Birthdate: _____ Occupation: _____

Address: _____ City, State, Zip: _____

Employer: _____

Work #_____ Home/Cell #_____ Email _____

***Authorization and Release**:* I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. **I give Dr. Joey Achacoso, LPC, the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to him for services rendered and/or for cancelled or missed appointments.** My signature below confirms my agreement to these terms.

X_____ **X**_____

Signature of patient or parent/legal guardian if minor Date of signature

Your Child's Education

Name of School:_____ School District:_____ Phone:_____
Main Teacher (or teacher who knows your child best):_____Current Grade:_____

Placement and Services (current or past)	**No**	**Yes**	**Describe (e.g. when, which subject failed or grade repeated)**
Early Intervention			
Repeated Grade			
Suspended			
Failed or is failing a grade or subject			
Received any special education services			

Please describe any current special education services (e.g. IEP, 504 Plan, resource room support):

_____
_____
_____
_____
_____

Previous Evaluations and Treatments (please bring copies of any reports)

Testing (such as educational, emotional, speech/language)

Date	Type of Testing	Where was the testing done? (e,g, School, Private Psychologist, etc)

Outpatient Mental Health Professionals Seen:

Professional's Name/Specialty (e.g. psychiatrist, psychologist, social worker, school counselor)	Start Date	End Date	Type of services received

What do school personnel tell you about your child? _____

Your Child's Education (cont.)

Grade	School	Average Grade	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Your Child's Family

Member	Name	Age/Grade	Describe child's relationship with member
Father			
Mother			
Sister(s)			
Brother(s)			
StepFather			
StepMother			
StepSister(s)			
StepBrother(s)			

List other people who live in the home with this child:

Your Child's Routine

What kinds of physical exercise does your child get? _____

_____

How much coffee, cola, tea, or other caffeine does your child consume each day _____

_____

Is your child's eating restricted in any way? How? Why? _____

_____

Bedtime: _____ Wake-up Time: _____ Hours of sleep on an average night: _____

Does your child have any problems getting enough sleep? ____ If yes, please describe: _____

_____

Your Child's Health

Who is your child's pediatrician? _____ When was the last visit? _____

Any concerns shared by the doctor?_____

_____

_____

Anything else you are concerned about? _____

_____

_____

_____

_____

(These questions are regarding older children)

Is this child in a gang? _____ Has this child used drugs? _____. If so, describe which drugs, frequency,

age at first use, and amounts_____

Has this child ever been pregnant or fathered a child? _____ If yes, please tell what happened _____

_____

_____

Your Child's Health (cont.)

Is there any history of physical or sexual abuse?

_____

_____

_____

_____

_____

Child Protective Services Report? _____

If your child has taken medication for attention, behavior, or emotional problems, please list:

Medication	Dosage (e.g. 20 mg 3x day)	Start	End	Prescribed By	Adverse Effects

Please List ANY Drug or Food Allergies_____

If your child takes any other medication or supplements for any other reason, please list:

_____

Psychiatric Hospitalization or Inpatient Drug Treatment

Place	Date Started	Date Stopped	Reason for admission

Has your child or family received services or case management through an agency (e.g. Child Protective Services, Department of Mental Health and Mental Retardation, etc.)?

Agency:_____ Service:_____

Agency:_____ Service:_____

Your Child's Developmental History

Pregnancy and Delivery

Age of mother at birth: _____ yrs
Medications taken during pregnancy: _____
Gestational diabetes? Yes No
Problems with blood pressure or toxemia? Yes No
Infections (including herpes) _____
Smoking (if so, how many packs per day) _____
Alcohol _____
Drugs taken _____
Any problems during labor or delivery: _____
Duration of pregnancy: _____weeks
Type of labor: _____
Birth weight: _____
Any problems after birth: _____

Infancy/Toddler

Describe your child as an infant and toddler: _____

Problems with feeding	Y	N
Severe colic or excessive crying	Y	N
Irritable	Y	N
Overactive	Y	N
Easily overstimulated	Y	N
Withdrawn	Y	N
Didn't like to be held	Y	N
Difficult to soothe	Y	N

Developmental Milestones:

Indicate the age at which your child achieved the following:

Sit up _____
Crawl _____
Walk without assistance _____
Speak in 2 word sentences _____
Toilet trained during the day _____
Dry at night _____

Your Child's Medical History

Medical History

Major Illness	Date	Hospitalized?	Surgery?

Has your child ever had a head injury with loss of consciousness? If yes, please describe:

_____

Has your child ever had a seizure? If yes, please describe:

_____

Family History

Does anyone in the child' **biological** family have:	No	Yes	Relationship to child
Attention problems/ADHD			
Behavior problems in youth			
Learning Disability			
Seizures			
Mental Retardation			
Tics/Tourette's Syndrome			
Autistic spectrum disorder			
Thyroid Problems			
Heart Problems before age 50			
Depression			
Bipolar Disorder			
Anxiety or Panic Attacks			
Obsessive Compulsive Disorder			
Schizophrenia			
Alcohol Problems			
Drug Problems			
Trouble with the law			

Any other significant family medical or psychiatric history_____

_____

Your Child's Symptoms

- ☐ Accident-prone
- ☐ Affectionate
- ☐ Aggressive
- ☐ Argues
- ☐ Assaults
- ☐ Bathroom language
- ☐ Bigoted
- ☐ Bossy to others
- ☐ Breaks rules
- ☐ Breaks the law
- ☐ Bullied by others
- ☐ Bullies others
- ☐ Cheats
- ☐ Clowns around
- ☐ Competition
- ☐ Complains
- ☐ Complains of feeling sick
- ☐ Compliant
- ☐ Concern for others
- ☐ Conflicts at school
- ☐ Conflicts at home
- ☐ Conflicts with friends
- ☐ Conflicts with police
- ☐ Cries easily
- ☐ Cruel to animals
- ☐ Dares others
- ☐ Dawdles
- ☐ Daydreams
- ☐ Defiant
- ☐ Dependent
- ☐ Destructive
- ☐ Developmental delays
- ☐ Difficulty w parent's partner
- ☐ Disobedient
- ☐ Disrupts family activities
- ☐ Distractible
- ☐ Dropping out of school
- ☐ Drug or alcohol use
- ☐ Drug sales
- ☐ Eating Issues
- ☐ Failure in school
- ☐ Fantasy life
- ☐ Fearful
- ☐ Feelings are easily hurt
- ☐ Fidgety
- ☐ Fighting
- ☐ Finger sucking
- ☐ Fire setting
- ☐ Friendly
- ☐ Hair chewing
- ☐ Head banging
- ☐ Hitting
- ☐ Hostile
- ☐ Hyperactive
- ☐ Hypochondriac
- ☐ Imaginary playmates
- ☐ Immature
- ☐ Inappro. sexual behaviors
- ☐ Inattentive
- ☐ Independent
- ☐ Inflicts pain on others
- ☐ Insults others
- ☐ Interrupts
- ☐ Intimidated by others
- ☐ Intimidates others
- ☐ Intolerant
- ☐ Irritability
- ☐ Isolates
- ☐ Lacks organization
- ☐ Lacks respect for authority
- ☐ Learning disability
- ☐ Legal difficulties
- ☐ Lethargic
- ☐ Likes to be alone
- ☐ Loitering
- ☐ Loss of friends
- ☐ Low frustration tolerance
- ☐ Lying
- ☐ Manipulates
- ☐ Masturbation
- ☐ Mental retardation
- ☐ Moody
- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Name calling
- ☐ Needs constant supervision
- ☐ Negativism
- ☐ Nervous
- ☐ New school
- ☐ Nightmares
- ☐ Noisy
- ☐ Noncompliant
- ☐ Obedient
- ☐ Obesity
- ☐ Only younger playmates
- ☐ Oppositional
- ☐ Outgoing
- ☐ Out-of-seat behaviors
- ☐ Overactive
- ☐ Picks on others
- ☐ Poor concentration
- ☐ Pouts
- ☐ Prejudiced
- ☐ Procrastinates
- ☐ Provokes others
- ☐ Rages
- ☐ Recent move
- ☐ Refuses
- ☐ Relationships with friends
- ☐ Relationships with siblings
- ☐ Relationships with teachers
- ☐ Repetitive movements
- ☐ Resists
- ☐ Responsible
- ☐ Restless
- ☐ Runs away
- ☐ Sad
- ☐ School avoiding
- ☐ Self-harming behaviors
- ☐ Sexual preoccupation
- ☐ Sexually active
- ☐ Shy
- ☐ Slow-moving
- ☐ Slow-responding
- ☐ Smart-alecky
- ☐ Smoking
- ☐ Social
- ☐ Speech difficulties
- ☐ Stealing
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing
- ☐ Talks back
- ☐ Talks out
- ☐ Teased
- ☐ Teases others
- ☐ Temper tantrums
- ☐ Threatens
- ☐ Thumb sucking
- ☐ Tics-movements or noises
- ☐ Timid
- ☐ Truancy
- ☐ Uncooperative
- ☐ Uncoordinated
- ☐ Underactive
- ☐ Unhappy
- ☐ Unprepared
- ☐ Vandalism
- ☐ Violent
- ☐ Wastes time
- ☐ Wetting/soiling bed/clothes
- ☐ Withdraws
- ☐ Work problems
- ☐ Yells
- ☐ Any other characteristics:

_____

_____

About Dr. Joey Achacoso, LPC

Please initial each line to indicate that you understand each statement.

__ I understand that Dr. Joey Achacoso is a Professional Counselor licensed in Texas, Play Therapist, and Parent Coach who earned a doctorate in Educational Psychology from The University of Texas at Austin.

__ I understand that Dr. Joey Achacoso works with children, adolescents, and adults in individual, group, and family counseling.

__ I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

__ I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.

__ I understand that if I am concerned about slow progress or lack of progress I have the right to speak to Dr. Joey Achacoso about this.

__ I understand that Dr. Joey Achacoso does not perform formal testing but refers to those who do.

__ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.

__ I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Dr. Joey Achacoso to tell someone else in writing or verbally, b) Dr. Joey Achacoso determines that his client poses a threat to them self or others, c) he is ordered by a court to disclose information, or d) He suspects that child abuse has taken place, at which time he will notify Child Protective Services.

__ I understand that counseling can improve as well as upset the equilibrium in any person or family.

__ I understand that I cannot resolve a complaint with Dr. Joey Achacoso and wish to file a formal complaint, I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

__ I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to Dr. Joey Achacoso.

__ I understand that there is a returned check fee of $25.00 and that if a returned check is not cleared up in 30 days, Dr. Joey Achacoso will file a suit with the Travis County District Attorney's Office.

__ I understand that all co-pays are due at the time of service.

__ I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged the full fee that will be debited from my Visa or MasterCard.

__ I understand that the rate for an initial session is $125.00 and for subsequent sessions is $100.00. These fees are for 30-minute sessions.

__ I understand that Dr. Joey Achacoso is not a psychiatrist; he is a doctoral-level therapist. As such, he cannot recommend or prescribe medication, but can encourage clients to see an M.D. for evaluation.

By signing below I confirm that I have read, agree to, and understand the above information:

X_____ **X**_____

Signature of patient or parent/legal guardian if minor Date of signature

Agreement for Therapy with a Minor

I, _____, the parent/legal guardian of the minor, _____,

❒ Give my permission for this minor to receive therapeutic services provided from Dr. Joey Achacoso.

❒ I have read, understood, and signed the Professional Disclosure Statement of Dr. Joey Achacoso and I understand the risks and benefits of receiving these services and the risks and benefits of *not* receiving these services, for both this minor and his or her family.

❒ Furthermore, I understand that I am expected to participate in this process by meeting with the therapist at least once per month while my child is in therapy.

My signature below means that I understand and agree with all of the points above.

X_____ **X**_____

Signature of patient or parent/legal guardian if minor Date of signature

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.
You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services. You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of April 14, 2003.

THIS IS YOUR COPY TO KEEP

Acknowledgement of Receiving Notice of Privacy Practices

I acknowledge that I have received and understand the Notice of Privacy Practices for this office:

X_____ **X**_____

Signature of patient or parent/legal guardian if minor Date of signature

Consent for Use and Disclosure of Health Information

I hereby permit Dr. Joey Achacoso, LPC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

X_____ **X**_____

Signature of patient or parent/legal guardian if minor Date of signature

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Please see our Notice of Privacy Practices for more complete description. You will find this Notice of Privacy Practices on a bulletin board in the hallway of our office suite. If this consent form is revised in the future, you may obtain a revised copy from this office.