CHECE PSYCHOLOGICAL, LLC

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STEPHEN D. CHECE, PH.D.
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NJ License # 35SIOO419900 / NY License # 012341-1 / PA License # PS-008279-L
Independent Forensic, Clinical, Neuropsychological & Psychological Evaluations

Biographical Information Form – Child AGE 14 +

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Information supplied by:_____ **Relationship:**_____

Personal History

Child's Name: _____ Age:_____ Gender:_____M_____F SS#____ - ___ -_____

Weight:_____ Height:_____ Eye color: _____ Hair color:_____ Race: _____

Address

_____
Street &. Number City State Zip

Today's Date: _____ Date of Birth: _____
Home Phone: _____ Year in School: _____

Has the child ever been involved in previous counseling? Yes _____ No _____
If Yes, please briefly describe:_____

_____

Why is the child coming to counseling?_____

_____

_____

How long has this problem persisted (from previous question)?_____

_____

Under what conditions do your problems usually get worse?_____

_____

Under what conditions are your problems usually improved? _____

_____

Medical History

Name and Address of primary care physician:
Physicians Name : _____
Address: _____

Most recent physical exam:_____ Results:_____

List any major illnesses and/or operations the child has had: _____

_____

_____

List any physical concerns the child is having at present (e.g. high blood pressure, headaches, dizziness, etc): _____

_____

List any other physical concerns (head trauma, seizures, etc) experienced in the past: _____

_____

_____

On average, how many hours of sleep does the child receive daily? _____
Does the child have trouble falling asleep at night?:_____Yes ___No

If yes, how long has this been a problem:_____

Describe the child's appetite (during past week):
_____ poor appetite ___ average appetite _____ large appetite

What medications (and dosages) are being taken at present, and for what purpose?

Medication	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Mother's age:_____ If deceased, how old was the child when she passed away? _____
Father's age:_____ If deceased, how old was the child when he passed away_____
If parents are separated or divorced, how old was the child then? _____
Number of brother(s):_____ Their ages _____ _____ _____ _____ _____ _____ _____
Number of sister(s): _____ Their ages _____ _____ _____ _____ _____ _____ _____
Child number _____ being in a family of _____ children.
Is the child adopted or raised with parents other than your natural parents? ____Yes _____No
Briefly describe the child's relationship with brothers and/or sisters.
Biological siblings:_____

_____

_____

Step and/or half siblings:_____

_____

_____

Other:_____

_____

What is the family relationship between the child and his /her custodial parents?
Check all that apply:

_____ Single parent mother _____ Single parent father _____ Parents unmarried
_____ Parents married, together _____ Parents divorced _____ Parents separated
_____ With mother and stepfather _____ With father and stepmother
_____ Child adopted _____ other, describe:_____

Is there a history or recent occurrence(s) of child abuse to this child? _____Yes ____No
If Yes, which type of abuse? _____ Verbal _____ Physical _____ Sexual
Comments:_____

Parent's occupations: Mother:_____ Father:_____

Briefly describe the style of parenting used in the household:_____

Developmental History

Briefly describe any problems in the child's mother's pregnancy and/or childbirth:

Please fill in when the following developmental milestones took place:

Behavior	Age Began	Comments
Walking		
Talking		
Toilet trained		

List any drugs used by mother or father at time of conception, or by mother during pregnancy:

Please rate your opinion of the child's development (compared to others the same age) in the following areas

	Below Average	About Average	Above Average
Social			
Physical			
Language			
Intellectual			
Emotional			

For each type of development that you rated above as *below average,* please describe current areas of concern. Be specific.

List the child's three greatest strengths:

1) _____
2) _____
3) _____

List the child's three greatest weaknesses or needed areas of improvement:

1) _____
2) _____
3) _____

List the child's main difficulties at school:

1) _____
2) _____
3) _____

List the child's main difficulties at home:

1) _____
2) _____
3) _____

Briefly describe the child's friendships:_____
_____
_____
_____

What report card grades does the child usually receive?: _____
Have these changed lately? _____ Yes _____ No If Yes, how? _____

Briefly describe the child's hobbies and interests:_____
_____
_____

Describe how your child is disciplined: _____
_____
_____
_____
_____

For what reason is your child disciplined?_____
_____
_____

Behaviors of Concern

Please check how often the following behaviors occur. Those occurring FREQUENTLY or of special concern may be described on the next page.

1.	Loses temper easily	___ Never	____ Rarely	____ Sometimes	___ Frequently
2.	Argues with adults	___ Never	____ Rarely	____ Sometimes	___ Frequently
3.	Refuses adults requests	___ Never	____ Rarely	____ Sometimes	___ Frequently
4.	Deliberately annoys people	____ Never	____ Rarely	____ Sometimes	___ Frequently
5.	Blames other for own mistakes	___ Never	____ Rarely	____ Sometimes	___ Frequently
6.	Easily annoyed by others	___ Never	____ Rarely	____ Sometimes	___ Frequently
7.	Angry/resentful	___ Never	____ Rarely	____ Sometimes	___ Frequently
8.	Spiteful/vindictive	___ Never	____ Rarely	____ Sometimes	___ Frequently
9.	Defiant	___ Never	____ Rarely	____ Sometimes	___ Frequently
10.	Bullies/teases others	___ Never	____ Rarely	____ Sometimes	___ Frequently
11.	Initiates fights	___ Never	____ Rarely	____ Sometimes	___ Frequently
12.	Uses a weapon	___ Never	____ Rarely	____ Sometimes	___ Frequently
13.	Physically cruel to people	___ Never	____ Rarely	____ Sometimes	___ Frequently
14.	Physically cruel to animals	___ Never	____ Rarely	____ Sometimes	___ Frequently
15.	Stealing	___ Never	____ Rarely	____ Sometimes	___ Frequently
16.	Forced sexual activity	___ Never	____ Rarely	____ Sometimes	___ Frequently
17.	Intentional arson	___ Never	____ Rarely	____ Sometimes	___ Frequently
18.	Burglary	___ Never	____ Rarely	____ Sometimes	___ Frequently
19.	“Cons” other people	___ Never	____ Rarely	____ Sometimes	___ Frequently
20.	Runs away from home	___ Never	____ Rarely	____ Sometimes	___ Frequently
21.	Truant at school	___ Never	____ Rarely	____ Sometimes	___ Frequently
22.	Doesn’t pay attention to details	___ Never	____ Rarely	____ Sometimes	___ Frequently
23.	Several careless mistakes	___ Never	____ Rarely	____ Sometimes	___ Frequently
24.	Does not listen when spoken to	___ Never	____ Rarely	____ Sometimes	___ Frequently
25.	Doesn’t finish chores/homework	___ Never	____ Rarely	____ Sometimes	___ Frequently
26.	Difficulty organizing tasks	___ Never	____ Rarely	____ Sometimes	___ Frequently
27.	Loses everything	___ Never	____ Rarely	____ Sometimes	___ Frequently
28.	Easily distracted	___ Never	____ Rarely	____ Sometimes	___ Frequently
29.	Forgetful in daily activities	___ Never	____ Rarely	____ Sometimes	___ Frequently
30.	Fidgety/squirmy	___ Never	____ Rarely	____ Sometimes	___ Frequently
31.	Difficulty remaining seated	___ Never	____ Rarely	____ Sometimes	___ Frequently
32.	Runs/climbs around excessively	___ Never	____ Rarely	____ Sometimes	___ Frequently
33.	Difficulty playing quietly	___ Never	____ Rarely	____ Sometimes	___ Frequently
34.	Hyperactive	___ Never	____ Rarely	____ Sometimes	___ Frequently
35.	Difficulty awaiting turn	___ Never	____ Rarely	____ Sometimes	___ Frequently
36.	Interrupts others	___ Never	____ Rarely	____ Sometimes	___ Frequently
37.	Problems pronouncing words	___ Never	____ Rarely	____ Sometimes	___ Frequently
38.	Poor grades in school	___ Never	____ Rarely	____ Sometimes	___ Frequently
39.	Expelled from school	___ Never	____ Rarely	____ Sometimes	___ Frequently
40.	Drug use	___ Never	____ Rarely	____ Sometimes	___ Frequently
41.	Alcohol consumption	___ Never	____ Rarely	____ Sometimes	___ Frequently
42.	Depression	___ Never	____ Rarely	____ Sometimes	___ Frequently
43.	Shy/avoidant/withdrawn	___ Never	____ Rarely	____ Sometimes	___ Frequently
44.	Suicidal/threats/attempts	___ Never	____ Rarely	____ Sometimes	___ Frequently
45.	Fatigued	___ Never	____ Rarely	____ Sometimes	___ Frequently

For each of the behaviors noted on the previous page as occurring FREQUENTLY, or if it causes significant impairment, write a brief description of how it impacts the child's or other people's lives. Give examples. Use back of this page as needed.

Behaviors of Concern	Impact on Child or Others

Briefly describe the child's ways of expressing the following emotions or behaviors:

ANGER: _____

HAPPINESS _____

SADNESS _____

ANXIETY _____

List the child's behaviors that you would like to see change:

_____

_____

_____

_____

_____

_____

_____

Additional information you believe would be helpful: _____

_____

_____

_____

_____

_____

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PLEASE RETURN THIS AND OTHER ASSESSMENT MATERIALS TO THIS OFFICE AT LEAST TWO DAYS BEFORE YOUR NEXT APPOINTMENT

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CLIENT RIGHTS FORM

1. I understand that I have the right to decide not to enter therapy (although depending on my situation there may be legal or other consequences for not entering or completing therapy), not to participate in any particular type of therapy, and to terminate therapy at any time. If I wish to terminate therapy here and continue therapy elsewhere, I will be given a list of providers with whom I can continue. Initials:_____

2. I understand that I have the right to a safe environment during therapy, free from physical, sexual and emotional abuse. Initials: _____

3. I understand that I have the right to complete and accurate information about my treatment plan, goals, methods, potential risks and benefits, and progress.
   Initials: _____

4. I understand that I have the right to information about the professional capabilities and limitations of any clinicians) involved in my therapy, including their certification/licensure, education and training, experience, specialization, and supervision. I have the right to be treated only by persons who are trained and qualified to provide the treatment I receive. Initials: _____

5. I understand that I have the right to written information about fees, payment methods, co-payments, length and duration of sessions and treatment.
   Initials: _____

6. I understand that my confidentiality will be protected, and information regarding my treatment will not be disclosed to any person or agency without my written permission except under circumstances where the law requires such information to be disclosed. I understand that I have the right to know the limits of confidentiality, the situations in which the therapist or agency is legally required to disclose information about my case to outside agencies, and the types of information which *must* be disclosed.
   Initials: _____

7. I understand that I have the right to know if my therapist will discuss my case with supervisors or peers. I understand that no portion of my therapy may be recorded in audio or video form without my informed written consent, and that if I consent to have any portion of my therapy recorded I have the right to know who will see or hear the recording(s), for what purpose(s) the recording(s) will be used, and when and how the recording(s) will be erased or destroyed. Initials:_____

8. I understand that I have the right to request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status. Initials: _____

9. I understand that I have the right to request the release of my clinical information to any agency or person I choose. Initials: _____

X _____

Signature of Client / Responsible Party /Parent or Guardian acting on Client's behalf Date

Printed Name: _____

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CONSENT FOR TREATMENT

1. I have been fully informed of my rights as a client of this office, the extent and limits of confidentiality in therapy, and the goals associated with therapy. With that knowledge, I request and consent to receive therapy from Stephen D. Chece, Ph.D..

   Initials:_____

2. I understand that Stephen D. Chece, PhD. may not disclose information about my therapy to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow Stephen D. Chece, PhD. to provide some information about my therapy to a referring agency and/or an insurance company or other payor, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed.

   Initials: _____

_____

_____

_____

_____

_____

_____

_____

X _____
Signature of Client / Responsible Party /Parent or Guardian acting on Client's behalf Date

Printed Name: _____

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CONTRACT FOR SAFETY

I _____ agree to speak to or notify staff or an adult if ever I feel that I am a danger to myself or to others. This includes but is not limited to suicidal/homicidal thoughts, gestures, and hearing voices, seeing things that other people think aren't there, an urge to run away, an urge to hit someone, use an illicit substance, etc. I understand that this contract is to help ensure my safety and the safety of those around me.

Name: _____ Date: _____

Witness: _____ Date: _____

Parent: _____ Date: _____

Parent: _____ Date: _____

Therapist: _____ Date: _____

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RELEASE OF INFORMATION

I, _____ hereby authorize the release and disclosure of the following
(Name of Client or Parent/Guardian)
clinical and/or therapeutic records for the following purpose(s):

☐ Authorization to release information regarding counseling, therapy care and treatment.

☐ Authorization to release information held under the Drug Office and Treatment Act of 1972 (pL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974.

☐ Authorization to release information related to Human Immunodeficiency Virus (HlV) and Acquired Immune Deficiency Syndrome (AIDS).

Please release authorized information between Dr. Chece and: _____
_____
_____
_____

__ Specific information to be released (Clients initials to approve release):
__ Assessments and evaluations __ Psychosocial history
__ Continued care and treatment __ Discharge summary

Correspondence (specify): _____
Other (specify): _____
Purpose (s) for which information is to be released:
_____
_____
_____

__ Revocation/Expiration: This Release of Information is subject to revocation by the under-signed at any time except to the extent that information has already been disclosed based on authorization contained herein. Unless further limited by a date stated here, _____, this Release of Information will automatically expire after a period of 180 days from the date signed. I have the right to receive a copy of this Release of Information upon my request.

Client/Guardian's Name: _____Signature: _____Date _____

Therapist Name: _____Signature: _____Date:_____