

Margaret A. MacDevitt, Ph.D., P.C.
Licensed Psychologist

123 East Arch Street
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Phone: (906) 226-9584
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Adolescent Initial Client Information Form

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____ Grade in school: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Anger management | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Coping | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Fear/phobias | <input type="checkbox"/> Mental confusion | <input type="checkbox"/> Sexual concerns |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Addictive behaviors | <input type="checkbox"/> Alcohol/drugs | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Other mental health concerns (specify): _____ | | | |

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____

Were the child's parents ever married? Yes No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? Yes No

If Yes, describe: _____

Client's Mother

Name: _____ Age: _____ Occupation: _____ FT PT

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? Yes No

Natural parent Step-parent Adoptive parent Foster home Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

Yes No If Yes, please explain: _____

How is the child disciplined by the mother? _____

For what reasons is the child disciplined by the mother? _____

Client's Father

Name: _____ Age: _____ Occupation: _____ FT PT

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? _____ Yes _____ No

___ Natural parent ___ Step-parent ___ Adoptive parent ___ Foster home ___ Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

___ Yes ___ No If Yes, please explain: _____

How is the child disciplined by the father? _____

For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	_____	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	_____	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	_____	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
_____	_____	___ F ___ M	___ home ___ away	___ poor ___ average ___ good
Others living in the household			Relationship (e.g., cousin, foster child)	
_____	_____	___ F ___ M	_____	___ poor ___ average ___ good
_____	_____	___ F ___ M	_____	___ poor ___ average ___ good
_____	_____	___ F ___ M	_____	___ poor ___ average ___ good
_____	_____	___ F ___ M	_____	___ poor ___ average ___ good

Comments: _____

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

- | | | |
|-----------------------|-------------------------|-------------------------------|
| ___ Allergies | ___ Deafness | ___ Muscular Dystrophy |
| ___ Anemia | ___ Diabetes | ___ Nervousness |
| ___ Asthma | ___ Glandular problems | ___ Perceptual motor disorder |
| ___ Bleeding tendency | ___ Heart diseases | ___ Mental Retardation |
| ___ Blindness | ___ High blood pressure | ___ Seizures |
| ___ Cancer | ___ Kidney disease | ___ Spinal Bifida |
| ___ Cerebral Palsy | ___ Mental illness | ___ Suicide |
| ___ Cleft lips | ___ Migraines | ___ Other (specify): _____ |
| ___ Cleft palate | ___ Multiple sclerosis | _____ |

Comments re: Family Health: _____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? _____ Yes _____ No

If Yes, describe: _____

Was the pregnancy with child planned? _____ Yes _____ No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number ____ of ____ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? _____ Yes _____ No If Yes, what amount? _____

Did the mother use drugs of alcohol? _____ Yes _____ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication)
_____ Yes _____ No

If Yes, describe: _____

Length of labor: _____ Induced: _____ Yes _____ No Caesarean? _____ Yes _____ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

Describe any complications for the mother or the baby after the birth: _____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddler hood Check all which apply:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Breast fed | <input type="checkbox"/> Milk allergies | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bottle-fed | <input type="checkbox"/> Rashes | <input type="checkbox"/> Colic | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Not cuddly | <input type="checkbox"/> Cried often | <input type="checkbox"/> Rarely cried | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Resisted solid food | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Irritable when awakened | <input type="checkbox"/> Lethargic |

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: _____ slow _____ average _____ fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

Education

Current school: _____ School phone number: _____

Type of school: Public Private Home schooled Other (specify): _____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? Yes No If Yes, describe: _____

In gifted program? Yes No If Yes, describe: _____

Has child ever been held back in school? Yes No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? Yes No

If Yes, describe: _____

Has the child been tested psychologically? Yes No

If Yes, describe: _____

Check the descriptions, which specifically relate to your child.

Feelings about School Work:

Anxious Passive Enthusiastic Fearful
 Eager No expression Bored Rebellious
 Other (describe): _____

Approach to School Work:

Organized Industrious Responsible Interested
 Self-directed No initiative Refuses Does only what is expected
 Sloppy Disorganized Cooperative Doesn't complete assignments
 Other (describe): _____

Performance in School (Parent's Opinion):

Satisfactory Underachiever Overachiever
 Other (describe): _____

Child's Peer Relationships:

Spontaneous Follower Leader Difficulty making friends
 Makes friends easily Long-time friends Shares easily
 Other (describe): _____

Who handles responsibility for your child in the following areas?

School: Mother Father Shared Other (specify): _____

Health: Mother Father Shared Other (specify): _____

Problem behavior: Mother Father Shared Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? Poor Average Good Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? Lower Same Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hives | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Influenza | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congenital problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Severe colds |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Severe head injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Wearing glasses |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other skin rashes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Paralysis | _____ |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Pleurisy | |

List any current health concerns: _____

List any recent health or physical changes: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	<input type="checkbox"/> No <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/> High
Lunch	____ / week	_____	<input type="checkbox"/> No <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/> High
Dinner	____ / week	_____	<input type="checkbox"/> No <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/> High
Snacks	____ / week	_____	<input type="checkbox"/> No <input type="checkbox"/> Low <input type="checkbox"/> Med <input type="checkbox"/> High

Comments: _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Physician (s) _____

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio		
2 months	___	___	15 months	___ MMR (Measles, Mumps, Rubella)
4 months	___	___	24 months	___ HBPV (Hib)
6 months	___	___	Prior to school	___ HepB
18 months	___	___		
4–5 years	___	___		

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes ___ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____

Behavioral/Emotional

Please check any of the following that are typical for your child:

- | | | |
|---|---|---|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Gambling | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Generous | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Attachment to dolls | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Avoids adults | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Shares |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Irritable | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Lazy | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Listens to reason | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Loner | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Suicidal threats |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Messy | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Moody | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Obedient | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Often sick | <input type="checkbox"/> Tics or twitching |
| <input type="checkbox"/> Drugs dependence | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Over active | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Over weight | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Psychiatric problems | _____ |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Quarrels | _____ |

Please describe any of the above (or other) concerns: _____

How are problem behaviors generally handled? _____

What are the family's favorite activities? _____

What does the child/adolescent do with unstructured time? _____

Has the child/adolescent experienced death? (friends, family pets, other) _____ Yes _____ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

___ Yes ___ No If Yes, describe: _____

Any additional information that you believe would assist us in understanding your child/adolescent?

Any additional information that would assist us in understanding current concerns or problems?

What are your goals for the child's therapy? _____

What family involvement would you like to see in the therapy? _____

Do you believe the child is suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

Diag: _____
(To be completed by Dr. MacDevitt)

PATIENT INSURANCE INFORMATION

Full Name: _____ Today's Date: _____

Address _____

Street City State Zip
Phone number: _____ Work phone: _____ Date of Birth: ____/____/____

Gender: M F Age: _____ Source of referral: _____

Employer: _____ Social Security #: _____

Primary Insurance Company: _____

Insur Co Address: _____

Street City State Zip
Insur Co. Telephone: _____

Policy holder: _____ Policy #: _____

Employer/Group # _____ SS #: _____

Patient's relationship to Policy Holder: _____ Policy Holder Date of Birth: ____/____/____

If there is other (**Secondary Insurance**) please complete the following:

Secondary Insurance Company: _____

Address: _____

Street City State Zip
Telephone: _____

Policy Holder: _____ Policy #: _____

Employer/Group #: _____ SS#: _____

Patient's relationship to Policy Holder: _____ Policy Holder Date of Birth: ____/____/____

IMPORTANT THAT YOU SIGN BELOW IF YOU WANT US TO BILL YOUR INSURANCE

RELEASE

I certify the information given by me regarding my insurance plans is correct to the best of my knowledge. I authorize release of all records required and request payment of authorized benefits be made in my behalf to Dr. MacDevitt. I understand that in the case of payment made at the time of service, insurance payments will be made directly to me or to the responsible party as appropriate.

Authorized Signature: _____

Relationship to patient: _____

Agreement Regarding Appointments and Fees

I understand that I am requesting psychotherapy, counseling and related services from Margaret A. MacDevitt, Ph.D. and that such services will be provided under the terms of the following agreement. In particular, I acknowledge that all charges accruing from such services are to be paid my me according to this agreement. As used in the Agreement, "Psychologist" is Margaret A. MacDevitt, Ph.D.,P.C., as above and I am identified as the "Client". My name, address, and telephone number are as listed below. Although I am identified as the "Client", I may not be the person receiving services directly for the Psychologist; however, I agree that I am the person financially responsible for all charges for such services.

APPOINTMENTS: normally an individual, couple, or family is seen for a 50 minute session at a time. These sessions are scheduled at a frequency (usually once per week) which is mutually determined by the Client and Psychologist with regard to their mutual needs and available time.

FEES: Psychotherapy and counseling sessions are often partially covered by insurance (BlueCross, Champus, and many others). The fees for treatment are listed on the attached schedule, which is incorporated as part of this agreement. PERSONS FOR WHOM THE FEE REPRESENTS AN OBSTACLE TO TREATMENT ARE ENCOURAGED TO DISCUSS THIS WITH THE PSYCHOLOGIST.

INSURANCE: The Psychologist contracts with a billing service to file Insurance claims for you, but assumes no liability or responsibility in doing so. Client understands that Client is responsible for all charges regardless of the actions of Client's insurance carrier, and any assistance by the Psychologist to help the Client obtain benefits in no way constitutes a waiver by the Psychologist of any portion of the fees charged.

If any action is brought to enforce this agreement, the Psychologist shall be entitled to its attorney's fees and costs if it is the prevailing party; in addition, the Psychologist shall be entitled to reimbursement for its reasonable expenses in attempting to collect unpaid fees.

PAYMENT PLAN: Fees are payable at time of service rendered unless otherwise arranged and may be paid by check or cash. Alternative payment arrangements should be discussed during your first visit.

UNKEPT APPOINTMENTS: cancellation of appointment must be made 24 hours in advance of the time of the appointment. Failure to keep an appointment or cancellation of an appointment less than 24 hour in advance will result in the Client being charged unless the appointment time is used by another Client who could not otherwise have been accommodated.

TERMINATION OF SERVICES: The Client may terminate the services of the Psychologist at any time, subject to the above requirement to cancel appointments. The Psychologist retains the right to terminate any obligation to the Client to provide continuing treatment by giving the Client (7) days notice of intent to do so. The Psychologist may also elect to refer the Client to such professionals as the Psychologist, in her discretion, sees fit.

The Psychologist shall have no other obligations to the Client and the Psychologist's professional liability shall be limited to any acts which depart from usual professional practices where acceptable standards are not followed and due care not exercised.

DATED: _____

Client Signature

BY: _____

Psychologist
Margaret A. MacDevitt, Ph.D.

Person Responsible for Payment

Address

Telephone #

A copy of “The Notice of Privacy Policies and Practices” for Margaret A. MacDevitt, Ph.D. is available on this web site and is also located on top of the waiting room bookcase (next to the coffee pot) for your review. If you would like to have a copy of that, please download one from this web site or ask Dr. MacDevitt during your session with her.

Please **sign below** indicating that you have been given the opportunity to read the “Privacy Policy”:

Patient/Representative: _____

Date: _____

Margaret A. MacDevitt, Ph.D., P.C.
Licensed Psychologist

123 East Arch Street
Marquette, Michigan 49855
(906) 226-9584

Fees For Services Rendered

Initial Diagnostic Interview (50 minutes).....	\$200.00
Psychotherapy, Individual (50 minutes).....	\$125.00
Psychotherapy, Couple/Family (50 minutes).....	\$150.00
Late Cancellation or No Show.....	\$125.00

