Russel Thompson, PhD
7400 Blanco Rd, Suite 126
San Antonio, TX 78216
Office: 210-699-8700
Fax: 210-587-2454

Patient Registration Information

Patient Name: _____ , _____ Sex: M [ ] F [ ]
Last *First* *Middle*

Date of Birth: _____ Home Phone: (___)_____ Cell/Work Phone: (___)_____

Address: _____ City: _____ State _____ Zip _____

Please check if we may leave a message on your ☐ Home Phone? ☐ Cell Phone?

If Patient is a Minor below the age of 18:

Guardian's Name: _____ Cell/Work Phone: (__)_____

In Case of Emergency, Please Notify: Name: _____ Relationship _____Phone Number (___)_____

Chose Clinic Because/Referred to Clinic by (Please check one box)

☐ Dr. _____ ☐ Insurance Plan ☐ Hospital ☐ Family/Friend ☐ Convenient location ☐ Yellow Pages

☐ Other: _____

Payment (check one)

☐ I will pay for these services directly and do not wish to have you my bill insurance.

☐ Please bill my insurance using the following information

INSURANCE INFORMATION

Patient's SS#: _____

Primary Insurance Name: _____ Name of Insured: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID or Policy Number: _____ Group Number: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: ( ) _____

Secondary Insurance Name: _____ Name of Insured: _____

Id or Policy Number: _____ Group Number: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

___ (initials) I authorize Russel Thompson, PhD & the above insurance provider(s) to release any information required to process my claims.

Cancellation Policy

___ (initial) Failure to cancel an appointment within 24 hours of the scheduled time is considered a "No-show" and is billed at the full rate. I understand that insurance usually does not pay for no-shows, and I will be responsible for the fee myself.

Authorization of treatment and payment

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Russel Thompson, PhD. I understand that I am financially responsible for any balance.

Signature: _____ Date: _____

Print Name: _____

Russel Thompson, PhD

NOTICE OF RECEIPT OF POLICY REGARDING PROTECTED HEALTH INFORMATION

Please sign below to indicate that you have been given the opportunity to review Russel Thompson, PhD's policies regarding protected health information. If you request it, we will provide you with a paper copy of the policy

_____

Printed Name

_____ _____

Signature **Date**

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Child Assessment Custody Information

Your Name: _____ Child's Name: _____

Your relationship to the Child: _____

Do you have legal authority to consent to medical & psychological care for your child? ❑ Yes ❑ No

Please confirm the following by initialing:

___ If the parents are divorced, our office requires a copy of the divorce decree for our records. We will not conduct an assessment until we have a copy of the most recent divorce decree that confirms that you are the custodial parent with authority to consent to medical and psychological treatment. If at all possible, we prefer for both parents to consent to the assessment, regardless of custody arrangements.

I, the undersigned, have read and understand the purpose for assessment, the potential uses of the information, and the limits of confidentiality. I affirm that I have legal authority to consent to medical and psychological care for my child.

I consent to the evaluation.

_____ _____ _____

Signature Printed Name Date

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CHILD/ADOLESCENT NEUROPSYCHOLOGY QUESTIONNAIRE

The following is a questionnaire about the child's development, medical history, and current functioning at home and at school. This information will be integrated with the testing results to provide a better picture of the child's abilities as well as any problem areas. Please fill out this questionnaire as completely as you can.

Child's Name: _____ Today's Date: _____
Birthdate: _____ Age: _____
Birth Country: _____ Age on arrival in country if born elsewhere: _____
Person filling out this form: _____ Relationship to child: _____

What questions do you hope will be answered?

What Concerns Bring You Here?

Child's Family

Biological Mother's Name: _____ Age: _____ Highest Grade Completed: _____
Number of years of education: _____ Degree/Diploma (if applicable): _____
Occupation: _____
Biological Fathers Name: _____ Age: _____ Highest Grade Completed: _____
Number of years of education: _____ Degree/Diploma (if applicable): _____
Occupation: _____
Marital status of biological parents: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Other: _____
If biological parents are separated or divorced:
How old was this child when the separation occurred?
Who has legal custody of the child? _____
Stepparents' Name: _____ Age: _____ Occupation: _____
If this child is not living with either biological parents:
Reason: _____
❑ Adoptive Parents ❑ Foster Parents ❑ Other Family Members ❑ Group Home ❑ Other: _____
Name(s) of legal guardians(s):

List all people currently living in the child's household

Name	Relationship to child	Age

If any brothers or sisters are living outside the home, list their names and ages:

Primary language spoken in the home: _____
Other languages spoken in the home: _____
If the child's first language is not English, please complete the following:
Child's first language: _____ Age at which the child learned English: _____

Current Medications

Medication	Reason Taken	Dosage (if known)	Start Date

Check the behaviors you believe the child exhibits to an excessive degree compared to other children his or her age.

- ❑ Nightmares
- ❑ Problems going to sleep
- ❑ Problems staying asleep
- ❑ Eats poorly
- ❑ Eats excessively

❑ Dangerous to self or others (describe):

❑ Purposely harms or injures self (describe):

❑ Talks about killing self (describe):

Check the behaviors you believe the child exhibits to an excessive degree compared to other children his or her age.

Social Development

- ❑ Prefers to be alone
- ❑ Very shy or timid
- ❑ Difficulty making friends
- ❑ Teased by other children
- ❑ Bullies other children
- ❑ Not sought out for friendship by peers
- ❑ Difficulty seeing another person's point of view
- ❑ Doesn't empathize with others
- ❑ Overly trusting of others
- ❑ Doesn't appreciate humor

❑Unusual fears, habits or mannerisms (describe):

- ❑ Depressed
- ❑ Cries frequently
- ❑ Worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug abuse
- ❑ Alcohol abuse
- ❑ Sexually active

Behavior

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Frequent tantrums
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with adults
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Runs away
- ❑ Needs lots of supervision
- ❑ Impulsive (does things without thinking)
- ❑ Poor sense of danger
- ❑ Skips school

Other Problems

- ❑ Bladder control problems (not during seizures)
- ❑ Bowel control
- ❑ Motor/vocal tics
- ❑ Overreacts to noises
- ❑ Excessive daydreaming and fantasy life
- ❑ Problems with taste or smell

Motor Skills

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination

Other problems: _____

Education Program

Where does the child go to school? _____ Grade: _____

Does you child have a modified learning program? ❑ Yes ❑ No

Is there an individual education plan (IEP)? ❑ Yes ❑ No

Are you satisfied with the child's current learning program? If not, please explain:

Has the child been held back a grade? ❑ No ❑ Yes If so, what grade(s)? _____

Is the child in any special education classes? ❑ No ❑ Yes. If yes, please explain:

Is the child in any special education classes? ❑ No ❑ Yes. If yes, please explain:

Is the child receiving learning assistance in or after school? ❑ No ❑ Yes. If yes, please explain:

Has the child ever been suspended or expelled from school? ❑ No ❑ Yes. If yes, please explain:

Has the child ever received tutoring? ❑ No ❑ Yes. If yes, please explain:

Please describe classroom or school problems, if applicable:

Rate the child's cognitive skills compared to other children of the same age

	Above Average	Average	Below Average	Severe Problem
Speech	❑	❑	❑	❑
Comprehension of Speech	❑	❑	❑	❑
Problem solving	❑	❑	❑	❑
Attention span	❑	❑	❑	❑
Organization skills	❑	❑	❑	❑
Remembering events	❑	❑	❑	❑
Remembering facts	❑	❑	❑	❑
Learning from experience	❑	❑	❑	❑
Understanding concepts	❑	❑	❑	❑
Overall intelligence	❑	❑	❑	❑

Check any specific problems

- ❑ Poor articulation
- ❑ Difficulty finding words to express self
- ❑ Disorganized speech
- ❑ Ungrammatical speech
- ❑ Talks like a younger child
- ❑ Slow learner
- ❑ Forgets to do things
- ❑ Easily distracted
- ❑ Frequently loses belongings
- ❑ Difficulty planning tasks
- ❑ Doesn't foresee consequences
- ❑ Slow thinking
- ❑ Difficulty with math/handling money
- ❑ Poor understanding of time
- ❑ Frequently forgets instructions
- ❑ Poor articulation/speech defect

Describe any other cognitive problems that the child has:

Describe any special skills or abilities that the child has:

Developmental History

During pregnancy, did the mother of this child:

Take any medication? ❑ Yes ❑ No. If yes, what ? _____

Smoke? ❑ Yes ❑ No. If yes, how many cigarettes per day ? _____

Drink Alcohol? ❑ Yes ❑ No. If yes, what did she drink and how much per day or week? _____

Use drugs? ❑ Yes ❑ No. If yes, what and how often? _____

List any complications during pregnancy (vomiting, staining/blood loss, threatened miscarriage, infections, toxemia, etc)

Duration of pregnancy (weeks): _____ Duration of labor (hours): _____ APGAR: _____ / _____

Were there any indications of fetal distress? ❑ Yes ❑ No. If yes, what ? _____

Check any that apply to the birth: ❑ Labor induced ❑ Forceps ❑ Breech ❑ C-Section
If so, for what reason?

What was the child's birth weight? _____

Check any problems for the child after birth ❑ Jaundice ❑ Breathing problems ❑ Incubator ❑ Birth defects
If so, please describe:
Were there any other complications? ❑ Yes ❑ No. If yes, what ? _____
Were there any feeding problems? ❑ Yes ❑ No. If yes, what ? _____
Were there any sleeping problems? ❑ Yes ❑ No. If yes, what ? _____
Were there any developmental problems? ❑ Yes ❑ No. If yes, what ? _____

Were any of the following present (to a significant degree) during infancy or the 1st few years of life?

❑ Unusually quiet or active
❑ Did not like to be held or coddled
❑ Not alert
❑ Difficult to soothe
❑ Colic
❑ Excessive restlessness
❑ Excessive sleep
❑ Diminished sleep
❑ Headbanging
❑ Constantly into everything
❑ Excessive number of accidents

Please indicate the approximate age at which the child first showed the following behaviors. Check "Never" if you child has never shown the behavior.

	Early	Average	Late	Never		Early	Average	Late	Never
Smiled	❑	❑	❑	❑	Tied shoelaces	❑	❑	❑	❑
Rolled over	❑	❑	❑	❑	Dressed self	❑	❑	❑	❑
Sat Alone	❑	❑	❑	❑	Fed self	❑	❑	❑	❑
Crawled	❑	❑	❑	❑	Bladder trained, day	❑	❑	❑	❑
Walked	❑	❑	❑	❑	Bladder trained, night	❑	❑	❑	❑
Babbled	❑	❑	❑	❑	Bowel trained	❑	❑	❑	❑
First word	❑	❑	❑	❑	Rode tricycle	❑	❑	❑	❑
Sentences	❑	❑	❑	❑	Rode bicycle	❑	❑	❑	❑

Medical History

Vision problems ❑ No ❑ Yes (Describe: _____) Date of last vision exam: _____
Hearing problems ❑ No ❑ Yes (Describe: _____) Date of last hearing exam: _____

Please a check next to any illness/condition the child has had, along with the approximate date or age of the illness.

Illness/Condition	Date(s)/age(s)
❑ Measles	_____
❑ Attention deficit	_____
❑ Mumps	_____
❑ Chicken Pox	_____
❑ Whooping cough	_____
❑ Diptheria	_____
❑ Scarlet fever	_____
❑ Meningitis	_____
❑ Encephalitis	_____
❑ High fever	_____
❑ Seizures	_____
❑ Allergy	_____
❑ Hay fever	_____
❑ Injuries to head	_____
❑ Broken bones	_____
❑ Hospitalizations	_____
❑ Operations	_____
❑ Ear infections	_____
❑ Paralysis	_____

Illness/Condition	Date(s)/Age(s)
❑ Loss of consciousness	_____
❑ Poisoning	_____
❑ Severe headaches	_____
❑ Rheumatic fever	_____
❑ Tuberculosis	_____
❑ Bone or joint disease	_____
❑ Sexually transmitted disease	_____
❑ Anemia	_____
❑ Jaundice/hepatitis	_____
❑ Diabetes	_____
❑ Cencer	_____
❑ High blood pressure	_____
❑ Heart disease	_____
❑ Asthma	_____
❑ Bleeding problems	_____
❑ Eczema	_____
❑ Physical abuse	_____
❑ Sexual abuse	_____
❑ Other	_____

Family Medical History *Check any problem that any family member has had*

Illness/Condition	Relationship to child	Illness/Condition	Relationship to child
❑ Seizures/epilepsy	_____	❑ Tics or Tourette's syndrome	_____
❑ Attention deficit	_____	❑ Alcohol abuse	_____
❑ Learning Disabilities	_____	❑ Suicide attempt	_____
❑ Intellectual Disability	_____	❑ Physical abuse	_____
❑ Behavior Problems	_____	❑ Sexual abuse	_____
❑ Mental Illness	_____	❑ Parkinson's disease	_____
❑ Depression or Anxiety	_____	❑ Huntington's disease	_____
❑ Neurological disease	_____	❑ Antisocial behavior	_____

List any previous assessments the child has had:

	Dates of testing	Name of examiner
Psychiatric	_____	_____
Psychiatric	_____	_____
Neuropsychological	_____	_____
Educational	_____	_____
Speech pathology	_____	_____

List any form of mental health treatment the child has had (e.g., psychotherapy, family therapy, residential treatment)

Type of treatment	Dates	Name of therapist
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any recent stressors that might be contributing to the child's difficulties (e.g., illness, deaths, operations, accidents, separations, divorce, parent changed job, changed schools, family moved, family financiel problems, remarriage, sexual trauma, other losses?

Other Information

What are the child's favorite activities?

Has the child ever been in trouble with the law? ❑ Yes ❑ No. If yes, please describe:

On the average, what percentage of the time does the child comply with requests or commands? _____

Please describe the typical form of discipline for this child

What have you found the be the most satisfactory ways of helping the child?

What are the child's assets or strengths?

Is there any other information that may help me in assessing the child?

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CREDIT CARD AUTHORIZATION

We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable, including, but not limited to, copayments, coinsurance, any amount applied to your deductible, no show appointment fees, and other billing charges. If you have any questions or concerns about this policy, please discuss with your psychologist before signing.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account.

I authorize Russel Thompson, PhD and Associates to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

□ Visa □ Mastercard

Credit Card Number _____

Expiration Date _____ / _____ / _____ 3digit Security Code__ ___ ___

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Russel Thompson, PhD and Associates to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Russel Thompson, PhD and Associates. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Russel Thompson, PhD and Associates in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____