PATIENT PACKET INTAKE FORM: ***PLEASE GET BACK TO ME AS SOON AS POSSIBLE!!!***
PLEASE FILL OUT THIS FORM IN AS MUCH DETAIL AS POSSIBLE!
SO I CAN HELP YOUR CHILD AS MUCH AS POSSIBLE!!

DATE ____________________ CHILD'S FULL NAME ________________________________

Parent's Full Name ____

Email ____________________@____

Child's Home Address with *City or Town & Zip Code* ______________________________

____

(Please include full address including town and zip code)

Mother's Tel. #s: Home ____________________ Cell ________________ Work ____________

Father's Tel. #s: Home (If Separated) ________________ Cell ________________ Work ____________

Child's School & Grade __________________________ DOB ______________ Age ____________

How did you find Dr. Sussman? Insurance Company List Psychology Today Website

<u>(Circle all that apply)</u> Healthgrades.com Internet Search Sussmankids.com

Referral From _________________________

Are you or someone close to you a psychotherapist? If yes, in private practice? _________

I am bringing my child for help because ____

____

____

____

____

<u>My child is in or receives</u> regular classes an IEP 504 Plan

accommodations pullout classes resource room special education therapeutic school

home schooling speech therapy occupational therapy physical therapy tutoring

What does the teacher(s) say about your child? __________________________________

____

____

What are your child's school issues, if any? _____________________________________

____

____

FAMILY: Name DOB Education/Employment Personality How Do They Get Along with Patient?

(PLEASE ANSWER ALL OF THE CATEGORIES)

Mother ____

____

____

Father____

____

____

Step-Parents (If Any)____

____

____

Parents are- Living Together?____________________Separated?__________Divorced?___________

How are the child's parents getting along? Explain--____

____

What nationalities or religions, if any, does your child's family identify with aside from American? Are you particularly religious? ____

Siblings (Indicate Brother/Sister and/or Step-Sibling, Age, Grade, Personality, Getting Along w Patient?)

(1)____________ ____

(2)____________ ____

(3)____________ ____

(4)____________ ____

(5)____________ ____

HOW WERE THE CHILD'S BIOLOGICAL PARENTS WHEN THEY WERE HIS OR HER AGE? SIMILAR? DIFFERENT? THE SAME?____

____

My child's home life and emotional climate is best described as ______________________________

____

IS YOUR CHILD ADOPTED? If Yes, Age & Circumstances of the Adoption ___________________

____

PSYCH. HISTORY OF CHILD'S BLOOD RELATIVES (Indicate YES or No and Relation)

Alcohol Abuse________________________________ Drug Abuse ________________________________

ADD or AD/HD ______________________________ Anxiety______________________________

Regular Depression ___________________________ Bi-Polar____________________________________

Obsessive/Compulsive__________________ Eating Disorder ______________________________

Aspergers or Autism___________________________ Schizophrenia________________________________

Suicide or Homicide ________________________Other____________________________________

DEVELOPMENTAL HISTORY

Pregnancy/Delivery Problems (If Any)____

____

Describe Infancy (Temperament, Eating, Sleeping, Crying Etc.)______________________________

____

Walking, Talking, & Toilet Training (At What Age? Any Problems?)__________________________

____

Early Childhood Personality (Toddler/PreSchool)____

____

Current Personality____

____

Social Skills & Popularity____

____

MEDICAL HISTORY (Complete all that apply)

Pediatrician & Office Address & Telephone ____

Past & Present Medical Conditions & Medications (Include Any Food/Drug Allergies)_________________

____

Child Neurologist or Psychiatrist, Medications & Dosages____

____

DOES YOUR CHILD HAVE ANY SIGNIFICANT DOCTOR APPTS COMING UP?_______________________

____

MANY INSURANCE COMPANIES REQUIRE THAT WE COORDINATE CARE WITH YOUR CHILD'S PHYSICIANS.
PLEASE SIGN BELOW IF YOU GIVE YOUR PERMISSION TO DO SO
I GIVE DR. SUSSMAN PERMISSION TO SHARE INFORMATION WITH MY CHILD'S PHYSICIANS

____

(SIGNATURE) (DATE)

PSYCHOLOGICAL TRAUMA: (Has Your Child Ever Been Abused or Traumatized?)

__No or Yes__ or Maybe__ (Explain)____

____

HAS YOUR CHILD BEEN INVOLVED (OR LIKELY TO BE) IN ANY LEGAL CASES? (If Yes - Explain e.g., custody, visitation, abuse, accident related, immigration disability, etc. Do you foresee your lawyer or a court wanting your child's treatment records?____

____

HAS YOUR CHILD PREVIOUSLY RECEIVED PSYCHOTHERAPY?

With Whom? ____When?______________________________

For What Issues?____

Were you in the sessions?_____________ What was the therapist's approach and method(s)?

____

How did your child respond? Did they like it? Did they improve and/or change?

____

What did you learn from the therapy? ____

Have Mom/Dad/Sibs Been in Therapy?__If Yes, With Whom?_______________________________________

Since When?__________For What Issues?____

____

DESCRIBE YOUR CHILD'S

Appearance________________________________Height/Weight___________________________________

Athleticism________________________________Intelligence____________________________________

Moods____________________________________Self-Esteem____________________________________

Judgment__________________________________Insight (Into Self & Others) ___________________________

SUMMARIZE YOUR CHILD'S PERSONALITY (Include Strengths and Weaknesses):

(STRENGTHS)____

____

(WEAKNESSES)____

____

GOALS (What Should Your Child Learn From Coming to The Child & Teen Success Center?)

1)____

2) ____

3)____

ADDITIONAL QUESTIONS ABOUT YOUR CHILD

REPEATING Do you have to repeat yourself constantly to get your child to do something? _____________

____

____

WAKING UP Do you have trouble getting your child to wake up? If yes I recommend a sleep apnea study____

____

HOMEWORK/STUDY Do you have trouble getting your child to do their homework and/or study? ______

____

____

SLEEPING Do you have trouble getting your child to go to bed and stay in their bed? Fall asleep? _______

____

____

____

MESSY Does your child leave stuff all over the house? Is their room messy and disorganized? __________

____

SIBLING(S) Does your child target one or more of his siblings? ______________________________

____

____

TANTRUMS Does your child throw temper tantrums often? What do they do? How long does it take for them to calm down? ____

____

____

MEALS Does your child frequently get up from the dinner table? Do they take a long time to finish their meal? ____

____

____

SPECIAL INTERESTS Does your child have strong interest(s) in any particular sports team, hobby, collectible cards, toys, music, skills, etc.?____

____

PLEASE USE BELOW BLANK LINES TO ANSWER

DOES YOUR CHILD HAVE ANY KNOWN/SUSPECTED ALCOHOL/DRUG/TOBACCO USE AND/OR SEXUAL ACTIVITY?

DOES YOUR CHILD HAVE ACCESS TO GUNS OR WEAPONS IN THE HOME AND/OR ELSEWHERE?

DOES YOUR CHILD EXPRESS ANIMOSITY TOWARD OTHER ETHNIC GROUPS?

____

____

____

____

____

____

____

____

____

____

____

____

NOTE: IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS PLEASE CALL DR. SUSSMAN AT 908 217 8106; AS YOUR CHILD MAY NOT BE APPROPRIATE FOR DR. SUSSMAN'S THERAPY METHOD AND REQUIRE SPECIALIZED INDIVIDUAL THERAPY.

(ATTACH ADDITIONAL PAGE(S) IF NECESSARY TO EXPLAIN)

CHILD SYMPTOM CHECKLIST

CHILD'S NAME______________________ YOUR NAME________________________

CHILD'S DOB_____________ SCHOOL ATTENDING_____________ GRADE____________________

Please check all items that apply to child for <u>at least</u> the past 6 months.

___often fails to give close attention to details or makes careless mistakes

___often has difficulty sustaining attention in tasks or play activities

___often does not seem to listen when spoken to directly

___often does not follow through on instructions and fails to finish schoolwork or chores, which is not due to oppositional behavior or lack of understanding

___often has difficulty organizing tasks and activities

___often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

___often loses things necessary for tasks/ activities (i.e. toys, books, pencils, assignments)

___is often easily distracted by extraneous stimuli

___is often forgetful of daily activities or routines

(6 or more suggests Attention Deficit Disorder-Inattentive Type)

___often fidgets with hands or feet or squirms in seat

___often leaves seat in classroom situation or in other situations in which remaining seated is expected

___often runs about or climbs excessively in situations in which it is inappropriate (for adolescents this may be limited to feelings of restlessness)

___often has difficulty in playing or engaging in leisure activities quietly

___is often "on the go" or acts as if "driven by a motor"

___often talks excessively

___often blurts out answers before questions have been completed

___often has difficulty waiting his turn

___often interrupts or intrudes on others (butts into conversations or games)

(6 or more Suggests Attention Deficit Disorder- Hyperactive/Impulsive Type)

Have you and/or a professional thought your child has an Attention Deficit Disorder? If yes, Who and When? ____

____

___often loses temper
___often argues with others
___often actively defies or refuses to comply with adults' requests or rules
___often deliberately annoys others
___often blames others for his/her mistakes or behavior
___is often "touchy" or easily annoyed by others
___is often angry or resentful
___is often spiteful and vindictive
___often throws or breaks objects
___often hits or physically threatens-(Circle) mother, father, grandparents, siblings
(4 or more suggests Oppositional Defiant Disorder)

___often bullies, threatens, or intimidates other children
___often initiates physical fights
___has deliberately destroy other's property
___has broken into someone's house, car or building
___often lies to obtain goods, favors, or to avoid obligations (e.g. cons others)
___has stolen items of value without facing the victim (e.g. shoplifting, forgery)
___often stays out at night despite parental prohibitions
___has run away from home overnight at least twice
___often cuts classes and/or truant from school
___shows little remorse: and even then, it is to obtain a lesser punishment
(3 or more after age 14 suggests Antisocial Personality)

___often has rages that last for hours at a time
___often displays or expresses excessive fears or worries about many things, especially bad fortune to him or herself or family members
___often unable to engage in activities or play due to nervousness or worries
___does not seem interested in the activities that once brought pleasure
___is often moody, tearful, and/or overly sensitive to perceived criticism or imagined slights
___has experienced significant weight gain or loss in past 12 months
___has sleep difficulties (e.g. falling asleep or staying asleep, early morning awakenings, or trouble getting up in morning)
___often exhibits social anxiety (i.e., avoids interacting with anyone other than friends or family)
(3 or more Indicators of Anxiety and/or Depression)

___has few friends and has little interest in having friends
___has excessive interest in things as opposed to people
___prefers to be alone
___often gets teased or bullied - by whom?__________________________
___has excessive knowledge, like an encyclopedia, about an unusual topic
___has little interest in the latest popular fad in toys, clothes and music
___has an unusual tone of voice and/or lacks inflection
___has an exceptional memory for events that occurred long ago
___lacks empathy and understanding of others
___lacks the ability for social imaginative (pretend) play
___has a tendency to flap or rock when distressed
___does "stemming" - wringing of hands and/or fingers
(3 or more Indicators of Pervasive Developmental Disorders)

Has any professional suggested or diagnosed your child with Oppositional Defiant Disorder, Autistic Spectrum Disorder, Pervasive Developmental Disorder, Aspergers' Disorder, Anxiety, Depression?

If yes, Who and When?____

If no, do you suspect your child has any of the above? Why?______________________________

____

***IF YOU ARE COMFORTABLE*, PLEASE GIVE THE FORM ON THE NEXT PAGE TO AT LEAST ONE OF YOUR CHILD'S TEACHER(S).**

THE TEACHER(S) SHOULD BE THE ONE(S) WHO KNOWS YOUR CHILD WELL. IT IS BEST IF THE TEACHER HAS BEEN WORKING WITH YOUR CHILD FOR AT LEAST TWO MONTHS.

THE TEACHERS' FEEDBACK CAN BE VERY HELPFUL TO MY WORK WITH YOUR CHILD.

NOTE: FROM JULY THROUGH MID-OCTOBER TRY TO GET LAST YEAR'S TEACHER(S) TO FILL IT OUT.

TEACHER'S RATING SCALE

TO BE COMPLETED BY TEACHER WHO KNOWS THE CHILD BEST.

PLEASE READ EACH ITEM AND ***COMPARE THE CHILD'S BEHAVIOR WITH THAT OF THEIR CLASSMATES.*** CIRCLE THE NUMBER THAT MOST CLOSELY CORRESPONDS WITH YOUR EVALUATION. THANK YOU FOR YOUR HELP.

CHILD'S NAME________________________ TEACHER______________________________ DATE__________

ATTENTION	**Almost Never>>>>>>>>>Almost Always**				
1. Works well independently	1	2	3	4	5
2. Persists with task for reasonable amount of time	1	2	3	4	5
3. Completes assigned task satisfactorily with little help	1	2	3	4	5
4. Follows simple directions accurately	1	2	3	4	5
5. Follows a sequence of instructions	1	2	3	4	5
6. Functions well in the classroom	1	2	3	4	5

HYPERACTIVITY/IMPULSIVITY	**Almost Never>>>>>>>>>Almost Always**				
1. Extremely overactive (out of seat, "on the go)	1	2	3	4	5
2. Overreacts	1	2	3	4	5
3. Fidgety (hands always busy)	1	2	3	4	5
4. Impulsive (acts or talks without thinking)	1	2	3	4	5
5. Restless (squirms in seat)	1	2	3	4	5
6. Invades others' personal space	1	2	3	4	5

OPPOSITIONAL	**Almost Never>>>>>>>>>Almost Always**				
1. Tries to get others in trouble	1	2	3	4	5
2. Starts fights over nothing	1	2	3	4	5
3. Makes malicious fun of people	1	2	3	4	5
4. Defies authority	1	2	3	4	5
5. Picks on others	1	2	3	4	5
6. Mean and cruel to other children	1	2	3	4	5

SOCIAL SKILLS	**Almost Never>>>>>>>>>Almost Always**				
1. Is able to admit fault and apologize if necessary	1	2	3	4	5
2. Is considered well-liked and/or popular	1	2	3	4	5
3. Is respectful of other children and their belongings	1	2	3	4	5
4. Has trouble making and maintaining friendships	1	2	3	4	5
5. Bullies other children	1	2	3	4	5
6. Is a sore loser	1	2	3	4	5

You may give to parent or mail to Dr. Steven Sussman 615 Sherwood Pkwy, Mountainside, NJ 07092

STEVEN SUSSMAN, PHD
LICENSED NJ & NY PSYCHOLOGIST

615 Sherwood Parkway Mountainside, N.J. 07092 (908) 217 8106

HIPPA PRIVACY NOTIFICATION

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "Hippa," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.
You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201
1-202-619-0257 or Toll Free: 1-877-696-6775

STEVEN SUSSMAN, PHD
LICENSED NJ & NY PSYCHOLOGIST

615 Sherwood Parkway **Mountainside, N.J. 07092**

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPPA (SEE PREVIOUS TWO PAGES) PRIVACY NOTICE FOR THE OFFICE OF STEVEN SUSSMAN, PhD

PATIENT NAME____

DATE OF BIRTH____

PARENT NAME____

SIGNATURE____

DATE____

PLEASE SIGN FORM.

ATTENDANCEAGREEMENT

I, _____________________________, the parent of _______________ am aware of the attendance policy. I understand the importance of regular attendance and punctuality. I realize that if I do not honor my commitment to attendance, it conveys to my child that therapy and other commitments (e.g. schoolwork, homework, promises, etc.) are not important.

I am aware that if my child misses their first appointment for any reason other than sickness Dr.Sussman will not be able to give them another one. Once treatment starts if my child has inconsistent attendance, especially in the beginning of therapy, Dr. Sussman will need to reassign my child's spot to another child.

The only reason my child will miss a session is for illness or something unavoidable. I understand that having too much homework, needing to study for a test, wanting to take a family member or friend out to dinner, etc. are not appropriate reasons to miss therapy.

If I have a job that periodically requires overtime, preventing me and my child from attending, I will let Dr. Sussman know at the beginning of therapy. I understand that such a situation may result in Dr. Sussman not being able to treat my child.

To prevent absences I will check my upcoming schedule at all times and try to reschedule any upcoming events or appointments that conflict with my child's therapy appointments.

If my child is in (or going to be in) a sport or activity that will conflict with therapy, I will notify Dr. Sussman as soon as possible. *I understand this will require a switch to another session provided one is available.*

I agree to give Dr. Sussman advanced notice (by cell 908-2106, voicemail or text, or email stevensussman75@gmail.com) of any sessions my child will miss and the reason.

Mentioning it verbally to Dr. Sussman before, during or after a therapy session is insufficient as Dr. Sussman needs to focus on the children at these times.

I understand that if my child misses 2 consecutive sessions their spot may need to be reassigned to another child on the wait list. If my child misses 3 consecutive sessions my child's spot will immediately be reassigned.

If weather is inclement, I will call Dr. Sussman at (908) 217-8106 before leaving for my appointment. His voicemail will announce if the office is closed due to weather.

Dr. Sussman reserves the right to charge for excessive missed appointments.

____

Signature Date

WHY I DEVELOPED THIS UNCONVENTIONAL APPROACH

I developed this approach in 1997 because difficult uncooperative kids did not cooperate adequately in traditional therapy. I have obtained much better results with this approach than traditional talk or play therapy.

There are over 120 parent reviews on Healthgrades.com. The reviews attest to the approach's efficacy as well as my therapeutic use of "edgy and outrageous" humor to keep everyone entertained and interested.

IF YOU ARE EVER UNCOMFORTABLE WITH MY HUMOR, PLEASE LET ME KNOW ASAP, SO WE CAN DISCUSS IT AND DETERMINE IF WE CAN WORK TOGETHER. IF NOT, I WILL GLADLY REFER YOU TO A MORE CONVENTIONAL THERAPIST.

DURING THE CORONA VIRUS SITUATION

GROUP SESSIONS IN THE OFFICE REQUIRE CHILDREN AND PARENTS TO SIT CLOSELY TOGETHER (NOT 6 FEET APART). I EXPECT TO ONLY BE DOING VIDEO CONFERENCING SESSIONS UNTIL IT IS TOTALLY SAFE TO DO SO.

For the video conference sessions the link is

https:/doxy.me/drstevensussman (do not underline in browser.)

I am told that Chrome or Safari are the best browsers for the app as opposed to Firefox and others.

When you first log on you will be in a "waiting room." I will admit you when I begin the session. Please try to be on time.

Please keep on mute if you are not speaking...so we do not get any background noise from your home (kids, animals, televisions, etc.)

If you have trouble getting into the session, call my cell 908 217 8106 and you can participate by cell......if you have an I Phone call me on Facetime.

If you are in a session and start to have reception problems such as audio or video, etc. …try going out and then coming back in. Sometimes it solves the problem(s).