STEVEN SUSSMAN, Ph.D. CHILD & TEEN SUCCESS CTRS Fax 908 654 4676

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?_____

Are you or a close friend/or relative a psychotherapist?_____

I am bringing my child for help because _____

_____

_____

_____

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

_____

_____

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?_____
Siblings (Indicate Brother/Sister and/or Step-Sibling, Age, Grade, Personality, Getting Along w Patient?) (1)_____

_____ (2)_____

_____

(3)_____
(4)_____ _____

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/Frug 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 etc. Do you foresee your lawyer or the 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)_____

ANY IMPORTANT ADDITIONAL INFORMATION ABOUT YOUR CHILD?
*(Over Age 12, Include Known/Suspected Alcohol/Drug/Tobacco Use and Sexual Activity)

_____

_____
(ATTACH ADDITIONAL PAGE IF NECESSARY TO EXPLAIN)

STEVEN SUSSMAN, PhD **CHILD & TEEN SUCCESS CENTERS**
56 SEGUINE AVE. 615 SHERWOOD PKWY
STATEN ISLAND, N.Y.10309 MOUNTAINSIDE, NJ07092

CHILD SYMPTOM CHECKLIST

CHILD'S NAME_____PARENT'S NAME_____
DATE_____CHILD'S DOB_____AGE, SCHOOL & 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)

Has any professional suggested or diagnosed your child with AD/HD-Attention Deficit Disorder? If yes, Who and When? _____

_____

If no (especially if your child has several of the above checked off) do you suspect your child has AD/HD or not? Why?_____

___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 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 TEACHER'S 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. Impusive (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. Has no trouble making or keeping friends	1	2	3	4	5
2. Is considered well-liked and/or popular	1	2	3	4	5
3. Is never seen as a bully or an aggressor	1	2	3	4	5
4. Is respectful of other children and their belongings	1	2	3	4	5
5. Is able to admit fault and apologize if necessary	1	2	3	4	5

You may give to parent or fax to (908) 654 4676 or mail to Dr. Steven Sussman 615 Sherwood Pkwy, Mountainside, NJ 07092 or 56 Seguine Ave., Staten Island, NY 10309 **(YOU MAY CALL MY CELL 908 217 8106)**

STEVEN SUSSMAN, PhD
LICENSED NJ & NY PSYCHOLOGIST

615 Sherwood Parkway
Mountainside, N.J. 07092

56 Seguine Ave.
S.I., N.Y. 10309

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

PATIENT NAME_____

DATE OF BIRTH_____

PARENT NAME_____

SIGNATURE_____

DATE_____

PLEASE SIGN FORM AND BRING TO FIRST APPOINTMENT

STEVEN SUSSMAN, PHD
LICENSED NJ & NY PSYCHOLOGIST

615 Sherwood Parkway
Mountainside, N.J. 07092

56 Seguine Ave.
S.I., N.Y.10309

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
(202)619-0257 or Toll Free: 1-877-696-6775