PLEASE COMPLETE THIS FORM IN AS MUCH DETAIL AS POSSIBLE!
SO DR. SUSSMAN 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? (Circle all that apply)

Insurance Company List
Healthgrades.com
sussmankids.com
Psychology Today Website
Internet Search
Referral From _______________

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

I am bringing my child for help because ______________________________________
____
____
____
____

My child is in or receives

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 the names of your child's primary teacher(s)?_________________________
____

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, DOB, 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/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? ____
____
____

PLEASE USE BELOW BLANK LINES TO ANSWER

*(OVER AGE 12, INCLUDE 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)

STEVEN SUSSMAN, PhD
615 SHERWOOD PKWY

CHILD & TEEN SUCCESS CENTER
MOUNTAINSIDE, NJ 07092

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 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 fax to (908) 654 4676 or mail to Dr. Steven Sussman 615 Sherwood Pkwy, Mountainside, NJ 07092 **(YOU MAY CALL MY CELL 908 217 8106)**

IF ANY QUESTIONS, **YOU ARE ENCOURAGED TO CALL MY CELL 908 217 8106.**

STEVEN SUSSMAN, PHD
LICENSED NJ & NY PSYCHOLOGIST

615 Sherwood Parkway Mountainside, N.J. 07092

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 be 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

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 <u>the reason.</u>

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