When you schedule an appointment at Inova Kellar Center, you are asking a professional to hold a specific block of time for you. In order to efficiently serve the community, we have instituted a 24 cancellation policy. If you must cancel a scheduled appointment, please do so at least 24 business hours in advance to avoid a charge. The charge for missed appointments, cancelled appointments, or appointment changes with less than 24 business hours notice is $75. This fee will not be billed to your insurance and will be collected from you at the time of your next appointment.

If you do not comply with the cancellation-missed appointment policy twice within a three-month period, you will be discharged from treatment and provided with referrals.

I agree to the terms of Inova Kellar Center Cancellation / Missed Appointment Policy:

Patient Signature	Date / Time
Parent or Guardian Signature	Date / Time

PATIENT IDENTIFICATION

Inova Kellar Center

24 Hour Cancellation Policy

CAT # 20226DT /R082013 • PKGS OF 25

INOVA™

In accord with Federal and State confidentiality laws, it is necessary for those involved in your or your child's treatment to be able to exchange information. Your signature on this form will allow outside groups and individuals to exchange confidential information necessary to your or your child's treatment.

Note: No medical records will be released without a signed Release/Disclosure of Protected Information form.

Name of Patient ________ _Date of Birth_ ________

Patient Address ________ _City_ ____ _State_ ____ _Zip Code_ ____

I authorize the following identified members of my/my child's treatment team to communicate with the Inova Kellar Center staff for the purpose of ongoing care.
Please complete below and check all that apply.

		Mental Health	Alcohol & Drug
Parent or Guardians	_Phone_	☐	☐
Primary Care Physician	_Phone_	☐	☐
Individual/Agency Name	_Phone_	☐	☐
Individual/Agency Name	_Phone_	☐	☐
Individual/Agency Name	_Phone_	☐	☐
Name of School			
Contact Person(s)/Department	_Phone_	☐	☐

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. Such revocation will be discussed and may result in an inability to treat. I understand written notification is necessary to cancel this authorization and must be addressed to the Medical Record Department. I understand that this consent automatically expires 90 days after the end of treatment at Inova Kellar Center.

Patient's Signature ________ _Date / Time_ ________

I acknowledge that the clinical and legal purpose and intent of this form have been explained to me.

Parent/Guardian Signature ________ _Date / Time_ ________

PATIENT IDENTIFICATION

Inova Kellar Center

Coordination of Treatment Consent

CAT # 20227OT/R082013 • PKGS OF 100

INOVA

2HP

Child's Name:______________________________ Date of Birth:______________

Prenatal History

1. How was mother's health during pregnancy? _______ Good _______ Fair _______ Poor
2. Did mother smoke, consume any alcohol, or use prescription or nonprescription drugs during your pregnancy? ☐ Yes ☐ No If yes, please describe: ______________________________

____

Birth History

3. Were there any difficulties with labor or delivery? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

4. Was your child born on schedule? ☐ Yes ☐ No

If no, when was he/she born ______________________________

5. What was the child's birth weight and length? ______________________________
6. Were there any health complications following birth? ☐ Yes ☐ No

If yes, please explain ______________________________

____

Developmental Milestones and Early Temperament

7. Were there any difficulties with motor development, language development, or toilet training?

☐ Yes ☐ No If yes, please describe: ______________________________

____

8. Would you describe your child's early temperament as:
   - ☐ Easy (regular sleeping and eating patterns, adaptable to change, average activity level, average mood)
   - ☐ Difficult (irregular sleeping and eating patterns, poor adaptability, highly active, wide range in mood
   - ☐ Other ______________________________

____

PATIENT IDENTIFICATION

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R082013 • PKGS OF 100

INOVA

2HP

School History

9. Has there been any concern expressed by either teachers or yourself regarding your child's academic progress or behaviour in school? ☐ Yes ☐ No If yes, please describe: ____________________

____

____

____

10. What school does your child currently attend? ____________________

11 What is your child's current grade placement? ____________________

12. Has your child ever received special education services? ☐ Yes ☐ No

If yes, please describe: ____________________

____

____

Family Composition

13. Please provide the following information in regard to everyone living at home:

Name	age	relationship	occupation	education

14. Please provide the following information in regard to significant family members not living at home:

Name	age	relationship	occupation	education

PATIENT IDENTIFICATION

CAT # 20256DT / R082013 • PKGS OF 100

INOVA

15. Are parents presently married? ☐ Yes ☐ No

If not married, please comment on the relationship each parent has with the child. ____________

____

____

____

Stressful Events in the Child and/or Families Life

16. Please list any stressful events which have occurred in the past. Also include when these events took place and your child's reaction to them. ____________________________

____

____

____

17. Does your child have any known history of physical or sexual abuse? ☐ Yes ☐ No

If yes, please describe: ____________________________

18. Do you or does your child have any concerns about his/her sexual history and orientation? ☐ Yes ☐ No

If yes, please describe: ____________________________

19. Has any family member had prior contact with the court system, protective services or any other legal/social service agency? ☐ Yes ☐ No If yes, please explain ____________

____

____

20. Are there weapons in the house ☐ Yes ☐ No

If yes describe method of storage ____________________________

____

____

____

____

PATIENT IDENTIFICATION

Inova Kellar Center

Developmental and Social History

CAT # 20256DT/R082013 • PKGS OF 100

INOVA

Family History

21. Please indicate any family history of behavioral, emotional, substance abuse or academic difficulties:

Mother and/or Maternal Relatives

____

____

____

Father and/or Paternal Relatives

____

____

____

Siblings

____

____

____

Support System

22. Please list resources which you find helpful in coping with your child/family's difficulties (*e.g.* church, extended family, friends, *etc.*) ____

____

____

Spirituality in Family

23. Affiliated with religious organization, church or synagogue? ☐ Yes ☐ No

Name: ____

Level of involvement: ☐ Minimal ☐ Sporadic ☐ Regular ☐ Very Active

Belief in a Spiritual Being or Higher Power? ☐ Yes ☐ No

PATIENT IDENTIFICATION

Inova Kellar Center

Developmental and Social History

CAT # 20256DT / R082013 • PKGS OF 100

INOVA

2HP

Social History

24. Does your child have any difficulty making or keeping friends? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

____

25. Do you have any concerns about the type of friend(s) your child has? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

____

26. What are your child's favourite play activities, hobbies or pastimes? ______________________________

____

____

Strengths

27. What are the best things about your child? ______________________________

____

____

Medical History

Height: _______ Weight: _______ lb/kg List allergies to medication or food: ______________________________

28. How would you describe your child's current general health? _____ Good _____ Fair _____ Poor

29. Does your child have any current medical problems ☐ Yes ☐ No

If yes, please describe: ______________________________

30. Has your child had any recent major accidents or illnesses? ☐ Yes ☐ No

If yes, please describe: ______________________________

30. Has your child had any recent surgeries or hospitalizations? ☐ Yes ☐ No

If yes, please describe: ______________________________

PATIENT IDENTIFICATION

Inova Kellar Center

Developmental and Social History

INOVA™

2HP

32. Does your child have any past history of seizures or other medical problems? ☐ Yes ☐ No

    If yes, please describe: ____________________

33. Please list your child's primary care physician's name and phone #: ____________________

34. When was your child's last physical exam? ____________________

35. Do you see any reason to have your child undergo a physical examination at this time? (yes/no) __________

36. Is your child's immunization status current? ☐ Yes ☐ No

Nutritional Assessment

37. Without reason, has your child gained or lost more than 10 lbs. in the last 3 months? ☐ Yes ☐ No

38. Does your child take laxatives or vomit after eating? ☐ Yes ☐ No

39. Does your child frequently have diarrahea or constipation? ☐ Yes ☐ No

Pain Assessment

40. Is your child experiencing any significant physical pain? ☐ Yes ☐ No

    If yes, please describe: ____________________

On a scale of 1 to 10, (1 being the least amount of pain and 10 being the most) what is the pain level?

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Functional Assessment

41. Does your child have any significant difficulty moving about or problems with coordination? ☐ Yes ☐ No

    If yes, please describe: ____________________

42. Does your child have any significant difficulty playing sports? ☐ Yes ☐ No

    If yes, please describe: ____________________

Other Assessments

43. Does your child have any significant difficulties with vision or hearing? ☐ Yes ☐ No

    If yes, please describe: ____________________

44. Do you have any concerns regarding your child's oral health or hygiene? ☐ Yes ☐ No

    If yes, please describe: ____________________

PATIENT IDENTIFICATION

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If you answered yes to any of the above questions or indicated your child's health is fair or poor, is he/she under the care of a physician or other healthcare provider? ☐ Yes ☐ No

Condition for which he/she is being treated: ______________________________

Name of physician/healthcare provider and phone #: ______________________________

Mental Health Treatment History

45. Has your child had any prior treatment for emotional/behavioral difficulties? ☐ Yes ☐ No

If yes, please list the name of the provider(s), date(s) seen and outcome: ______________________________

____

____

Was medication prescribed? ☐ Yes ☐ No

If yes, please list: ______________________________

____

____

Other Concerns

46. Are any destructive, self destructive or risky behaviors present (examples: threats to hurt oneself or others; killing or harming animals; fire setting; use of illicit substances; participation in gangs; sexual activity or other actions) which may put the child in harm's way? If yes, please describe:

____

____

____

47. Please list any other concerns or ideas you have regarding your child's current behavioral, emotional or academic functioning ______________________________

____

____

PATIENT IDENTIFICATION

48. What do you hope will be different at the end of this treatment? ______________________________

____

____

Completed by: ______________________________ Date/Time: ______________

THERAPIST: A yes to any question numbered 37 to 39 indicates that a referral is to be made to the appropriate healthcare provider un less the patient is currently being treated for that condition.

Referral needed: ☐ Yes ☐ No

If yes, for: ☐ Pain ☐ Nutrition ☐ Physical out of date ☐ Substance Abuse

Referred to: ____

Follow up: ____

____

Reviewed by: ______________________________ Date/Time: ______________