ADDSOI Testing Center

The ADD SOI Testing Center
Manhattan Beach, CA 90266
310-546-8583 fax 310-546-9068 www.ADDSOI.com

Child Intake Questionnaire

Child's Information

Child's Name: _____ Person Completing Form: _____

Child's DOB: _____ Was Child Adopted?: _____ Today's Date: _____

School: _____ Grade: _____ Wears Glasses: _____

Medication currently taking: _____ Referred by: _____

Parent email _____

Mother/Guardian Information

Name: _____ DOB: _____ Occupation: _____

Home Address: _____ Primary Phone #: _____

_____ Alternate Phone #: _____

_____ May I leave messages? _____

Father/Guardian Information

Name: _____ DOB: _____ Occupation: _____

Home Address: _____ Primary Phone #: _____

_____ Alternate Phone #: _____

_____ May I leave messages? _____

Household Information

With whom does the child live? _____

Other people in household (Names & Ages):

_____

_____

_____

_____

What changes would you like to see in your child? _____

_____

_____

_____

_____

I authorize ADD SOI Testing Center and The ADD Diagnosis and Treatment Center to provide psychological services, including assessments, for the child name above.

X_____ Date: _____

(Parent or Guardian's signature)

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PreNatal History

Length of pregnancy: _____ Weight at birth: _____ Length at birth: _____

Was delivery normal, breeched or cesarean section? _____

Were there any pregnancy complications? _____

Medications used during pregnancy: _____

Did mother smoke cigarettes during pregnancy? ____ Did mother use any type of recreational drugs during pregnancy? ____

Did mother drink alcohol during pregnancy? If yes, what type and how often: _____

Infancy and Early Childhood

Please circle all that apply:

Colicky	Did not enjoy cuddling	Feeding problems	Headbanging
Sleeping problems	Accident prone	Restlessness	Active

Child's approximate age when began: Crawling: _____ Walking: _____ Talking (single words): _____

Speaking short sentences: _____ Toilet training: _____ Daytime: _____ Nighttime: _____

Childhood

Was there any childhood surgery? _____

Any other hospitalizations? _____

Please circle any of the following diseases your child has or had:

Anemia	Lead poisoning	Meningitis	Heavy Metal Toxicity
Encephalitis	Seizures	Epilepsy	Cerebral Palsy

Other:_____

History of ear infections? Yes/No If yes, frequency and years_____Antibiotics taken? _____

Tubes in ears? Yes/No If yes, what year put in and what year taken out, (please indicate if tubes still in) _____

Please list any unusual or traumatic events in this child's life, and the age of which they occurred:

_____

_____

_____

_____

_____

Family History

Please circle if your child, a family member or an extended family member (e.g. cousins, aunts, uncles, grandparents) has had any of the following. Please specify the relationship of the family member to the child.

	Child	Family /Extended Family Member
Mental Health		
AD/HD	Yes No	Yes No If yes, who: _____
ADD	Yes No	Yes No If yes, who: _____

Dyslexia	Yes No	Yes No If yes, who: _____
Depression	Yes No	Yes No If yes, who: _____
Anxiety	Yes No	Yes No If yes, who: _____
Obsessive-compulsive	Yes No	Yes No If yes, who: _____
Bi-polar disorder	Yes No	Yes No If yes, who: _____
Psychiatric illness	Yes No	Yes No If yes, who: _____
Other:	Yes No	Yes No If yes, who: _____

Traits	Child	Family /Extended Family Member
Procrastinates	Yes No	Yes No If yes, who: _____
Easily distracted	Yes No	Yes No If yes, who: _____
Impatient/Irritable	Yes No	Yes No If yes, who: _____
Impulsive	Yes No	Yes No If yes, who: _____
Packrat	Yes No	Yes No If yes, who: _____
Time management problems	Yes No	Yes No If yes, who: _____
Often overwhelmed	Yes No	Yes No If yes, who: _____
Disorganized	Yes No	Yes No If yes, who: _____
Chronically late	Yes No	Yes No If yes, who: _____
Can't complete tasks started	Yes No	Yes No If yes, who: _____

Medical Conditions	Child	Family /Extended Family Member
Head injury	Yes No	Yes No If yes, who: _____
Thyroid	Yes No	Yes No If yes, who: _____
Seizures	Yes No	Yes No If yes, who: _____
Allergies	Yes No	Yes No If yes, who: _____
Tics or spasms	Yes No	Yes No If yes, who: _____
Sleep disorders	Yes No	Yes No If yes, who: _____
Asthma	Yes No	Yes No If yes, who: _____
Diabetes	Yes No	Yes No If yes, who: _____
Alcoholism/Drug addiction	Yes No	Yes No If yes, who: _____

Previous Assessments	Child	Family /Extended Family Member
ADD or ADHD	_____	_____
	Date(s):_____	Outcome: _____
	Location: _____	_____

Please list any known learning disabilities of school problems that your child has or other family members had:

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Please rate your child using the following scale:

DK- Don't Know 1-Never 2-Rarely 3-Sometimes 4-Often 5-Always

VISION OBSERVATIONS & SYMPTOMS	**RATING SCALE**	**COMMENTS**
1. Eyes feel uncomfortable, sore or strained when reading	DK 1 2 3 4 5	
2. Problems understanding/remembering what you read	DK 1 2 3 4 5	
3. Often skip, lose your place or reread words/lines	DK 1 2 3 4 5	
4. Experience double vision when reading	DK 1 2 3 4 5	
5. Transposition of letters or numbers (was-saw, 21-12)	DK 1 2 3 4 5	
6. Sensitive or fatigued by bright lights/glare/sunlight	DK 1 2 3 4 5	
7. Feel there isn't enough/too much light when reading	DK 1 2 3 4 5	
8. Experiences headaches associated with visual tasks	DK 1 2 3 4 5	
9. Words move/jump/float when reading	DK 1 2 3 4 5	
10. Words blur or come in and out of focus when reading	DK 1 2 3 4 5	
11. Ever wore an eye patch?	DK 1 2 3 4 5	

AUDITORY/LANGUAGE PROCESSING	**RATING SCALE**	**COMMENTS**
1. Slow processing/delayed response	DK 1 2 3 4 5	
2. Oversensitivity to certain/loud sounds	DK 1 2 3 4 5	
3. Difficulty with phonics	DK 1 2 3 4 5	
4. Requests instructions to be repeated	DK 1 2 3 4 5	
5. Difficulty with spelling	DK 1 2 3 4 5	
6. Misunderstands what you say	DK 1 2 3 4 5	
7. Gets "confused" in noisy situations	DK 1 2 3 4 5	
8. Difficulty expressing self verbally	DK 1 2 3 4 5	
9. Mumbles/Stutters (note if speech class past or present)	DK 1 2 3 4 5	
10. Mispronounces typical word Sounds	DK 1 2 3 4 5	
11. Voice volume too loud or too soft (circle one)	DK 1 2 3 4 5	

COORDINATION/SENSORY INTEGRATION	**RATING SCALE**	**COMMENTS**
1. Tires more easily or seems weaker than other kids	DK 1 2 3 4 5	
2. Clumsy, bumps into things	DK 1 2 3 4 5	
3. Poor motor coordination, i.e. catching a ball	DK 1 2 3 4 5	
4. Poor balance or rhythm	DK 1 2 3 4 5	
5. Attracted to moving activities (swinging, spinning, etc)	DK 1 2 3 4 5	
6. Confusion of left and right side of body	DK 1 2 3 4 5	
7. Difficulty hopping, jumping, or skipping	DK 1 2 3 4 5	
8. Messy Handwriting	DK 1 2 3 4 5	

9. Difficulty using scissors, buttons, or zippers	DK 1 2 3 4 5	
10. Lack of motion sensitivity—never gets dizzy	DK 1 2 3 4 5	
11. Reacts negatively or emotionally to being touched	DK 1 2 3 4 5	
12. Bothered by clothes, textures, shirt collars, tags, hats	DK 1 2 3 4 5	
13. Accident prone	DK 1 2 3 4 5	

ACADEMIC PERFORMANCE	**RATING SCALE**	**COMMENTS**
1. Poor academic/study skills	DK 1 2 3 4 5	
2. Trouble organizing, finishing or turning in schoolwork	DK 1 2 3 4 5	\
3. Trouble with math computations/concepts	DK 1 2 3 4 5	
4. Trouble with reading comprehension	DK 1 2 3 4 5	
5. Trouble with essay writing	DK 1 2 3 4 5	
6. Trouble with language/grammar/spelling	DK 1 2 3 4 5	
7. Spends too long on homework	DK 1 2 3 4 5	
8. Needs extra help in schoolwork and/or works slowly	DK 1 2 3 4 5	
9. Class clown	DK 1 2 3 4 5	
10. Poor test taker	DK 1 2 3 4 5	
11. Poor memory	DK 1 2 3 4 5	
12. Avoidance of schoolwork/ works too hard on work	DK 1 2 3 4 5	
13. Has been or currently in special ed/resource class	DK 1 2 3 4 5	

BEHAVIOR	**RATING SCALE**	**COMMENTS**
1. Temper tantrums	DK 1 2 3 4 5	
2. Lies	DK 1 2 3 4 5	
3. Defiant	DK 1 2 3 4 5	
4. Disruptive	DK 1 2 3 4 5	
5. Lack of self-control/Impulsive	DK 1 2 3 4 5	
6. Hyperactive/Fidgety	DK 1 2 3 4 5	
7. Difficulty making transitions	DK 1 2 3 4 5	
8. Lack of motivation	DK 1 2 3 4 5	
9. Repetitive behaviors (washing hands, touching, etc)	DK 1 2 3 4 5	
10. Destructive	DK 1 2 3 4 5	
11. Steals	DK 1 2 3 4 5	

SOCIAL SKILLS	**RATING SCALE**	**COMMENTS**
1. Shy	DK 1 2 3 4 5	
2. Few friends/doesn't make friends easily	DK 1 2 3 4 5	
3. Bullies others	DK 1 2 3 4 5	

4.	Isolative	DK 1 2 3 4 5	
5.	Poor communication skills	DK 1 2 3 4 5	
6.	Overly Talkative/Interrupts others	DK 1 2 3 4 5	

EMOTIONAL	**RATING SCALE**	**COMMENTS**
1. Low self esteem	DK 1 2 3 4 5	
2. Excessively emotional	DK 1 2 3 4 5	
3. Cries easily/often	DK 1 2 3 4 5	
4. Easily frustrated	DK 1 2 3 4 5	
5. Sad/sullen	DK 1 2 3 4 5	
6. Angry/quick tempered	DK 1 2 3 4 5	
7. Immature compared to other kids their age	DK 1 2 3 4 5	

DIET/NUTRITION	**RATING SCALE**	**COMMENTS**
1. Eats fast food	DK 1 2 3 4 5	
2. Eats pre-packaged/processed food	DK 1 2 3 4 5	
3. Rarely eats home-cooked meals	DK 1 2 3 4 5	
4. Picky eater	DK 1 2 3 4 5	
5. Dislikes certain foods because of texture i.e. too mushy	DK 1 2 3 4 5	
6. Allergies to certain foods	DK 1 2 3 4 5	
7. Overeats/Undereats	DK 1 2 3 4 5	
8. Overweight/Underweight	DK 1 2 3 4 5	
9. Eats dairy (milk, cheese, yogurt, ice cream, cream cheese)	DK 1 2 3 4 5	
10. Eats cereal or other carbs for breakfast	DK 1 2 3 4 5	Type:
a. If rated 1-3, what else?		
11. Eats out or school provided lunch	DK 1 2 3 4 5	
a. If rated 1-3, then where else is lunch obtained?		
12. Eats out for dinner	DK 1 2 3 4 5	
a. If rated 1-3, then where else is dinner obtained?		
13. What kinds of snacks are eaten?		
14. Currently taking supplements?	Yes No	
a. If yes, which ones?		
15. Currently taking multi-vitamin?	Yes No	
a. If yes, what brand?		

EXERCISE/EXTRACURRICULAR ACTIVITIES	**RATING SCALE**	**COMMENTS**
1. Exercises or does physical activity on a daily basis	Yes No	
2. Plays sports	Yes No	

a. If yes, what sports: _____

b. Competitively? _____

3. Involved in other physical extracurricular activities Yes No _____
   a. If yes, what kinds? _____
4. Involved in other non-physical extracurricular activities? Yes No _____
   a. If yes, what kinds? _____
5. Plays musical instruments Yes No _____
   a. If yes, which ones? _____

INJURIES/ACCIDENTS

1. Ever fallen and hit head/had concussion? Yes No _____
   a. If yes, date: _____ Description: _____
2. Ever been in a serious car accident or other accident Yes No _____
   a. If yes, date: _____ Description: _____
3. Ever had any major surgeries? Yes No _____
   a. If yes, date: _____ Description: _____
4. Ever had neck or back injuries? Yes No _____
   a. If yes, date: _____ Description: _____
5. Any other major injuries? Yes No _____
   a. If yes, date: _____ Description: _____

MEDICATION **RATING SCALE COMMENTS**

1. Currently taking medication? Yes No _____
   a. If yes, type and dosage _____
   b. Prescribing Dr. _____
   c. List any side effects: _____
2. Taken medication before? Yes No _____
   a. If yes, type and dosage _____
   b. Prescribing Dr. _____
   c. List any side effects: _____
3. Open to Medication? Please circle: Yes As last resort Need more info No

Please use this space to tell us about anything else that you think is important to know about your child:

_____

_____

_____

_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

71b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

Phone 310-546-8583
Fax 310-546-9068

ADD SOI Testing Center
Dr. Valerie Maxwell, Director

Insurance Questionnaire / Payment Agreement

In order to determine what insurance benefits, you have available, we ***require*** you to contact your insurance company at the phone number listed on your insurance card and ask the following information. **Failure to fill this form out *COMPLETELY* will disable us from billing your insurance provider for services rendered. It is your responsibility to pay for any outstanding balance.** Psychological Services and Therapy are *confidential* processes to which we are legally and ethically bound. However, if you file for insurance benefits or reimbursement, please be aware that your confidentiality may be compromised. Once you have completed this form, please email it with a copy of the front and back of your insurance card to drchristinaddsoi@hotmail.com.

Our office must receive this information BEFORE you will be scheduled for an assessment if you need authorization.

***Be sure you call or are transferred to the Mental Health department, *not* medical. When you reach a representative please state:**

"I AM CALLING TO CHECK MY OUTPATIENT MENTAL HEALTH BENEFITS."

1. **Is Dr. Valerie Maxwell a provider under my plan? Yes / No**
2. **Is my mental health insurance carved out to a different insurance provider? Yes / No**
   a. **(If #2 is Yes) What insurance covers mental health? _____**
3. **Is there a deductible for Psychological Testing or Counseling? (if none, enter "0"): $ _____**
   a. **(If #3 is *not* 0) Has the Deductible been met? Yes / No**
4. **What is my co-payment? _____**
5. **Do I need an authorization for mental health? Yes / No**
   a. **(If #5 is Yes) What is the authorization number? _____**
   b. **(If you have an authorization #) How many sessions are authorized to start? _____**
   c. **What is the start and end dates of the authorized sessions? Start_____ End_____**
6. **What is the MAXIMUM number of sessions I can use? _____**
7. **Do I need an authorization for Psychological Testing? Yes / No**
8. **Address to send Mental Health Claims:**
   (Often times different than address on card, please ask)
   Insurance provider:_____
   Address:_____
   _____

11. **Ph# Called:_____**
    Date of Call:_____

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR SERVICES NOT COVERED BY MY INSURANCE, WHETHER BECAUSE I FAILED TO OBTAIN AUTHORIZATION, DENIAL, OR LIMITATION OF BENEFITS, CO-PAY, ETC. I HEREBY UNDERSTAND THAT IF I HAVE AN OUTSTANDING BALANCE, I WILL MAKE ARRANGEMENTS TO PAY THE AMOUNT DUE.

_____ _____
Signature Date

_____ _____
Print Name Client Name (Print)

Our office reserves the right to charge an administrative fee of $25 if the answers on this form are incomplete or incorrect.