Appointment and Cancellation Policy

DEPARTMENT OF PSYCHOLOGY

200 Henry Clay Avenue • New Orleans, LA 70118 • (504) 899-9511 • www.chnola.org

No shows, last minute cancellations, and late arrivals are disruptive to your child's care and your clinician's schedule. Below are the policies that have been implemented regarding these situations:

** New patients who no show for their first appointment will not be re-scheduled immediately; the patient will be returned to the waiting list to await future services.

** Cancellations must occur at least 24 hours in advance of your appointment. Last minute cancellations (within 24 hours) and no shows are discouraged. If you cancel last minute or no show for **two** appointments, regardless of appointment type, services will be discontinued.

ADDITIONAL POLICIES:

60 minute outpatient therapy sessions:

- Please arrive for your child's appointment at or before the specified time. Patients are scheduled hourly and a late arrival will shorten your appointment length. If you arrive more than **20 minutes late** for your child's appointment, you will be required to reschedule. Rescheduling in this manner will be considered a no show.

- If you cancel in advance for **two** appointments, you are at risk for a discontinuation of service. We will discuss strategies to ensure future attendance at that time. An additional (**third**) advance cancellation will result in termination of service.

30 minute medication management appointments:

- Please arrive for your child's appointment **30 minutes prior** to your specified appointment time. All paper work must be complete and turned in upon your arrival. Early arrival is necessary in order to obtain vital signs and ensure a timely appointment. If you arrive more than **10 minutes late** for your child's appointment and/or **paperwork is not complete**, you may be required to reschedule. Rescheduling in this manner will be considered a no show.

Evaluation Appointments (neuropsychological testing, psychological testing, Autism Spectrum Disorder testing):

- Please arrive for your child's appointment at or before the specified time. If you arrive more than **30 minutes late** for your child's appointment, you may be required to reschedule. Rescheduling in this manner will be considered a no show.

If I have any question regarding this information, I understand that I may call (504) 896-9484 or inquire during session.

I understand and agree with the above described policy.

Print Patient's Name	
Parent/Guardian's Signature **X**	Date / /

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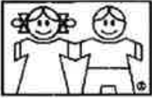

AUTISM CENTER INTAKE

PLACE PATIENT'S LABEL HERE

Thank you for completing the following questions. This information is confidential and will not be released without your permission.

BASIC INFORMATION ABOUT CHILD

Name ______________________ Today's Date ____________

Gender Male Female Age ______ Child's Birthdate ____________

Race/Ethnicity
- White (Caucasian)
- Hispanic / Latino
- American Indian / Aleut / Eskimo
- Black (African American)
- Asian / Pacific Islander
- Other ____________

Current School ______________ Parish __________ Grade ______

BASIC INFORMATION ABOUT CAREGIVER(S)

Legal Guardian Name ______________________ Relation to Child __________

Home Address ______________________ Home Phone ____________

______________________ Work Phone ____________

Parish ______________________

Person completing this form ______________________

Who referred you here? ______________________ Title ____________

Address ______________________ Phone ____________

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PRESENTING PROBLEMS

Briefly describe your child's current difficulties ______________________

____

____

____

How long has this problem been a concern for you? ______________________

When did you first notice the problem? ______________________

Do any family members have similar problems? Yes No If yes, whom? ____________

PSYOP60

DEVELOPMENTAL HISTORY

PREGNANCY

Duration of pregnancy (weeks or months) ______________

During the pregnancy did the mother

- ______ Suffer from illness or disease
- ______ Undergo surgery
- ______ Take medication
- ______ Have X-rays
- ______ Use tobacco/smoke cigarettes
- ______ Use alcohol
- ______ Use drugs
- ______ Suffer from an accident

Complications of this pregnancy included

- ______ Excessive vomiting
- ______ Excessive staining or blood loss
- ______ Threatened miscarriage/premature labor
- ______ Infection(s)
- ______ Toxemia
- ______ Diabetes
- ______ High blood pressure
- ______ Poor nutrition
- ______ Amniocentesis
- ______ Loss of consciousness in mother

DELIVERY

Duration of Labor ________ hours Birth Weight __________ Length __________

Type of Labor Spontaneous Induced Type of Delivery Normal Cesarean Breech

Complications

- ______ None
- ______ Cord around neck
- ______ Problems with placenta
- ______ Hemorrhage
- ______ Delay in breathing
- ______ Injury to infant
- ______ Other (describe ______________)

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NEWBORN and POST-DELIVERY PERIOD

Was your baby in the Neonatal Intensive Care Unit (NICU)? Yes No If yes, how long? ________

Total days baby was in the hospital after delivery ______________________

Complications

- ______ None
- ______ Addiction
- ______ Anemia
- ______ Diarrhea
- ______ Jaundice (yellow skin)
- ______ Infection
- ______ Seizures
- ______ Vomiting
- ______ Intraventricular hemorrhage
- ______ Meconium staining or aspiration
- ______ Needed respirator/resuscitation
- ______ Cyanosis (turned blue)

INFANCY and TODDLER PERIOD

As a baby, the child was

- ______ Active
- ______ Cranky
- ______ Calm
- ______ Difficult
- ______ Easy
- ______ Happy
- ______ Shy
- ______ Sleepy
- ______ Social
- ______ Hard to please
- ______ Lazy or slow moving
- ______ Persistent

Were any of the following present in the first five years of life?

_______ Colic
_______ Difficulty sleeping
_______ Feeding problems
_______ Frequent headbanging
_______ Excessive restlessness
_______ Did not enjoy cuddling
_______ Constantly into everything
_______ Temper tantrums
_______ Clingy or difficulty separating from caregivers
_______ Slow or unable to adapt to changes in routines
_______ Excessively **high** or **low** activity level (circle one)
_______ Not calmed by being held and/or stroked
_______ Excessive number of accidents compared to other children
_______ Withdrawal or other problems adjusting to new people or situations
_______ Variable or irregular body functions (sleep, hunger, bowel movements, etc.)
_______ Reaction to or allergy to the DPT shot or pertussis vaccine

Were there any special problems in the development of the child during the first years? Yes No

If yes, please describe ____

____

____

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DEVELOPMENTAL MILESTONES

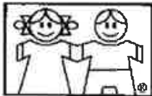
Please indicate the age at which your child first demonstrated each of the following behaviors. If you are unsure, please write a question mark.

Behavior	Age
Sat up unassisted	____________
Walked alone	____________
Spoke first word	____________
Put several words together	____________
Became toilet trained (bladder)	____________
Became toilet trained (bowel)	____________
Stayed dry at night	____________
Fed self with fork or spoon	____________
Rode tricycle	____________

Compared to other children, how do you view your child's development? Normal Delayed Advanced

Is your child able to speak sentences with at least three words on a daily basis? Yes No

If yes, is your child's speech consistently understood by unfamiliar individuals? Yes No



AUTISM CENTER INTAKE

CHILDREN'S HOSPITAL

PLACE PATIENT'S LABEL HERE

MEDICAL HISTORY

Please place a check next to any illness or condition that your child has. Please also note the date or child's age at the time of the illness.

	Illness or Condition	Age/Dates		Illness or Condition	Age/Dates
______	AIDS or HIV positive	______	______	Headaches	______
______	Allergies	______	______	Heart problems/disease	______
______	Anemia	______	______	Heavy metal poisoning	______
______	Aneurysm	______	______	Hepatitis	______
______	Anoxia	______	______	Herpes	______
______	Arteriovenous malformation	______	______	High blood pressure	______
______	Arthritis	______	______	Jaundice	______
______	Asthma	______	______	Leukemia	______
______	Ataxia	______	______	Malnutrition	______
______	Automobile accident	______	______	Meningitis	______
______	Back pain/problems	______	______	Muscular disease	______
______	Bleeding problems	______	______	Pain problems	______
______	Blood disorders	______	______	Paralysis	______
______	Bone or joint disease	______	______	Pituitary disorder	______
______	Broken bones	______	______	Pneumonia	______
______	Cancer	______	______	Poisoning	______
______	Coma	______	______	Rheumatic fever	______
______	Cystic Fibrosis	______	______	Scarlet fever	______
______	Dazed or unconscious	______	______	Sensory losses	______
______	Dementia	______	______	Sexual molestation	______
______	Diabetes	______	______	Speech/language problems	______
______	Dysarthria	______	______	Spells (____________)	______
______	Dyspraxia or Apraxia	______	______	Stroke	______
______	Ear infections (PE tubes)	______	______	Suicide attempt/thoughts	______
______	Other ear problems	______	______	Sunstroke/heat exhaustion	______
______	Eczema or hives	______	______	Thyroid disorder/problem	______
______	Encephalitis	______	______	Trauma (__________)	______
______	Epilepsy, seizures, fits	______	______	Tuberculosis	______
______	Fainting spells	______	______	Tumor	______
______	Fetal Alcohol Syndrome	______	______	Visual problems	______
______	Fever (if high or prolonged)	______	______	Whooping cough	______
______	Guillian-Barre Syndrome	______	______	Other medical problems:	
______	Head injury	______		______________________	

Indicate if child has had any of these medical tests and if yes, indicate age/dates

	Test	Age/Dates		Test	Age/Dates
______	Electroencephalogram (EEG)	______	______	MRI scan	______
______	Skull X-rays	______	______	Opthalmological (vision)	______
______	CT scan	______	______	Audiological (hearing)	______

Has your child ever suffered from a head injury which caused confusion/loss of consciousness? Yes No

Please list any chronic/serious illnesses or operations your child has had and child's age

____

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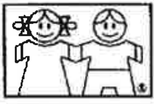

CHILDREN'S HOSPITAL

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Pediatrician's name and address ______________________________

If your child is taking any medication other than for colds and minor infections, please list them below:

Medication	Age	Reason Prescribed	Prescriber

Did your child take his/her medications as usual on the day of the appointment with Psychology? Yes No

Has your child's hearing been evaluated? Yes No If yes, date of testing ______________

If yes, type of provider who completed test (physician, audiologist) ______________

Was hearing test within normal limits? Yes No

Has your child ever had a seizure? Yes No

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FAMILY MEDICAL HISTORY

Please place a check next to any illness, condition, or problem experienced by any blood relative(s). When you check an item, please note the family member's relationship to the child.

Condition	Relationship to Child
_______ Alcoholism	
_______ Anxiety	
_______ Attention-Deficit/Hyperactivity Disorder (ADHD)	
_______ Autism Spectrum Disorder (ASD)	
_______ Bipolar disorder (manic-depressive disorder)	
_______ Depression	
_______ Drug addiction or drug problems	
_______ Head injury	
_______ Hyperactivity	
_______ Learning problems	
_______ Intellectual disability (mental retardation)	
_______ Movement disorders	
_______ Schizophrenia	
_______ Seizures, epilepsy, or convulsions	
_______ Speech delays	
_______ Suicide or suicide attempt	
_______ Other (specify: ______________________)	

PLACE PATIENT'S LABEL HERE

HOME INFORMATION

Mother's name ______________________ Age ______
Occupation ______________________ Number years of education ______

Father's name ______________________ Age ______
Occupation ______________________ Number years of education ______

Stepmother's name ______________________ Age ______
Occupation ______________________ Number years of education ______

Stepfather's name ______________________ Age ______
Occupation ______________________ Number years of education ______

If parents are separated or divorced, how old was child when the separation occurred? ______________

What are the current custody/visitation arrangements? ______________________________

Was your child adopted? Yes No Date of adoption ________ Child's age at adoption ________

Please list all people living **in** the household

Name	Relationship to Child	Age

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Please list any family members (including stepfamily) who live **outside** the household

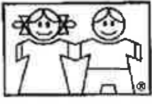
Name	Relationship to Child	Age

Who, if anyone, shares the child's room? ______________________________

Primary language spoken in the home ____________ Other languages spoken at home ____________

Describe any other important information about the child's home situation ______________________

____



AUTISM CENTER INTAKE
CHILDREN'S HOSPITAL

PLACE PATIENT'S LABEL HERE

EDUCATIONAL HISTORY

Current School ______________ Current Grade ______ Grade(s) Repeated ______

Is this school public or private? Public Private If public, which parish? ______________

Teacher's Name ______________ Recent Report Card Grades ______________

Does/did your child attend preschool/nursery school? Yes No If yes, starting at what age ________

Has your child ever been evaluated for services through the public school system? Yes No

If yes, date of testing ____________

If yes, please circle your child's primary exceptionality listed on his/her Individualized Education Program (IEP):

Developmental Delay Speech/Language Impairment Autism Other Health Impairment

Mental Disability Specific Learning Disability Other: ______________

Does your child have a secondary exceptionality on his/her IEP? Yes No

If yes, please list ______________

Does your child receive special education services? Yes No

If yes, please circle all that apply:

Self-contained classroom Number minutes per day __________ Number days per week ______
Resource classroom Number minutes per day __________ Number days per week ______
Gifted/Talented classroom Number minutes per day __________ Number days per week ______
Speech therapy ______ times per week for ________ minutes
Occupational therapy ______ times per week for ________ minutes
Adapted Physical Education (APE) ______ times per week for ________ minutes
Physical Therapy ______ times per week for ________ minutes
Other ____________ How often ______________

Current educational problem areas include

______ Reading
______ Math
______ Writing
______ Spelling
______ Other subjects
______ Memory problems
______ Excessive absences
______ Does not respect others' rights
______ Fights with classmates
______ Detention and/or suspension
______ Does not like school
______ Does not complete homework
______ Conflict with teacher(s)
______ Does not work well independently
______ Cheats
______ Inattentive/distracted
______ Disrupts classroom
______ Overactive/fidgets
______ Poor study skills
______ Worries about school

Describe any other classroom problem(s) ______________

____

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Is your child able to:

Identify body parts	Yes	No	Identify numbers	Yes	No
Identify colors	Yes	No	Write his/her name	Yes	No
Identify basic shapes (circle, square)	Yes	No	Read simple words (i.e., cat)	Yes	No
Recite the alphabet	Yes	No	Read complete sentences	Yes	No
Count (if yes, how high?______)	Yes	No	Add or subtract numbers	Yes	No
Identify letters	Yes	No	Understand what he/she reads	Yes	No

EVALUATION/INTERVENTION HISTORY

Does/did your child receive early intervention services prior to three years of age (i.e., Early Steps)? Yes No

If yes, how old was your child when services began ________________

If yes, please circle all that apply:

Special instruction _______ times per week for __________ minutes
Speech therapy _______ times per week for __________ minutes
Occupational therapy _______ times per week for __________ minutes
Physical therapy _______ times per week for __________ minutes
Other ______________ How often ____

Does your child currently receive any additional therapies or interventions such as Applied Behavior Analysis (ABA), counseling, biomedical therapies? Yes No

If yes, please list type of therapy, age of child when treatment started, and name and type provider of treatment (i.e., Pediatrician, Psychologist, Social Worker, Psychiatrist, Medical Psychologist, etc.).

Therapy/Treatment	Age	Name and Type of Provider

Has your child received any additional evaluation for your current concerns? Yes No

If yes, please list date of evaluation, outcome of evaluation, and name and type of provider who completed the evaluation (i.e., Psychologist, Neurologist, Developmental Pediatrician, Psychiatrist etc.).

Date of Evaluation	Outcome	Name and Type of Provider

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AUTISM CENTER INTAKE

CHILDREN'S HOSPITAL

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SOCIAL AND BEHAVIOR HISTORY

What disciplinary techniques to you usually use with your child? Please place a check next to each technique that you usually use.

_______ Criticize child
_______ Don't use any technique
_______ Ignore problem behavior
_______ Reason with child
_______ Redirect child's interest
_______ Send child to room
_______ Scold child
_______ Spank child
_______ Other technique (describe ____)

_______ Take away some activity
_______ Take away some belongings
_______ Take away food
_______ Tell child to sit in a chair
_______ Threaten child
_______ Punish child another way (describe _______________)
_______ Whip child
_______ Yell or scream at child

Which discipline techniques are usually effective? _______________________________

For what types of problem(s)? _______________________________

Which discipline techniques are usually ineffective? _______________________________

For what types of problem(s)? _______________________________

How consistent are the rules and discipline for your child? _______________________________

What are your child's favorite activities?

1. _______________ 2. _______________ 3. _______________

What activities does your child like least?

1. _______________ 2. _______________ 3. _______________

What are your child's strengths?_______________________________

____

Is there any additional information that you think may help us in working with your child?

____

____

____

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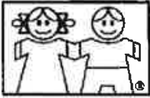

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INTEREST IN RECEIVING EMAILS ABOUT FUTURE SERVICES

Completion of this page is entirely optional.

Here at the Autism Center, we offer a variety of classes and workshops for families of individuals with autism spectrum disorder (ASD). Should your child be diagnosed with ASD and you're interested in receiving email updates about future services, please provide the information below.

If you child does not have ASD, you will not be contacted. If you are not interested in receiving emails, please *do not* complete the remainder of this page.

Child's Information

Name ______________________ Birthdate ______________

First Caregiver's Information

Legal Guardian Name ______________________ Relation to Child ______________

Email Address ______________________ Contact Number ______________

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Additional Caregiver's Information

Name ______________________ Relation to Child ______________

Email Address ______________________ Contact Number ______________

Reviewed by: ______________________ Date/Time ______________

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