Robinson-Kyles Counseling and Testing Services

**Phone: 863-398-6748**

**1604 E. Gary Rd. - Lakeland, Fl 33801**

**Fax: 863-688-3159**

**110 W. 7th St. – Lakeland Fl 33805**

**Fax: 863-213-4010**

**Today you will be seeing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child (under age of 18)**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name(s) of person(s) completing this form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to the child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_male\_\_\_\_female\_\_\_**

**Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact information**

**First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ middle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to the child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(If Applicable)**

**Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Copay Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This counseling center offers therapy groups (anxiety, depression, behavior management, etc).**

**Are you interested in your child joining a group? Yes\_\_\_\_ or No\_\_\_\_**

**How did you hear about this service?**

**Psychology Today Website\_\_\_\_ Friend\_\_\_\_\_**

**Other(please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Race/ Ethnicity (please circle):**

**African-American / black American Indian or Alaskan Native Asian American / Asian**

**Hispanic / Latino/a Native Hawaiian or Pacific Islander Multi-racial white**

**Self-identify(please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Religious or spiritual preferences (please circle):**

**Agnostic Atheist Buddhist Christian**

**Hindu Jewish Muslim**

**No preference Prefer not to answer**

**Self-identify (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe the reason for the child’s appointment.**

**On what date did the issue /illness begin?**

1. **What were the circumstances surrounding the start of the issue?**

**Who currently lives in the child’s household (brothers, sisters, etc.)?**

**List major illnesses that the child has had**

**Illness age treatment given (include surgery) reactions/after effects**

**\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does the child have any physical disabilities? Describe:**

**Please list the medications the child is currently taking**

**Medication Reason Date Started**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has the child ever abused substances?**

 **a. If so, what substances has he/she abused?**

 **b. During what time span (ages) were the substances abused? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **c. Any treatment for substance abuse?**

**Date of treatment Response to the treatment**

**\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does the child have any friends other than the ones who lives in the household?**

**Does the child display difficulties empathizing with others?**

**Does the child show remorse when they’ve made a mistake or hurt someone?**

**What does the child like to do for fun? How often does he/her engage in these activities**

**What school does the child attend and what grade is he/she in?**

**Is he/she in any special education classes, like ESE?**

**Are the child’s grades satisfactory? Why?**

**Has the child ever repeated or skipped a grade? If so, which one(s)**

**Are there behavioral issues at home or at school currently? Please explain.**

**Has the child had any previous evaluations or treatments for mental health concerns? If so, please list the dates and places of treatment.**

**Date of treatment Place of treatment Reason and Response to treatment**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has the child ever been hospitalized for mental health concerns? If so, please list the dates and places of treatment.**

**Date of treatment Place of treatment Reason and Response to treatment**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has your child experienced a traumatic event that caused him/her to feel intense fear, helplessness, or horror? How many times/ how frequently?**

 **Please circle those that apply:**

**childhood physical abuse, childhood sexual abuse, childhood emotional abuse,**

**physical attack, sexual violence, militarycombator war zone experience,**

**kidnapped or taken hostage, serious accident, terrorist attack,**

**near drowning, diagnosed with life threatening illness,**

**natural disaster, imprisonment or torture, animal attack,**

**Other\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you aware of the child’s seeing or hearing other things that other people have not seen or heard?**

**Has the child ever told you that he/she wants to hurt or kill himself? If so, please list the dates.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,**

**Has the child ever told you that he/she wants to hurt or kill someone else? If so please list the dates.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,**

**Please give a brief explanation of any significant medical, mental health, and learning problems in the immediate or extended family. If so, please describe the relationship to the child (e.g. mother, father, aunt, uncle, etc.) and the condition.**

**Does the child have any legal history (lawsuits, DCF incidents, child removal, arrests, DUIs, etc)? Please explain and give dates and reasons for each incident.**

**Developmental milestones – talking, walking, toilet training, etc. – were there any delays? If so, please explain?**

**Were there any issues with pregnancy or delivery? Born full-term? Type of delivery?**

**How would you describe the child’s sleep?**

**How would you describe the child’s appetite?**

**Have you engaged in experienced the following behaviors? Circle all that apply:**

**Eating less Eating more Bingeing Restricting Purging/Vomiting**

**Use of laxatives Use of diet pills/medications Use of diuretics**

**Significant weight gain(last 2 months) Significant weight loss (last 2 months)**

**Use of diet pills/medication**

**How does the child handle activities of daily living, such as dressing, showering, brushing his teeth, and overall taking care of himself?**

**Please circle the frequency that the following has occurred: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Never Less than monthly Monthly Weekly Daily**

1. **Feeling Sad**  **0 1 2 3 4**
2. **Crying**  **0 1 2 3 4**
3. **Over-eating 0 1 2 3 4**
4. **Not eating 0 1 2 3 4**
5. **Sleep for 8 hours & still sleepy** **0 1 2 3 4**
6. **Not slept for 24 hours & not sleepy 0 1 2 3 4**
7. **Feeling irritable 0 1 2 3 4**
8. **Feeling worried 0 1 2 3 4**
9. **Panic attacks 0 1 2 3 4**
10. **Impulsive (inpatient, make quick decisions) 0 1 2 3 4**
11. **Racing thoughts 0 1 2 3 4**
12. **Low energy 0 1 2 3 4**
13. **Aches and Pains 0 1 2 3 4**
14. **Feelings of guilt or hopelessness 0 1 2 3 4**
15. **Feelings of worthlessness 0 1 2 3 4**
16. **Feeling overwhelmed 0 1 2 3 4**
17. **Difficulty concentrating 0 1 2 3 4**
18. **Wanting to be alone 0 1 2 3 4**
19. **Thoughts of death or suicide 0 1 2 3 4**
20. **Drink alcohol or use substances 0 1 2 3 4**
21. **Intrusive thoughts or flashbacks 0 1 2 3 4**
22. **Visual or audio hallucinations 0 1 2 3 4**

**(seeing or hearing things that others do not)**

1. **Homicidal thoughts 0 1 2 3 4**
2. **Nightmares 0 1 2 3 4**
3. **Arguing with others 0 1 2 3 4**
4. **Have you been hospitalized over the last 7 days? Yes No**

**ROBINSON-KYLES COUNSELING AND TESTING SERVICES LLC**

**Consent and Agreement Form for Psychological Testing, Evaluation and Counseling**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to allow Robinson-Kyles Counseling and Testing Services to perform the following services of psychotherapy, testing, report writing, and consultation with other professionals:

This agreement concerns ❑  myself or ❑   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the practitioner’s time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, and any other activities to support these services. Though my health insurance may repay me for some of these fees, I understand that I am fully responsible for payment for these services.

I also understand the practitioner agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations.
2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the tests’ manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a secure place to maintain their confidentiality.

I agree to help as much as I can, by supplying full answers, providing records, making an honest effort, and working as best I can to make sure that the findings are accurate and that counseling is helpful.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or parent/guardian) Date

Robinson-Kyles Counseling and Testing Services LLC

Jeanene Robinson Kyles, PhD

Supervising Psychologist

863-398-6748 (Main Lakeland Office)

Your rights regarding your health information:

1. You can ask that we communicate with you in a way or at a certain place that is more private for you. For example, you can ask to receive calls at home, and not at work, to schedule or cancel an appointment.
2. You can ask to limit what is told to people involved in your care or the payment for your care, such as family members or friends.
3. You have the right to look at the health information about you, such as your medical and billing records. You can get a copy of these records, but there will be a charge for it.
4. If you believe that the information in your records is incorrect or missing something important, you can ask to make additions to your records to correct the situation. You must make this request in writing and you must also discuss the reasons you want to make the changes.
5. You have the right to a copy of this notice. If this notice is changed, you will receive a new version.
6. You have the right to file a complaint if you believe your privacy rights have been violated. Also, you may have other rights that are granted to you by the laws of our state and these may be the same as or different from the rights described above. These situations can be discussed with you now or as they arise.

IN CASE OF EMERGENCY

1. IN CASE OF EMERGENCY PLEASE CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM.
2. YOU MAY ALSO CALL THE SUICIDE HOTLINE 1-877-822-5205
3. National Suicide Prevention Lifeline 1-800- 273-8255