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Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

Welcome to the Pediatric Integrated Behavioral Health Clinic

Dear Parent/Caregiver,

Your child's medical team here at Texas Children's Hospital has referred your child for a consultation in the Pediatric Integrated Behavioral Health Clinic. This appointment is for a consultation with our psychologist Dr. Kazmerski who specializes in working with children who have medical conditions. Dr. Kazmerski works closely with the medical team to treat behavioral health concerns that occur across settings (medical, home and school). Dr. Kazmerski provides brief short-term behavior therapy services to address the presenting concerns.

What to expect on the day of your appointment:

- The psychologist will talk with you and your child about any concerns you and/or your child may have, especially those related to his/her medical condition and treatment. The psychologist will also ask you about your child's developmental, medical and educational history.
- At the end of your child's evaluation, the psychologist will provide your family with recommendations for a plan of care, which may include continued outpatient treatment. You may also meet with our clinic's social worker to receive more detailed resources based on the psychologist's recommendation.
- Plan for the evaluation to last approximately one hour.
- Our goal is to keep our clinic running smoothly and efficiently. Therefore, we ask that you **please arrive 15 minutes before your scheduled appointment time**. Due to the nature of the clinic, we regretfully **cannot see patients who arrive 10 minutes or more past their scheduled appointment time**.
- In this packet you will also find an Attendance agreement for your review

What to RETURN TO THE CLINIC before your appointment:

- Completed history form (attached)
- If there has ever been legal action which affects the custody of your child (such as a divorce or legal separation), you **must** bring a copy of court documentation to your visit.
- Please bring copies of previous records that may be relevant if available.

  Examples include:
  - Psychological (e.g., testing, therapy notes)
  - School (e.g., testing, behavior plan, IEP, 504, attendance, discipline, grades)

If you have any questions about the reason for this appointment, please call the Pulmonary and Sleep Medicine Clinic at 936-267-7744.

Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

To cancel or reschedule your visit, please call the Pulmonary and Sleep Medicine Clinic at 936-267-7744.

Thank you and we look forward to meeting you!

Sincerely,

Jennifer S. Kazmerski, Ph.D., BCBA-D

Texas Children's Hospital
www.texaschildrenshospital.org

Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

PATIENT HISTORY FORM

GENERAL BACKGROUND & CONTACT INFORMATION

Child's Name: Date of Birth: Age:

Your Name: Today's Date:

Your relation to child (circle one): Biological Parent - Adoptive Parent - Step-Parent - Legal Guardian - Custodial Grandparent - Other:

Do you have primary custody? YES I do NO I do not (if not, who is the primary custodian? ________________________)

Do you have the right to consent to psychological evaluation/treatment? YES I do NO I do not

*** If parents are divorced, a COPY OF THE DIVORCE DECREE is ***REQUIRED*** in order for us to see your child ***

Address:

Phone Numbers: Home: Work: Cell: Other:

(please put a star * next to the best number to reach you)

PLEASE DESCRIBE YOUR PRIMARY CONCERNS:

How long have these problems been evident? ____________

REFERRING PROVIDER: ____

PRIMARY CARE PROVIDER: ____

Please list ANY other physicians and their specialty: ________________________

____

____

FAMILY BACKGROUND

Who currently lives in home: Number of people in home:

Name:	Relation to Child:	Age:	Name:	Relation to Child:	Age:

Texas Children's Hospital
www.texaschildrenshospital.org

Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

Race/Ethnicity (optional):	Black (African American, Caribbean) – Hispanic/Latino - Caucasian (White, not Latino or Asian descent) - Asian - Native American - Arab - Bi-Racial – Other:

Language(s) spoken in home: 1st: Other:

Parents: Married - Never Married – Divorced - Remarried

Mother:	Age:	Highest grade completed:	Job:	Works Day - Night - Other:
Father:	Age:	Highest grade completed:	Job:	Works Day - Night - Other:

Current family stressors (please circle all that apply):

Dangerous Community - Financial Problems - Legal Problems – Lack of Insurance - Lack of Transportation - Family Accident or Illness -

Caregiver Health Problem - Recent Death In Family - Lack of Social Support - Conflict in family - Recent Divorce – Parenting across 2 households -

Birth of Sibling - Recent Family Move - Child changed schools - Child repeated a grade - Other:

BIRTH HISTORY & EARLY DEVELOPMENT

Prenatal problems/complications (please circle all that apply and explain):

Maternal illness – Gestational diabetes– Preterm labor – Maternal substance use (alcohol, cigarettes, prescription medication, other drugs) –

High blood pressure – Preeclampsia – Anemia – Malnutrition – Dehydration – Intrauterine growth retardation – Other:

Length of Pregnancy (wks):	Birth Weight:
Type of Labor Onset: Induced Spontaneous	Type of Birth: Vaginal C/Section (planned? Y / N emergency? Y / N)

Labor/Delivery problems/complications (please circle all that apply and explain):

Fetal distress – Premature rupture of membranes - Forceps assisted delivery – Difficult/prolonged labor – Other:

How would you describe your child as an infant (please circle all that apply):

Happy/Easy baby - Irritable – Slow To Warm Up - Hard To Soothe - Passive - Feeding Problems - Sleeping Problems – Other:

Developmental Milestones Please write in the age your child reached the following developmental milestones, and note any concerns.

	Age Reached	Concerns?		Age Reached	Concerns?
Walked			Spoke first words		

Texas Children's Hospital
www.texaschildrenshospital.org

Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

	Spoke first words			Toilet trained		

Current Concerns with:

Speech/articulation	Y / N	Social skills	Y / N		
Language expression	Y / N	Fine-motor skills*	Y / N	* for example, handwriting, using scissors, tying shoes	
Language comprehension	Y / N	Coordination/ balance	Y / N		

MEDICAL & TREATMENT HISTORY

Does your child have a **chronic medical illness**? Y / N Please list all relevant medical diagnoses and primary treating doctor:

	Other medical problems	Past	Present	Treatment/Medication			Past	Present	Treatment/ Medication
?	Vision problems				?	Other injury			
?	Hearing problems				?	Asthma			
?	Motor Problems				?	Allergies			
?	Stomachaches				?	Ear infections			
?	Headaches				?	ADD/ADHD			
?	Seizures				?	Other:			
?	Head injury				?				

Please list all current medications and doses:

Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

Has your child ever received **psychotherapy or counseling**? **Y / N** If yes, please list type and dates:

Prior Evaluations	Dates	Place of Service	Treatment Services	Dates	Place of Service
[?] Educational Testing			[?] Special Education		
[?] Psychological Evaluation			[?] Speech/Language Therapy		
[?] Neuropsychological Eval			[?] Occupational Therapy		
[?] Psychiatric Evaluation			[?] Physical Therapy		
[?] Neurological Exam			[?] Other:		
[?] Brain Scan (CT, MRI)			[?]		
[?] Other:			[?]		

ACADEMIC HISTORY

Current Grade:	School:	District: ISD

Placement:	Regular Education	Special Education	Gifted & Talented	
Classification:	None	Other Health Impaired	Specific Learning Disability	Speech Impaired (SI)
(special education only)	Visual Impaired	Hearing Impaired	Other (specify) ______________________________	
Classroom:	Regular classroom	Resource classroom	Bilingual	English as a Second Language (ESL)
	Other special class (specify: ____)			

Does your child have a:		
504 Plan?	Y / N	* ***If yes, please bring a copy of the most recent plan***
Individualized Education Plan (IEP)?	Y / N	
Has your child ever been retained in grade?	Y / N	If yes, what grade(s)? ___________________
Has your child ever been <u>tested</u> for special education services?	Y / N	**** If yes, please bring a copy of the most recent report***

Texas Children's Hospital
www.texaschildrenshospital.org

Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

CURRENT CONCERNS Please check all boxes that apply to your child:	Old or New Problem?	Please rate your **level of concern**	Explain/Describe:
? Difficulty coping with chronic illness	Old / New	Low / Medium / High	
? Difficulty coping with medical treatment	Old / New	Low / Medium / High	
? Does not take care of medical problem	Old / New	Low / Medium / High	
? Behavior problem: ? Argues ? Aggressive ? Substance Abuse ? Other: ________________ Occurs at: ? Home ? School ? Hospital	Old / New	Low / Medium / High	
? Mood problem ? Depressed, sad ? Withdrawn ? Irritable, angry ? Suicidal thoughts	Old / New	Low / Medium / High	
? Anxiety (nervous, fearful) ? Generalized ? Medically-related (e.g., fear of needles)	Old / New	Low / Medium / High	
? Problems with self-image/self-esteem	Old / New	Low / Medium / High	
? Academic difficulties	Old / New	Low / Medium / High	
? Attention problems/ADD/ADHD ? Short attention span ? Disorganized ? Hyperactive ? Impulsive ? Does not complete work/chores	Old / New	Low / Medium / High	

Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

? Sleep Problems	Old / New	Low / Medium / High
? Eats too much / too little / loss of appetite	Old / New	Low / Medium / High
? Headaches ? Stomachaches ? Other Pain (Describe where:)	Old / New	Low / Medium / High
? Social Problems ? Few or no friends ? Teased ? Teases others ? Fights ? Friends involved in alcohol / drugs / gang	Old / New	Low / Medium / High
? Other:	Old / New	Low / Medium / High

Texas Children's Hospital
www.texaschildrenshospital.org

Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

FAMILY HISTORY Has anyone in your family (blood relatives) experienced the following:

Condition	Yes / No	Immediate Family			Paternal Grandparent, Aunt/Uncle	Maternal Grandparent, Aunt/Uncle
		Dad	Mom	Sibling		
Learning Problem: Reading/dyslexia, math problem, other	Yes No					
Attention-Deficit/Hyperactivity Disorder (ADD/ ADHD)	Yes No					
Intellectual Disability	Yes No					
Autism / PDD / Asperger's	Yes No					
Speech/Language Delay	Yes No					
Tourette's Syndrome – Tic Disorder	Yes No					
Depression	Yes No					
Bipolar Disorder (Manic Depression)	Yes No					
Anxiety	Yes No					
Panic Attacks	Yes No					
Obsessive Compulsive Disorder (OCD)	Yes No					
Schizophrenia	Yes No					
Alcoholism/Substance Abuse	Yes No					
Epilepsy/Seizure Disorder/Other Neurological disorder	Yes No					
Genetic Syndromes	Yes No					
Other:						

Texas Children's Hospital
www.texaschildrenshospital.org

Pediatric Health and Behavior Consultation Clinic

Texas Children's Hospital- The Woodlands

<u>Consent and Custody Verification Form</u>

Providers of Behavioral Health services at Texas Children's Hospital are required to make sure that the person bringing a child or adolescent for assessment and/or treatment has the *legal right to consent* to these services. Please answer the following brief questions to help us with this process.
Please note that if there has ever been any legal or court action taken that affects the custody of this child or who has the right to consent for evaluation/treatment of this child, copies of court documentation or papers must be provided before for this child can be seen for his/her appointment.

1. I am the:

 □ Biological parent of this child
 □ Adoptive parent of this child
 □ Legal guardian of this child
 □ Other (please specify: ____)

2. Are the <u>biological</u> parents of this child:

 □ Currently Married
 □ Not Currently Married
  □ Never Married
  □ Divorced
  □ Separated

3. Has any legal or court action ever been taken that affects the custody of this child or who has the right to consent for treatment of this child? Do you have any court paperwork about your child's custody?

 □ Yes – You MUST attach copies of court paperwork before your child can be seen
 □ No

By signing this form, you are stating that:

 □ You have the legal right to provide consent for your child's evaluation and/or treatment.
 □ You are providing the most complete and up-to-date court records regarding consent for your child's evaluation and/or treatment.
 □ You will inform the Psychology Service and/or your child's Psychology Service clinical provider of any changes that occur that impact consent for your child's evaluation and/or treatment.

_____________________________________	____
Signature of Parent/Legal Guardian	Date
_____________________________________	____
Printed Name of Parent/Legal Guardian	Relationship to Child