Newsom Psychological
Walter Scott Newsom, Ph.D.,
Licensed Psychologist
8500 Shoal Creek BLVD | Building 4, #201A |
Austin, Texas 78757
Office: 855.640.1700 Fax: 855.640.1700
NewsomPsychological.com

Client Information Form
Adult Age 18 - up

Today's date _____

Client Identification
The following questions refer to the Client only

Client's name: _____ Age: _____
LAST FIRST MIDDLE
Client's date of birth: _____ Client's Social Sec. # _____ Sex (check) M F

Home address: _____
STREET CITY STATE ZIP CODE
Home phone: _____ Cell phone: _____ **Email**: _____

Work phone: _____ Employer: _____

Marital Status (check) S M W D Referred by: _____

Primary Physician _____ Phone: _____

Medications and Prescribing Physicians: _____

Reason for seeking help: _____

_____

Emergency Contact _____ Relationship _____ Phone: _____

Spouse Identification
The following questions refer to the Spouse only

Spouse's name: _____ Age: _____
LAST FIRST MIDDLE
Spouse's date of birth: _____ Spouse's Social Sec. # _____ Sex (check) M F

Home address: _____
STREET CITY STATE ZIP CODE
Home phone: _____ Cell phone: _____

Work phone: _____ Employer: _____

The following questions refer to the Responsible Party only.
Responsible Party/Parent Information
Circle one: mother, stepmother, father, stepfather, legal guardian, other (write in) _____

Name: _____ Age: _____
LAST FIRST MIDDLE
Date of Birth: _____ Social Security _____ Sex M F

Home address: _____
STREET CITY STATE ZIP CODE
Home phone: _____ Cell phone: _____ **Marital Status (check) S M W D**

Work phone: _____ Employer: _____

Financial Information Form

Complete the following form so appropriate insurance arrangements for payment of professional fees can be made.

Client: _____
LAST FIRST MIDDLE

• Our office maintains a **48-hr cancellation policy** for all appointments. Any missed appointments, without prior cancellation, are subject to a cancellation fee of $150 per visit. Please be courteous and notify us ahead of time if you will need to reschedule your appointment. We appreciate your cooperation.

• If you are not using health insurance, please check here ____ and proceed to the back of this page.

Complete this section only if you will be using health insurance benefits to cover professional service fees.

Primary Insurance Co._____ Policy # _____

Policy Holder: _____ Group/Plan #: _____

Policy Holder's DOB: _____ Policy Holder's Soc. Sec. # _____

Policy Holder's home address: _____
STREET CITY STATE ZIP CODE

Policy Holder's employer _____work phone: _____

Secondary Insurance Co._____ Policy # _____

Policy Holder: _____ Group/Plan #:

Policy Holder's DOB: _____ Policy Holder's Soc. Sec. #

Policy Holder's home address: _____
STREET CITY STATE ZIP CODE

Policy Holder's employer _____work phone: _____

We are happy to file your claims with your primary and secondary insurance companies if they are in-network. However, it is not our policy to file claims for out of network insurance policies, although we can provide you with the paperwork to do this on your own.

• I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

• I understand that I am responsible for all charges, regardless of insurance coverage. I understand that insurance companies often pay for only a portion of the required hours for psychological testing, scoring, and report writing. I understand that I may be financially responsible for the remaining hours not covered by insurance. Payment of required co pays, coinsurance fees, or deductibles will be collected (cash, check, or credit card) at the time of service.

• Assignment of benefits. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this form is to be considered as good as the original.

_____ _____
Client's (or parent/guardian's) signature, Indicating agreement to all of the statements above — Date

_____
Printed name

Financial Information Form

Complete this page only if you are <u>not</u> using health insurance.

There are many excellent reasons why people choose not to file for health insurance benefits for psychological services. If you have any questions about this topic, please discuss them with Dr. Newsom.

Client name: _____ Social Security #: _____

Please check one of the following.

____I do not have health insurance and I will be paying professional fees directly to Dr. Newsom.
____I do have health insurance but I am choosing not to file any claims for benefits related to these services.

Please note:
If you have insurance and choose not to use it at this time, please understand that we cannot submit claims for prior services at a later date, should you change your mind about using your insurance.

I understand and agree with the statements listed above.

_____ _____
Client's (or parent/guardian's) signature, Indicating agreement to all of the statements above — Date

_____
Printed name

PAYMENT AGREEMENT, ASSIGNMENT, AND CONSENT

PAYMENT POLICY

- If an **in-network insurance company** is being billed, we will file the claim for you. You are, however, fully responsible for the balance. It is not our policy to file claims for out of network insurance policies, although we can provide you with the paperwork to do this on your own. All co-payments, deductibles, percentages, and balances not covered by your insurance carrier are due and payable when services are rendered. You will be billed for any balances the insurance company does not pay. This balance is due and payable within 15 days of the statement date even if you plan to appeal a denial.

- If you are **paying privately**, we do not bill an insurance company. The full amount for the initial interview is due at the time of service. For testing, one-half (1/2) of the estimated total is due and payable at the time of the first day of testing. The balance is to be paid prior to the report being released. For court appearances, a retainer will be required before the trial. Court appearances are not covered in the price of the evaluation. If time constraints do not allow, balances will be due within 15 days of the statement date. If such payment is not possible because of special circumstances, a specific payment plan must be agreed upon with the office manager prior to the beginning of services.

- If your account is **not paid as agreed**, any balance over 30 days will accrue a late fee of 1 1/2 % per month (18% APR) or a late fee of $25, which ever is greater. Balances over 60 days old will start in collection procedures and a 20% collection fee, or a collection fee of $75, which ever is greater, will be added to the balance. You agree to allow us to perform all activities that go along with normal collections, including but not limited to obtaining a credit report. You agree to pay all added charges associated with the collection activity including all legal and judgment fees. You also acknowledge that the collection activity will be reported to and adversely affect your credit rating.

CANCELATION FEES

A full forty-eight hour (48) notice is required for canceling appointments. Cancellations without full 48 hour notice will be billed at the applicable full session rate of **$150**. Sessions without cancellation notice (or "no-shows") will be billed at the applicable full session rate of $150. You agree to pay these cancellation fees.

ASSIGNMENT OF BENEFITS

I hereby authorize all insurance companies to make payment directly to Scott Newsom, Ph.D. I understand that this order does not relieve me of my obligation to pay the account, and that **any denied amounts, deductibles, co-payments, and percentages not covered by insurance are my responsibility**.

RELEASE OF MEDICAL INFORMATION

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities). With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities. These uses and disclosures are described more fully in our **Notice of Privacy Practices**.

I UNDERSTAND THAT IF THE INSURANCE COMPANY DOES NOT PAY I AM RESPONSIBLE FOR THE ENTIRE BALANCE, AND NON-PAYMENT COULD ADVERSELY AFFECT MY CREDIT. I HAVE READ, UNDERSTAND, AND RECEIVED A COPY OF THIS AGREEMENT, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE.

_____	_____	_____
Signature of Patient/Responsible Party	Date	Patient Name

_____

PRINT NAME

OFFICE COPY

PAYMENT AGREEMENT, ASSIGNMENT, AND CONSENT

PAYMENT POLICY

- If an **in-network insurance company** is being billed, we will file the claim for you. You are, however, fully responsible for the balance. It is not our policy to file claims for out of network insurance policies, although we can provide you with the paperwork to do this on your own. All co-payments, deductibles, percentages, and balances not covered by your insurance carrier are due and payable when services are rendered. You will be billed for any balances the insurance company does not pay. This balance is due and payable within 15 days of the statement date even if you plan to appeal a denial.

- If you are **paying privately**, we do not bill an insurance company. The full amount for the initial interview is due at the time of service. For testing, one-half (1/2) of the estimated total is due and payable at the time of the first day of testing. The balance is to be paid prior to the report being released. For court appearances, a retainer will be required before the trial. Court appearances are not covered in the price of the evaluation. If time constraints do not allow, balances will be due within 15 days of the statement date. If such payment is not possible because of special circumstances, a specific payment plan must be agreed upon with the office manager prior to the beginning of services.

- If your account is **not paid as agreed**, any balance over 30 days will accrue a late fee of 1 1/2 % per month (18% APR) or a late fee of $25, whichever is greater. Balances over 60 days old will start in collection procedures and a 20% collection fee, or a collection fee of $75, whichever is greater, will be added to the balance. You agree to allow us to perform all activities that go along with normal collections, including but not limited to obtaining a credit report. You agree to pay all added charges associated with the collection activity including all legal and judgment fees. You also acknowledge that the collection activity will be reported to and adversely affect your credit rating.

CANCELATION FEES

A full forty-eight hour (48) notice is required for canceling appointments. Cancellations without full 48 hour notice will be billed at the applicable full session rate of **$150**. Sessions without cancellation notice (or "no-shows") will be billed at the applicable full session rate of $150. You agree to pay these cancellation fees.

ASSIGNMENT OF BENEFITS

I hereby authorize all insurance companies to make payment directly to Scott Hammel, Ph.D. I understand that this order does not relieve me of my obligation to pay the account, and that **any denied amounts, deductibles, co-payments, and percentages not covered by insurance are my responsibility**.

RELEASE OF MEDICAL INFORMATION

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities). With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities. These uses and disclosures are described more fully in our **Notice of Privacy Practices**.

I UNDERSTAND THAT IF THE INSURANCE COMPANY DOES NOT PAY I AM RESPONSIBLE FOR THE ENTIRE BALANCE, AND NON-PAYMENT COULD ADVERSELY AFFECT MY CREDIT. I HAVE READ, UNDERSTAND, AND RECEIVED A COPY OF THIS AGREEMENT, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE.

PATIENT COPY

Newsom Psychological
Walter Scott Newsom, Ph.D.,
Licensed Psychologist
8500 Shoal Creek BLVD, Building 4, #201A
Austin, Texas 78757
(855) 640-1700 (ph) (855) 640-1700 (fax)
NewsomPsychological.com

Fee Schedule as of July 1, 2017

The following fees are in effect as of July 1, 2017.

Sessions

- Initial Diagnostic Interview (45-50 minutes): $200
- Individual Therapy Session (45-50 minutes): $150
- Extended Individual or Family Therapy (60 minutes): $175
- Feedback Session (45-90 minutes after completion of evaluation): $175
- Family Therapy Session: $160

Assessments and Evaluations

- Psychoeducational Assessment (full battery)*:$1,800 - $2,000
- Adult Neurodevelopmental (ADD/ADHD/Autism) Assessment*: $600 - $1,200
- Gifted and Talented Assessment*: $600 - $1,200
- Repeatable Battery for Dementia: $900

*****The total cost of your individual assessment or evaluation will be discussed at the initial diagnostic interview and a written total will be given to you before the testing.

Other Services

- Cognitive Behavioral Treatment for Insomnia (CBTi) : $900
- Career Assessment and Counseling: $900

Court Appearances, Depositions, Expert Witness

- $350 per hour with a minimum of four hours for depositions and a minimum of eight hours for court appearances. The minimum amount is collected in advance as a retainer and must be paid before the day of testimony.

I have read and agree with the above fee schedule. I understand that fees listed do not include insurance coverage and that it is my responsibility to check my benefits with my insurance provider.

Patient or Responsible Party Signature: _____

Date: _____

Newsom Psychological
Walter Scott Newsom, Ph.D.,
Licensed Psychologist
8500 Shoal Creek BLVD, Building 4, #201A
Austin, Texas 78757
(855) 640-1700 (ph) (855) 640-1700 (fax)
NewsomPsychological.com

Fee Schedule as of July 1, 2017

Sessions

- Initial Diagnostic Interview (45-50 minutes): $200
- Individual Therapy Session (45-50 minutes): $150
- Extended Individual or Family Therapy (60 minutes): $175
- Feedback Session (45-90 minutes after completion of evaluation): $175
- Family Therapy Session: $160

Assessments and Evaluations

- Neuropsychological Evaluation (full battery)*: $1,750 - $2,000
- ADD Assessment*: $700 - $1,000
- Gifted and Talented Assessment*: $600- $1,200
- Repeatable Battery for Dementia

*****The total cost of your individual assessment or evaluation will be discussed at the initial diagnostic interview and a written total will be given to you before the testing.

Other Programs

- Cognitive Behavioral Treatment for Insomnia: $900
- Career Assessment and Counseling: $900

Court Appearances, Depositions, Expert Witness

- $350 per hour with a minimum of four hours for depositions and a minimum of eight hours for court appearances. The minimum amount is collected in advance as a retainer and must be paid before the day of testimony.

I have read and agree with the above fee schedule. I understand that fees listed do not include insurance coverage and it is my responsibility to check my benefits with my insurance provider.

Patient Copy

PSYCHOLOGICAL & NEUROPSYCHOLOGICAL ASSESSMENT
INSURANCE DISCLAIMER FORM

I _____ understand that portions of my psychological/neuropsychological assessment may not be covered. I understand that it is my responsibility to verify my own benefits and that Dr. Newsom's office verifies benefits as a courtesy; benefits quoted are estimates received from the insurance company. Dr. Newsom's office files claims only for in-network insurance plans. Clients with out-of-network plans can file their own claims and request reimbursement from the insurance company. If a claim is denied or is processed incorrectly, Dr. Newsom's office will re-file the claim once. Any further billing problems will need to be handled by the client. I understand that if there are problems with my insurance paying my claims, I will contact my insurance company to resolve this matter.

Initial the following:

_____ I understand that I am responsible for all copays, co-insurance, and deductibles that are associated with my insurance plan and that the amount is due at the time of service.

_____ I understand that portions of psychological and neuropsychological assessment may not be covered by my insurance plan and I agree to pay for the amount not paid for by my insurance.

_____ If the full amount due cannot be paid on the date of assessment, I agree to sign a payment agreement in which I regularly make payments towards the balance until paid in full.

_____ I understand that the psychological/neuropsychological report will not be released until I have paid my balance.

_____ _____
Signature of Client or Responsible Party Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

This Office is required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be available upon request to the Privacy Officer. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint. Our Privacy Officer is Dr. Newsom. You can contact the Privacy Officer at (855) 640-1700.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

YOUR RIGHTS

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an account of certain disclosures made by us.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE ARE REQUIRED TO MAKE *WITHOUT* YOUR PERMISSION

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE ARE *ALLOWED* TO MAKE WITHOUT YOUR PERMISSION

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. We may disclose information from your record to a medical examiner or coroner. We may disclose information to funeral directors to allow them to carry out their duties upon your death. We may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation.

We may assist in health oversight activities, such as investigations of possible health care fraud. We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

We may use or disclose information from your record for research under certain conditions.

Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

Your provider (or office staff) may contact you to provide appointment reminders as a courtesy. However, you are responsible for remembering your appointment.

We may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

Patient _____

_____ _____

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all the apply):

- Home/Cell Telephone #_____
  - Leave message with detailed information
  - Leave message with call-back number only
- Work Telephone # _____
  - Leave message with detailed information
  - Leave message with call-back number only
- Written Communication
  - Mail to my home address
  - Mail to my work/office address
- Other Communication (e-mail, fax, etc.) _____

_____ _____

Patient Signature Date

***The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by an individual. Healthcare entities must keep records of PHI disclosures. The information provided below, if completed properly, will constitute an adequate record. ***

Note: Uses and disclosures may be permitted without prior consent in an emergency.

OFFICE USE ONLY

Record of Disclosures of Protected Health Information

Date of disclosure?	Disclosed to whom?	Disclosure authorized?	Description of disclosure	Who disclosed?	How was the disclosure made?

Adult History Form

Client's Name: _____ Today's Date: _____

Sex: _____M _____F Date of Birth: _____ Age: _____

Person Completing Information: _____

Relationship to Client: _____

Check one: ____ Work ____ Attend School ____ Both Work and Attend School

Name of Employer: School Attending:

_____ _____

_____ Grade: _____ Major: _____

Referral Source: _____

Are you taking medication? ___Yes ___No If Yes, what type? _____

_____

1. Please identify problem(s): _____

   _____

   _____

2. When did the problem(s) begin? _____

   _____

   _____

3. List anything you did to improve the problem(s): _____

   _____

   _____

Have you ever had a psychological or psychiatric evaluation? _____

If so, when and by whom? _____

_____

Have you attended any occupational therapy, physical therapy, or speech therapy? _____

_____

Please list the names of all family members with whom you live: (continue list on the pack of this page)

Name	Age	Relation to the You
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Was your mother employed outside the home? ____ Yes ____ No If so, where?_____

_____ How many hours per week? _____

Mother's occupation: _____

Mother's education level: _____

Was your father employed outside the home? ____ Yes ____ No If so, where?_____

_____ How many hours per week? _____

Father's occupation: _____

Father's education level: _____

Are your biological parents divorced?_____ separated?_____ widowed?_____

If so, how old were you when these events occurred? _____

_____

_____

If your biological parents were divorced, with whom did you live? _____

_____

Was English your first language? If not, what was the first language and when did you learn to speak English?

_____

_____

What activities do you enjoy? _____

_____

SCHOOLING

Please list schools attended:

Daycare? _____ Yes _____ No If so, at what ages?

Preschool? _____ Yes _____ No If so, at what ages?

Academic Year	School Name and City/State	Grades Earned
Grade School	_____	_____
	_____	_____
Middle School	_____	_____
	_____	_____
High School	_____	_____
	_____	_____
	_____	_____
College	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Special Education? ____Yes _____No If Yes, what type? _____

Did you skip or repeat any grades? ____

____

Best school subjects: ____

Worst school subjects and any particular problem areas: ____

____

____

Did your school performance ever change dramatically? If so, please explain: ________________________

____

____

- -

PRENATAL HISTORY

Were there any significant problems in the pregnancy? _____ Yes _____No If yes, please specify: __________

____

____

____

Any use of alcohol: ____

Amount: _________________________________ How often? ____

Any use of medications or drugs (including tobacco): ____

Amount: _________________________________ How often? ____

Length of: pregnancy _______________________; labor and delivery ____________________________________

Were there any complications in labor/delivery? ____ Yes ____ No If yes, please specify: _______________

____

____

NEONATAL HISTORY

Birth weight: ________________________

Did you have any significant problems at birth or in the newborn phase? ___ Yes ___ No ___ None Known

If yes, please specify: ____

____

____

- -

INFANCY (0 to 12 months)

Check if applicable, any significant problems, delays, and/or difficulties you had in the 1st year:

________ feeding
________ sleeping
________ breathing
________ colic
________ bowel and or urinary habits
________ inability to be consoled
________ crawling
________ allergies/ear infections
________ intolerance of affection
________ sitting unassisted
________ emotional responsiveness

Please specify any other significant problems: ____

____

- -

Check if applicable, any significant problems, delays, and/or difficulties you had between the ages of 1 to 3 years:

_______ walking unassisted	_______ feeding self	_______ allergies/ear infections
_______ first words	_______ using sentences	_______ severe temper tantrums
_______ entertaining self	_______ toilet training	_______ self-destructive behavior
_______ stranger anxiety	_______ overactivity	

Please specify any other significant problems: ____

____

____

- -

CHILDHOOD (3 to 11 years)

Check if applicable, any significant problems, delays, and/or difficulties you displayed since early childhood on in these areas:

_______ impulsive very shy	_______ aggressive	_______ self-destructive habits
_______ overactivity	_______ nervous/fearful	_______ completing tasks, chores
_______ uncoordinated	_______ short attention span	_______ severe temper tantrums
_______ reading skills	_______ bowel/urinary habits	_______ obeying adults
_______ academic failure	_______ writing skills	_______ math skills
_______ destroying property	_______ cooperating in group activities	
_______	_______ prolonged sadness or irritability	

Please specify any other significant problems: ____

____

____

- -

ADOLESCENCE (12 to 18 years)

Check if applicable, any significant problems, delays, and/or difficulties you displayed since early childhood on in these areas:

_______ prolonged sadness or irritability	_______ truancy	_______ delinquency
_______ "gang" membership	_______ academic failure	_______ social isolation
_______ aggressive	_______ impulsive	_______ sexually active
_______ pregnancy	_______ drug or alcohol use	_______ running away
_______ temper outbursts	_______ fighting	_______ eating/appetite

Please specify any other significant problems: ____

____

ADULT SELF-ASSESSMENT INVENTORY

Check all that apply

PROBLEMS WITH CONCENTRATION

_____I have trouble concentrating on one thing at a time.
_____My mind wanders.
_____I forget what I am supposed to be doing.
_____I get distracted easily.
_____I lose my place when I am reading.
_____I am easily distracted by noises.

PROBLEMS WITH RESTLESSNESS

_____I cannot sit still for very long.
_____I am jumpy and jittery.
_____I like to play active sports rather than quiet ones.
_____I am a restless sleeper.
_____I feel restless inside even if I am sitting still.

PROBLEMS WITH SELF-CONTROL

_____I say things without thinking.
_____I do things on impulse.
_____I am easily led to trouble.
_____I have trouble following rules.
_____When I want something, I have trouble stopping myself.

PROBLEMS WITH ANGER

_____I have a hot temper.
_____I tend to explode easily.
_____A lot of things irritate me.
_____People bug me and get me angry.
_____I have thoughts of hurting others.
_____I have hurt other people.
_____I have destroyed property when I was angry.

PROBLEMS WITH FRIENDS/OTHERS

_____I would like to have more friends.
_____I have trouble keeping friends.
_____I am a lonely person.
_____I don't get along well with the opposite sex.
_____I don't have many friends my age.
_____I have been physically hurt by another person.
_____I have been touched in ways that have made me uncomfortable.

PROBLEMS WITH CONFIDENCE

_____I am not sure of myself.
_____I wish I had more confidence in my abilities.
_____I don't like myself.
_____I have trouble making decisions.
_____I don't take credit for my accomplishments.
_____There are a lot of things I dislike about my behavior.
_____I act okay on the outside, but inside I am unsure of myself.
_____I wish I were smarter.

PROBLEMS WITH LEARNING

_____I have trouble with reading and spelling.
_____I have bad handwriting.
_____It takes a lot of effort to get my work done.
_____I tend to learn more slowly than I would like.
_____I forget things I have learned.
_____I have trouble organizing my work.
_____I am behind in my work.

PROBLEMS WITH FAMILY

_____My family doesn't do too many fun things together.
_____My family doesn't always get along very well.
_____I am not very close to my family.
_____There is a lot of yelling in our house.
_____I have been physically hurt by a family member.
_____I have been touched by a family member in ways that have made me uncomfortable.

PROBLEMS WITH FEELINGS

_____I get nervous.
_____I am an anxious person.
_____I feel sad and gloomy a lot.
_____The future seems hopeless to me.
_____I feel like killing myself.
_____I am easily upset.
_____A lot of things scare me even if I wouldn't admit it to others.
_____I have nightmares.
_____I have a lot of aches and pains.
_____I worry a lot about little things.
_____I feel like crying.
_____I am discouraged.
_____I am afraid to be alone.
_____I am nervous unless I am with others.
_____I sometimes hurt myself when I feel overwhelmed by my feelings.

PROBLEMS WITH THINKING

_____I have unusual thoughts.
_____I have problems remembering things that other people remember easily.
_____I hear voices that other people don't hear.
_____I see things that other people don't see.
_____I have fears that I don't understand.
_____I think one thought over and over.
_____I feel confused a lot of the time.
_____I sometimes have to repeat an action over and over.

PROBLEMS WITH HEALTH/EATING/NUTRITION

_____I have had one of the following health problems:
_____Cancer
_____Cancer treatment
_____Diabetes
_____Gastro-Intestinal problems
_____Kidney problems
_____Liver Disease
_____I have had a recent surgery, broken bone or severe burn.
_____I have recently lost a lot of weight.
_____I have recently gained a lot of weight.
_____I feel that I am overweight even though others don't agree.
_____I have tried to control my weight by not eating, by throwing up, or taking laxatives.
_____I have eaten very little in the last seven days or more.
_____I have problems chewing or swallowing.
_____I have recently had a lot of diarrhea or vomiting.

PROBLEMS WITH DRUGS/ALCOHOL

_____I use drugs or alcohol to help me deal with my feelings.
_____I have trouble saying "no" to drugs or alcohol.
_____Using drugs/alcohol have contributed to my problems.
_____It is okay with me if my friends use drugs or alcohol.

PROBLEMS WITH THE LEGAL SYSTEM

_____I have legal charges pending against me.
_____I am on probation.
_____I have stolen from others.
_____I have been arrested.

OTHER PROBLEMS I HAVE:

_____

_____

_____

_____

_____

MY ASSETS:

_____I can do a lot when I put my mind to it.
_____My mind is pretty sharp.
_____I have a good head on my shoulders.
_____I have overcome a lot of my problems.
_____People think I am a pretty good person.
_____I am calm and relaxed.
_____I get along well with others.
_____I tend to look on the bright side of things.
_____I have a lot of self-control when I need it.
_____I can be as cool as I need to.
_____I don't get rattled easily.
_____I can really stick to things when I want to.
_____I make friends easily.
_____I feel pretty comfortable with work.

OTHER STRONG POINTS I HAVE:

_____

_____

_____

Are there any other issues or concerns you would like to address:

Newsom Psychological
Walter Scott Newsom, Ph.D.
8500 Shoal Creek BLVD,
Building 4, # 201A
Austin, TX 78757
855-640-1700

CommunicationConsent Form

Today's Date_____

Patient Name _____

How would you prefer to receive appointment reminders?

Phone_____

Phone # _____

Email:_____

Email Address _____

I authorize Newsom Psychological to contact me through the above authorized modes of communication:

Client's Signature_____ Date: _____