FULLER DIAGNOSTICS, LLC

NEUROPSYCHOLOGICAL EVALUATION PAPERWORK

CHILD & ADOLESCENT FORMS

_____

Name of Patient

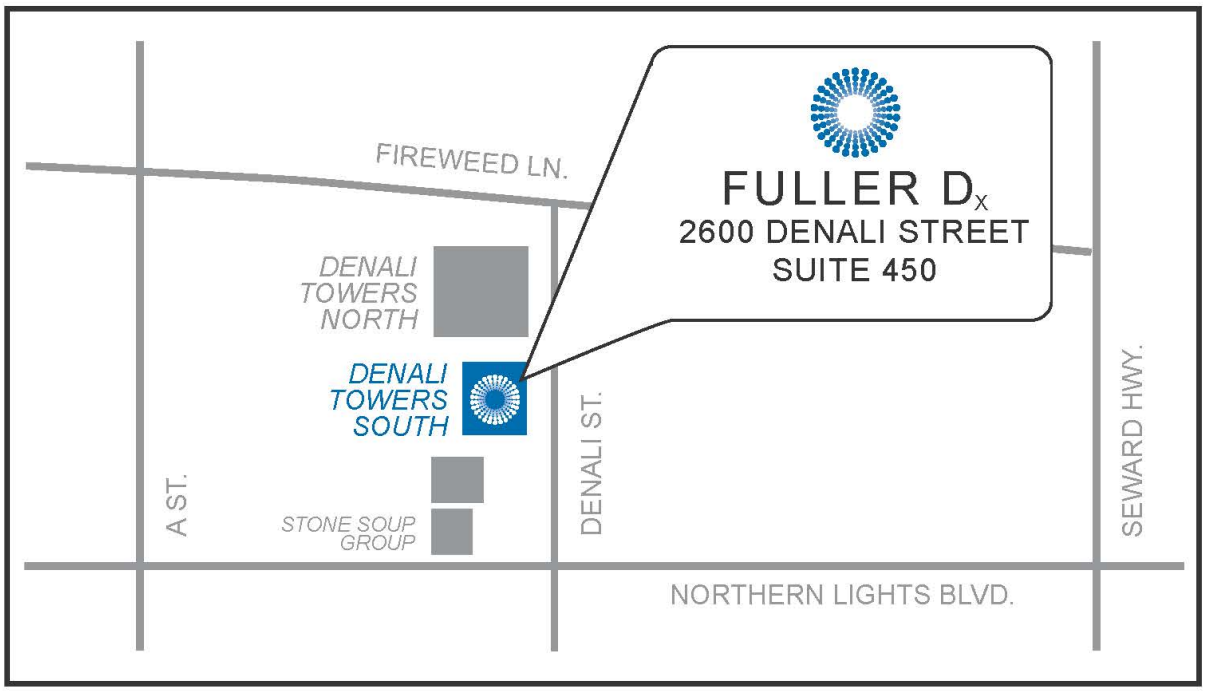
_____ ___/___/_____

Person Completing Date

Fuller Diagnostics, LLC • 2600 Denali Street, Suite 450 • Anchorage, Alaska 99503
Phone: 907.561.0552 *Fax:* 907.561.0562 *Email:* info@fulleralaska.com *Website:* www.fulleralaska.com

FULLER DIAGNOSTICS, LLC

NEUROPSYCHOLOGICAL ASSESSMENT • INDIVIDUAL & FAMILY THERAPY



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FULLER DIAGNOSTICS, LLC

Thank you for choosing FULLER DIAGNOSTICS, LLC. You will need to complete the information packet and return it within **TWO WEEKS PRIOR** to the initial scheduled appointment. If for any reason you are unable to complete the paperwork please contact our office. The information you provide will be used during the interview with your provider to better focus the time on specific concerns.

Please return this completed form to our office as soon as possible, you may send it via email, fax or mail.

Email: info@fulleralaska.com **Fax:** 907.561.0562

Mailing Address: Fuller Diagnostics, LLC • 2600 Denali Street, Suite 450 • Anchorage, AK 99503

Included within this packet:

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IMPORTANT INFORMATION REGARDING YOUR UPCOMING NEUROPSYCHOLOGICAL EVALUATION

What is a Neuropsychological evaluation?
A Neuropsychological evaluation is a complex process that integrates information from a wide variety of sources. The evaluation examines cognitive abilities, brain-behavior relationships, behavioral and adaptive functioning, and psychological/personality factors. The comprehensive nature of the evaluation enables more accurate diagnoses, determines areas of strength and weakness, and provides specific recommendations based on your child's needs.

Who is involved in my care?
Neuropsychologist – Kristi Fuller, Ph.D., ABPP-CN is a Board Certified Clinical Neuropsychologist specializing in pediatric neuropsychology. Richard Fuller, Ph.D provides comprehensive evaluations for adolescents, adults and geriatrics.

Psychologist – Christopher Cavanaugh, Ph.D are clinical psychologists specializing in psychological evaluations of children, adolescents, and young adults and are completing a posts doctoral fellowship at Fuller Diagnostics, LLC.

Psychometrist – A professional who administers standardized Neuropsychological tests under the supervision of Dr. Kristi Fuller, Dr. Richard Fuller and/or Dr. Christopher Cavanaugh.
Please note: the psychometrist cannot provide any information about test results or diagnosis.

What does the process look like?
Interview- Parents/Guardians will meet with their Fuller Diagnostics Provider for approximately one hour prior to the evaluation day. During this time, parents will have the opportunity to discuss their primary concerns and provide additional background information relevant to their child's evaluation. *(We request that children or siblings are not brought to the interview or feedback appointment)*

Assessment- The duration of the testing process varies based on the nature of the referral question, complexity of the situation, and patient's age. Testing is completed in morning and afternoon sessions. Children are given a lunch break, we recommend taking the child out of the clinic for lunch as this is more restorative. Results of standardized testing are then scored and interpreted in conjunction with additional information obtained during interviews, record review, and parent and teacher rating scales.

Feedback- Parents/Guardians will meet with their Fuller Diagnostics Provider to discuss the test results, answer questions and review recommendations. Diagnosis and specific treatment recommendations will be outlined during this hour-long appointment. *(We request that children or siblings are not brought to the interview or feedback appointment)*

Comprehensive Report – A final comprehensive written report is typically available four to six weeks after the feedback appointment. This report is mailed out to you and the referring provider.
Please note: this is an additional date of service billed to insurance and could result in additional patient copay's or co-insurance.

How do I prepare for the evaluation?
- **Arrive 15 minutes early** for your appointment.
- Make sure to get plenty of sleep the night before the appointment and eat a good breakfast.
- If traveling from out of town, please arrive at least one day prior to ensure a good night's sleep.
- Bring any hearing aids, contact lenses or glasses, additionally bring any snacks if desired.

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____ SSN: _____ Gender: M / F / O

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name & Phone: _____ Relation to patient: _____

Email address: _____

☐ I authorize the use of this email address for scheduling and billing purposes

PARENT/GUARDIAN/RESPONSIBLE PARTY: Who is the adult responsible for the bill?

Last Name: _____ First Name: _____ M.I.: _____

Relation to Patient: _____ *Photo ID and Proof of Guardianship Required*

***Any patient under the age of 18 and those requiring a guardian beyond the age of 18 must have their guardian available during the evaluation process.*

Marital Status: M / S / D SSN: _____ DOB: _____ Gender: M / F / O

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer's Name & Phone: _____

PRIMARY INSURANCE - *ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____

Claims Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O

DOB: _____ SSN: _____ Employer Name & Phone: _____

SECONDARY INSURANCE – *IF APPLICABLE, ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____

Claims Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O

DOB: _____ SSN: _____ Employer Name & Phone: _____

TERTIARY INSURANCE – *IF APPLICABLE, ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____

Claims Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O

DOB: _____ SSN: _____ Employer Name & Phone: _____

CLINIC POLICIES

Thank you for choosing FULLER DIAGNOSTICS, LLC we look forward to working with you. The purpose of this form is to provide you with important information regarding confidentiality and responsibility for payment of services.

CONFIDENTIALITY: The information discussed in the Neuropsychological evaluation will be incorporated into the Neuropsychological Evaluation report. Information obtained during the current evaluation is considered confidential and can generally only be released to other parties with your written permission. If you disclose information about the abuse of child, vulnerable adult, or elder, then we are required by law to report this to the appropriate authorities. Additionally, if you threaten to harm yourself, someone else, or the property of others, we may be required to notify the police and potential victim(s), or take other reasonable steps to prevent the threatened harm. Finally, if ordered by the court, we may have to testify or release your records. Please ask the front desk staff for a release of information (ROI) if you want us to be able to speak with additional family members or providers other than the referral source about your care. We will forward a copy of the final report with the results to the referral source after the evaluation.

Responsible Party initials ____

CHILDREN: A parent or legal guardian must accompany all children under the age of 18 years. Parents are asked to only bring the child who is to be tested, to the appointment. Additionally, we ask that you only bring the child to the evaluation day and not to the interview or feedback, unless otherwise instructed by Fuller Diagnostics, LLC. If you are unable to make prior arrangements for any additional children, please call our office to reschedule the appointment no later than 48 business hours prior to the appointment.

Responsible Party initials ____

ADDITIONAL ASSISTANCE: If your child needs assistance in toileting or if there is concern that your child may elope you will need to remain onsite for the full duration of testing.

Responsible Party initials ____

CANCELLATIONS/NO-SHOW: We complete a courtesy reminder call and email in advance for each appointment. You are responsible for confirming your appointment by responding to the phone call or email. If you are cancelling your testing appointment, you ***MUST*** do so at least 48 business hours in advance, directly with a staff member during business hours, otherwise you will be charged a "No Show/Late Cancel" fee of $500.00. For interview and feedback appointments, the appointment ***MUST*** be cancelled with at least 48 business hours' notice, or you will be charged a fee of $50.00. If the initial interview appointment is missed, the testing session will be rescheduled, which typically results in a very substantial delay. Please note insurance will not cover "No Show" fees. These fees will not be removed regardless of the reason the appointment was missed, and must be paid in full prior to rescheduling appointments.

Responsible Party initials ____

FINANCIAL: As a courtesy, we will bill your insurance if you provide **accurate proof of coverage** at the time of service. You are expected to pay any/all deductibles and co-pays at the time of service. **You are responsible for paying any balance that is not covered by your insurance.** We accept cash, check, Visa, MasterCard and American Express. Billing statements and receipts will be sent electronically if an email address has been provided. Your provision of the email address shall be considered your consent. If you fail to pay your final bill or to make financial arrangements to settle your account within thirty (30) days of receiving your statement, your account will be sent to a collection agency.

Responsible Party initials ____

FIREARMS/WEAPONS POILCY: It is FULLER DIAGNOSTICS, LLC's policy that all weapons including concealed firearms are prohibited on our premises. The State of Alaska Department of Public Safety dictates that the owners or management of facilities, may deny concealed carry on their premises.

Responsible Party initials ____

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS: In order to bill my insurance, I understand that they will have access to reports from services provided by FULLER DIAGNOSTICS, LLC. I authorize the exchange of information necessary for payment of services. I authorize payment directly to FULLER DIAGNOSTICS, LLC for services rendered to me regarding my evaluation. I also understand that I am responsible for any amount not covered or that is deemed over usual and customary fees by my insurance carrier or agency. **Self-paying patients:** I understand that I am responsible for my bill and that 50% of total charge must be paid two weeks prior to evaluation, and the remainder no later than the day of testing.

Responsible Party initials ____

PICTURE CONSENT: I authorize FULLER DIAGNOSTICS, LLC to take a digital photograph of my child for the purpose of the Neuropsychological evaluation process. I understand that this picture will remain in my child's medical record for patient identification purposes.

Responsible Party initials ____

AMENDMENT POLICY: It is FULLER DIAGNOSTICS, LLC policy that patient records are generally not amended if the requested change does not directly affect the diagnosis and/or treatment recommendations. Exceptions to this policy include factual errors in background information, or when the neuropsychologist notes that an addendum will be provided upon receipt of additional information in the initial written report. All requests for additions and/or changes are to be placed in writing to be authorized by Dr. Fuller. I acknowledge this policy and understand that any request to amend my final Neuropsychological evaluation will be denied if the requested information to be changed does not directly affect the diagnosis or treatment recommendations.

Responsible Party initials ____

EMAIL REPORT RELEASE: I give permission for the final report to be emailed to the following addresses: *Please ask for password protected if needed, email is not secure otherwise*

_____

_____

Responsible Party initials ____

FULLER DIAGNOSTICS, LLC clinic policies and privacy practices have been reviewed, understood, and agreed to by me.

Patient Name [print]: _____

Responsible Party Name [print]: _____

Responsible Party Signature: _____ Date: _____

CONSENT FOR NEUROPSYCHOLOGICAL EVALUATION

Please read this document carefully, as your signature will represent an agreement between you and FULLER DIAGNOSTICS, LLC.

Please be aware that you are encouraged to have a family member/significant other present during the interview to help provide information regarding your child's problems and offer support, but that they *may not* be present during the testing. It is also the policy of this office and American Academy of Clinical Neuropsychologists/National Academy of Neuropsychology guidelines that third-party observers (e.g., attorney, advocates, etc.) or recording devices are **not** allowed during the interview or testing.

During the assessment, various techniques and standardized tests will be introduced, including but not limited to; asking questions about certain topics, reading, drawing figures and shapes, viewing printed material, solving puzzles, using a computer keyboard, and manipulating objects. We work to make the appointment time as "fun" as possible for your child, as it is very important that they give their best effort on all tasks. This portion is scheduled for a full day, with breaks allowed as needed. Children will complete testing during the morning and afternoon with a break for lunch. Depending on the age and comfort level of the child, parents may need to be physically available for all or a portion of the evaluation appointment.

After the test results are obtained, Dr. Fuller will interpret this information and meet with parents/guardians to review the results. After this appointment, all results will be formatted into a comprehensive written report. The report will contain test data, provide detailed analysis, and integrate findings across information sources. The report will provide DSM-V-TR/ICD-10 diagnoses, and offer relevant recommendations.

I understand that if I am giving consent for a minor or someone over the age of 18 for whom I have legal guardianship, it is incumbent upon me to inform any other parent or legal guardian prior to giving consent and my signature below constitutes my attestation to having full authority and agreement on the part of all parties involved for consenting to the Neuropsychological evaluation process. I hereby release FULLER DIAGNOSTICS, LLC and shall hold them harmless from any obligation, real or implied to inform any other parent or legal guardian or obtain additional consent from any other party as my signature shall serve as permission granted by all parties involved and I will assume full responsibility for any other parent or legal guardian's consent.

I understand that I have the right to terminate the evaluation whenever I wish. I also recognize that in taking such action, the Neuropsychologist will be limited in their ability to complete the evaluation, generate a report, or provide valuable information requested by your child's health care provider.

I understand the Neuropsychologist also has the right to terminate the evaluation at any point should they become aware of any pending litigation, i.e., open custody cases, contested guardianship cases, worker's comp. etc., for which their report may be used. In which case, the evaluation will not be completed, a report will not be issued, insurance will not be billed and the patient will be solely responsible for payment of the time spent prior to the discovery of the undisclosed legal issues.

The terms of this evaluation have been reviewed, understood, and agreed to by me.

Patient Name [print]: _____

Responsible Party Name [print]: _____

Responsible Party Signature: _____ Date: _____

LIMITS OF CONFIDENTIALITY

Information obtained during the course of the Neuropsychological evaluation will be incorporated into a comprehensive written report that will be sent to the referring clinician and any other individuals/agencies identified on a Release of Information (ROI) signed prior to the evaluation. NOTE: A hard copy will be mailed to parent/guardian or emailed if preferred.

If the fee for this evaluation is being paid by an insurance company or other agency, it may be necessary to send a copy of the report to that agency to secure reimbursement, as noted in the signed Guarantee of Payment/Assignment of Benefits.

FULLER DIAGNOSTICS, LLC will not directly release reports to any School District. Parents may elect to share all or a portion of the written report, and will need to independently provide this information to the school.

This report, and any other information discussed in the evaluation, is confidential, and it will not be shared without written permission except under the following conditions:

- The patient threatens suicide.
- The patient threatens harm to another person(s), including murder, assault, and/or other harm.
- The patient reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
- The patient reports abuse of the elderly.

State law mandates that mental health professionals may need to report these situations to the appropriate persons or agencies.

Communications between FULLER DIAGNOSTICS, LLC and the patient will otherwise be deemed confidential as stated under Alaska State Law.

Having read and understood the above, I agree to the Limits of Confidentiality.

Patient Name [print]: _____

Responsible Party Name [print]: _____

Responsible Party Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to make changes to this Notice at any time, provided such changes are permitted by applicable law, and to make such changes effective for all health information we may already have about you. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the purposes of treatment, payment, and health care operations. For example:

Treatment: HIPAA allows us to use and disclose your health information to provide, coordinate, or manage your health care and related services. FULLER DIAGNOSTICS, LLC will not disclose your protected health information without your written or (in rare cases) verbal authorization for release of information, except in cases of emergency.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, accreditation, certification, licensing, or credentialing activities.

Your authorization: in addition to our use of your health information for treatment, payment, or health care operations, **you may give us additional written authorization** to use your health information or to disclose it to anyone for any purpose. **If you give us an authorization, you may revoke it in writing at any time.** Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, *but only if you agree that we may do so.*

Persons involved in care: We may use or disclose health information to notify or assist in the notification of a family member (including identifying or locating), your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common medical practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing health-related services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials: health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, or letters).

PATIENT RIGHTS

Access: You have the right to inspect or copy your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access from us directly, or by using the contact information listed at the end of this Notice. We will charge you a reasonable fee for document production expenses. If you request an alternative format, we will charge a reasonable fee for providing your health information in that format.

Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last six years.

HIPAA ACKNOWLEDGEMENT

My signature below acknowledges that I was offered a copy of the FULLER DIAGNOSTICS, LLC's Notice of Privacy Practices. I also acknowledge that pursuant to **Ethical Standard 9.04** "**Release of Test Data,"** the "Psychologists may refrain from releasing test data to protect a parent/patient or others from substantial harm, misuse or misrepresentation of the data or the test, recognizing that in many instances the release of confidential information under these circumstances is regulated by law." It is FULLER DIAGNOSTICS, LLC's standard policy that raw test data will not be released to anyone other than a licensed professional Neuropsychologist qualified to interpret the data. This request must be in writing.

_____ _____

Signature of Acknowledgement Date

CHILD/FAMILY HISTORY QUESTIONNAIRE

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN FULL

DEMOGRAPHIC INFORMATION

Form completed by: _____ Relationship to child: _____

Child's name: _____ Date of Birth: _____ Age: _____

Gender: M / F Race/Ethnicity: _____ Primary Language: _____

Handedness (*circle one*): Right / Left / Both Current Grade: _____

Current School: _____

Who referred you to this evaluation? _____

Who is your Pediatrician/Primary Care Provider? _____

What are your primary concerns regarding your child? _____

_____

FAMILY INFORMATION

Parents names and (age): **Occupation:**

Mother: _____ (____) _____

Father: _____ (____) _____

Guardian: _____ (____) _____

Are biological parent's separated? Yes / No **Child's age at separation:** _____

Who has custody: _____ Describe Visitation Schedule: _____

_____

If parent(s) have remarried:

Step-Father's Name: _____ Step-Mother's Name: _____

Contact/Relationship with biological mother: _____

Contact/Relationship with biological father: _____

Number of moves since child's birth? _____ History of OCS involvement? Yes / No

Is your child adopted? Yes / No **Age at adoption:** _____

Child's Religion: _____ How often does child attend service? _____

Other children in family?

Name Age Gender Grade Relationship

_____

_____

_____

_____

Any additional household members? _____

PREGNANCY HISTORY

Duration of pregnancy (weeks) _____ *(Full-term is 40 weeks)*

Circle any of the following problems during the pregnancy: (Please explain below)

Infections Excessive vomiting Preeclampsia Physical injury

Anemia Surgery/Hospitalizations Diabetes High blood pressure

Did biological mother use alcohol, smoke, or use recreational or prescription drugs during pregnancy? Yes / No

If yes, what and how much? _____

Other significant events, complications or medical procedures during pregnancy: _____

_____

Duration of Labor: _____ Spontaneous delivery: Yes / No C-Section: Yes / No

Planned C-Section: Yes / No Emergency C-Section Yes / No

Apgar scores (if known) _____ Birth weight: _____ lbs _____ounces

Complications: (please circle)

"Blue" baby Cord around neck Immature lungs Brain hemorrhage

Suction required Oxygen required Transfusions Treatment for jaundice

Other complications (i.e. infections, birth defects, injury): _____

_____

NICU or specialized care (incubator, oxygen tank, etc.): Yes / No If yes, number of days: ____

Number of days/weeks your child was in the hospital after delivery: _____

Developmental Milestones (months):

_____ Sat up _____ Walked _____ First words (3 words or more)
_____ Crawled _____ Bowel trained _____ Bladder trained (day)
_____ Bladder trained (night)

Does your child have ongoing bladder or bowel accidents: Yes / No

Was there anything in the first three years of your child's life that you thought might affect growth, development, or school success? _____

_____

Previous Illnesses (Circle all that apply):

High fevers	Allergies	Ear Tubes	Recurrent ear infections
Poor Growth	Surgeries	Meningitis	Seizures or staring spells
Breathing problems	Hearing or vision problems		

Please Describe: _____

_____

Any overnight medical hospitalizations? Yes / No If yes, please describe: _____

_____

Behavior Problems during early childhood *(Circle all that apply):*

Hyperactive	Stiff when held	Difficult to calm	Aggressive
Severe separation anxiety	Solitary play	Overly sensitive to sound/touch	
Extreme tantrums	Unusual motor behaviors		

Has your child ever had a serious hit to the head/Concussion or other brain injury?
Yes / No
How many times? _____ At what age(s)? _____
Did your child ever have a loss of consciousness (been knocked out)? Yes / No
How many times? _____ At what age(s)? _____
Additional information: _____

_____

_____

CURRENT MEDICAL INFORMATION

Height: _____ Weight: _____ Past or current medical problems: _____

_____

Does your child require glasses or contact lenses? Yes / No

Is their vision fully corrected with glasses/contact lenses? Yes / No

Does your child have a hearing impairment? Yes / No Hearing aid? Yes / No

Does your child have difficulty falling asleep? Yes / No Staying asleep? Yes / No

Typical bedtime: _____

Typically awake at: _____

Hours of sleep per night? _____

History of sleep study? Yes / No

Tonsils and/or adenoids removed? Yes / No Sleep better after? Yes / No

---

Does your child have problems with eating or appetite? Circle all that apply:

Recent weight gain/loss Binge eating Unaware of hunger or being full

Picky eater Hiding/hoarding food Appetite changes

Chronically hungry Foods rejected based on texture and/or appearance

Has your child had treatment for a psychological problem? Yes / No

When? _____ Type of treatment: *(circle all that apply)*

Individual Therapy Family Therapy Group Therapy Hospitalization Residential Care

What for? _____

Does your child take medications for behavioral/emotional problems? Yes / No

At what age did your child begin taking medications? ____ Prescribing Doctor _____

What medications has your child taken in the past? _____

Current Medications: _____

_____

_____

_____

Is your child currently receiving therapy (individual, family or group)? Yes / No

If Yes, with whom? _____

Has your child ever hurt themselves on purpose? Yes / No How? _____

Has your child ever threatened to hurt themselves? Yes / No

SUBSTANCE USE/ABUSE HISTORY

Has your child ever tried/used *(Circle all that apply)*:

Meth	Cocaine/crack	Gas/inhalants	Pain pills/sedatives	Marijuana
Mushrooms	Spice	LSD	Ecstasy	Alcohol

Other: _____

FAMILY HISTORY *(family defined as siblings, parents, grandparents aunts/uncles and first cousins)*

Condition	**Relation**
Learning Problems	_____
Depression/Bipolar Disorder	_____
Alcoholism/Drug Addiction	_____
Epilepsy	_____
Autism Spectrum Disorders	_____
Hyperactivity	_____
Anxiety	_____
Speech Delay	_____
Tic or nervous behaviors	_____
Psychiatric Hospitalization	_____
Other	_____

SCHOOL HISTORY

Current School: _____ **Grade:** _____ **Teacher:** _____

Previous schools attended (include preschool and grades)

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Does your child have a current IEP or 504? Yes / No

Classification?

☐ Specific learning disability (SLD) ☐ Speech/language disorder

☐ Emotionally disturbed (ED or SED) ☐ Other health impaired (OHI)

☐ Educational Autism ☐ Early Childhood developmental delay (ECDD)

☐ Intellectual disability ☐ Traumatic Brain Injury

What services and/or accommodations does your child receive?_____

_____

Has your child ever repeated a grade? Yes / No What grade(s): _____

Was your child ever suspended or expelled? Yes / No How many times? _____

Has your child's teacher(s) reported any of the problems below? (*Circle all that apply)*

Social problems	Attention/concentration	Learning/academic
Hyperactivity	Daydreaming	Aggression
Behavior problems	Not following directions	Poor memory
Distractibility	Poor handwriting	Problems with peer relationships

Time your child spends on homework each day _____ (hours)

Time you spend helping _____ (hours)

Comments about school: _____

_____

Does your child participate in sports or other recreational activities? Yes / No

If so, what are they?_____

Is your family/child involved in any litigation or legal proceedings with the following?

☐ Worker's Compensation ☐ Divorce ☐ Custody

☐ Personal injury ☐ DFYS/OCS

BEHAVIORAL HISTORY:

Please circle any of the following that concern you about your child:

Disobedience	Whining	Poor self/body awareness
Nightmares	Clumsiness	Immature/atypical play
Memory Problems	Moodiness	Verbal Communication
Difficulty sleeping	Headaches	Comprehension
Low self-esteem	Stomach aches	Judgement/Safety Issues
Frequent crying	Lack of friends	Rigid/ritualized behaviors
Dawdling	Unacceptable friends	Attachment
Disorganization	Stealing	Lack of remorse/empathy
Excessive screen time	Hitting	Arguing
Tantrums	Sexual behavior	Lying
Substance abuse	Sensory processing	Destroy property
Sexual or physical abuse		

When does your child need to be disciplined? _____

_____

_____

What do you do? _____

_____

_____

How does your child respond? _____

_____

_____

FAMILY ACTIVITIES

What does your child like to do? _____

What do you enjoy doing with your child? _____

What are your child's strong points? _____

What does your family do together? _____

How often do you read to your child? _____

How often does your child read alone? _____

How much screen time does your child have on a typical day? _____

On a typical weekend day? _____

What computer software/Apps do you have for your child? _____

Does your child have a best friend? Yes / No

Does your child play with a consistent group of children in school? Yes / No

In your neighborhood? Yes / No

What problem(s) does your child have in getting along with friends? _____

_____

What problem(s) does your child have in getting along with siblings? _____

What are your child's chores? _____

What problems are there getting them done? _____

ADDITIONAL INFORMATION

Please include any other information that will help us better understand your child.

_____

_____

_____

_____

_____

FULLER DIAGNOSTICS, LLC

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

I authorize FULLER DIAGNOSTICS, LLC to release/obtain information as stated below from the patient health information record:

Release To/From: Name:_____ Phone:_____ Fax: _____

Address:_____ Email:_____

Release To/From: Name: Fuller Diagnostics, LLC. Phone: (907)561-0552 Fax: (907)561-0562

Address: 2600 Denali Street Suite 450, Anchorage, AK 99503 Email: info@fulleralaska.com

Information to be Released via: ☐ Email ☐ Fax ☐ Mail ☐ Verbal

Email/Fax Number/ Mailing Address: _____

Information to be Released: _____

Dates of service for information requested:

Beginning: _____ thru _____

Purpose of Release:

☐ Continuing care ☐ Copies for own use ☐ Transfer to another provider

☐ Legal ☐ Coordination with School ☐ Other: _____

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time. I understand that once the information has been released according to the terms of this Authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This Authorization will expire one year from the date signed below unless another date or event is entered here _____.

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐Mental Health Treatment ☐Sexually Transmitted Diseases ☐AIDS/HIV Treatment

☐Alcohol/Drug Abuse Treatment

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

To be filled out by FULLER DIAGNOSTICS, LLC:

Date Records were released: _____

Signature of Employee: _____