Dear New Patient,

Thank you for choosing Kent Psychological Associates, LLC as your mental health care provider. If for any reason you are unable to keep your appointment, kindly call 24 hours in advance.

We ask that you please complete the following:

- Complete the paperwork attached to this letter and bring it with you for your first appointment.
- Arrive 20 minutes early for your appointment-there will be additional paperwork to do here.
- Please be prepared to pay your co-pay at the time of each visit.
- Call your insurance, verifying your out-patient mental health coverage including:
  - What is your annual deductible (amount that you are required to pay before your benefits start each year)? Deductible amounts almost always start over on Jan. 1 of each new year.
  - What is your office co-pay (amount you are required to pay at each office visit)?
  - The number of visits allowed per year (out-patient mental health code 90834)?
  - If your visits will be covered by an Employee Assistance Program, please contact your Human Resources Dept. for your referral/authorization.
  - Is a referral required from your primary care physician before your first visit?

If you have concerns or questions you can reach our business office Monday through Friday between the hours of 9 a.m. and 4 p.m. We look forward to meeting you.

190 Currie Hall Parkway, Kent, Ohio 44240 • Office: 330.673.5812 Fax: 330.673.7162 • www.kentpsychological.com

Kent Psychological Associates, LLC

DATE _____

CHILD BACKGROUND INFORMATION

NAME _____ DOB _____ AGE _____ SSN ____-____-_____
GENDER _____ PRONOUNS: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ ze/hir/hirs
ADDRESS _____ CITY _____ ZIP _____
PHONE (H) (____) _____ PARENTS WORK (____) _____
REFERRED BY: _____
EMERGENCY CONTACT: _____ PHONE(____) _____ RELATION _____
FAMILY PHYSICIAN: _____ PHONE (____) _____
REFERRED BY: _____

PERSON FILLING OUT THIS FORM: (CIRCLE ONE)
MOTHER FATHER STEPMOTHER STEPFATHER GUARDIAN FOSTER PARENT

HOUSEHOLD INFORMATION *Who lives in the home?*

NAME	RELATIONSHIP	AGE	SEX	OCCUPATION

DEVELOPMENTAL HISTORY:

Please check any which are problems in the home of the child:

____Frequent moves
____Parents divorce
____Parents remarriage
____Parents separated
____Family illness
____Personal illness
____Alcohol/Drugs
____Legal problems
____Parent conflict
____Parent job loss
____Financial stress
____Learning problems
____Death of family member
____Physical abuse/Neglect
____Sexual abuse
____Domestic violence
____Emotional problems
____Other

Help clarify a problem the child might have had effecting their development to age 18. *Check those that apply.*

____Premature birth
____Nervous
____Eating problems
____Learning difficulties
____Poor coordination
____Visual difficulties
____"Worry wart"
____ Overweight
____ Fighting
____Development delays
____Avoiding others
____Fidgety/restless
____Talking/refusing
____Speech problems
____Hearing/ear problems
____Fear leaving home
____ Leaving a loved one
____ Small for age
____Picked on
____Trouble with police
____Bedwetting
____Head injury
____Frequent tantrums
____Sleepwalking/Nightmares
____School behavior
____Behavioral problems
____Toilet training
____ Shy
____Repeated grade
____Engages in dangerous behavior
____Birth Defect
____Abuse/neglect
____Bad dreams
____School behavior
____Feeling rejected
____Strong willed
____Few friends/loner
____Ran away from home
____Did not like to be held as a baby

How would you rate your child's present relationship with the following? *If it does not apply put N/A.*

Father	____Good	____Fair	____Poor	____Problem for you	____N/A
Mother	____Good	____Fair	____Poor	____Problem for you	____N/A
Stepfather	____Good	____Fair	____Poor	____Problem for you	____N/A
Stepmother	____Good	____Fair	____Poor	____Problem for you	____N/A
Brother	____Good	____Fair	____Poor	____Problem for you	____N/A
Sister	____Good	____Fair	____Poor	____Problem for you	____N/A
Friends	____Good	____Fair	____Poor	____Problem for you	____N/A
Teacher	____Good	____Fair	____Poor	____Problem for you	____N/A

EDUCATIONAL HISTORY

School _____ Location _____
Is your child in a special education class? yes ____ no ____ What kind _____
Does you child received special tutoring or therapy in school? yes ____ no ____

OCCUPATIONAL HISTORY

Is your child presently employed? ___ yes ___ no Type of work _____ How long? _____

PRIOR MENTAL HEALTH HISTORY

Has your child ever had prior mental health treatment? ____yes ____no (If no, skip)
When _____ Who _____
Was this person a: ____Psychiatrist ____Psychologist ____Clinical social worker ____Clinical Counselor
____Minister ____Other
Has your child ever been hospitalized for emotional problems? ____yes ____no (If no, skip)
When _____ Where _____

ALCOHOL/DRUG HISTORY

Does your child have a history of alcohol/drug abuse? ____yes ____no (If no, skip)
Has your child ever been hospitalized for drug/alcohol abuse? ____yes ____no
When _____ Where _____

MEDICAL HISTORY

Date of last physical exam _____ Family physician _____
Where located? _____
Are immunizations up to date? ____yes ____no

Does your child have any special problems with hearing, speech or vision? ____yes ____no Please explain:
_____

_____
Is your child taking any medications? ____yes ____no
If yes, please list: _____

_____

Describe any side effects of medication(s) _____

_____

Please list any allergies, serious illnesses, injuries or surgeries? _____
_____

Place an X in the left column if this condition exists. In the right column write self, father, mother, brother, sister, aunt, uncle, etc.

____Alcoholism _____
____Allergies _____
____ Obesity _____
____ Degenerative dis. _____
____ Mental health probs. _____
____ Bi-Polar _____
____Schizophrenia _____
____ Developmental _____
Disabilites
____Attention Deficit _____

____Cancer _____
____Diabetes _____
____Epilepsy _____
____High blood press. _____
____Heart trouble _____
____Suicide _____
____Other _____
____Depression _____
____Anxiety _____

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now		Past/Now		Past/Now	
___	___ Academic underachievement	___	___ Anxiety	___	___ Anger Outbursts
___	___ Argumentative	___	___ Asthma	___	___ Baby Talk
___	___ Bedwetting	___	___ Body aches	___	___ Broken bones
___	___ Broken sleep	___	___ Constipation	___	___ Convulsions
___	___ Cries easily	___	___ Demands for attention	___	___ Depression
___	___ Difficulty going/staying asleep	___	___ Difficulty concentrating	___	___ Dieting
___	___ Dizziness	___	___ Eats non-edibles	___	___ Emotional upsets
___	___ Easily distracted	___	___Encopresis (soiling clothes)	___	___ Encephalitis
___	___ Excessive sexual interest	___	___ Fainting spells	___	___ Fatigue
___	___ Food craving for sweets	___	___ Frequent sex play w/ other children		
___	___ Headaches	___	___ Hears voices	___	___ High fever
___	___ Hospitalization(s)	___	___ Immature for age	___	___ Injuries to head
___	___ Itchy skin	___	___ Leg cramps	___	___ Loose bowel/gas often
___	___ Loses temper easily	___	___ Loss of consciousness	___	___ Lying
___	___ Masturbation	___	___ Memory problems	___	___ Mental condition
___	___ Moody often	___	___ Much sweating	___	___ Muscle twitching
___	___ Nervousness	___	___ Nightmares	___	___ Operation(s)
___	___ Over dependent	___	___ Overeating	___	___ Perfectionistic
___	___ Poor appetite	___	___ Poor nutrition	___	___ Rebellious
___	___ Sleepwalking	___	___ Stealing	___	___ Stomach upsets
___	___ Suicide attempt	___	___ Temper tantrum	___	___ Thumb sucking
___	___ Vomiting	___	___ Worries, insecurity		

CURRENT SOURCES OF STRESS

Briefly describe your child's current difficulties. _____

_____

_____

How long has this problem been a concern to you? _____

_____

Describe any unusual fears, habits, or behaviors. _____

_____

What is the main goal you wish to attain in seeking services for your child? _____

_____

_____

ADDITIONAL INFORMATION

Please add any special information you feel might be helpful in assisting in your child's treatment.

_____

_____

_____

Your signature below indicates that you understand the questions and could ask for assistance if needed.

_____ _____

Signature of parent or guardian Date

Date:_____ Name/ID:_____

RCADS-25

Please put a circle around the word that shows how often each of these things happens to you. There are no right or wrong answers.

1. I feel sad or empty	Never	Sometimes	Often	Always
2. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
3. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
4. Nothing is much fun anymore	Never	Sometimes	Often	Always
5. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
6. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
7. I worry what other people think of me	Never	Sometimes	Often	Always
8. I have trouble sleeping	Never	Sometimes	Often	Always
9. I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
10. I have problems with my appetite	Never	Sometimes	Often	Always
11. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
12. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
13. I have no energy for things	Never	Sometimes	Often	Always
14. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
15. I cannot think clearly	Never	Sometimes	Often	Always
16. I feel worthless	Never	Sometimes	Often	Always
17. I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
18. I think about death	Never	Sometimes	Often	Always
19. I feel like I don't want to move	Never	Sometimes	Often	Always
20. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
23. I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
24. I feel restless	Never	Sometimes	Often	Always
25. I worry that something bad will happen to me	Never	Sometimes	Often	Always

Date: _____ Name/ID: _____

RCADS-P-25 Relationship to Child: _____

Please put a circle around the word that shows how often each of these things happens for your child.

1. My child feels sad or empty	Never	Sometimes	Often	Always
2. My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
3. My child feels afraid of being alone at home	Never	Sometimes	Often	Always
4. Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
5. My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
6. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
7. My child worries what other people think of him/her	Never	Sometimes	Often	Always
8. My child has trouble sleeping	Never	Sometimes	Often	Always
9. My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
10. My child has problems with his/her appetite	Never	Sometimes	Often	Always
11. My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
12. My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
13. My child has no energy for things	Never	Sometimes	Often	Always
14. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
15. My child cannot think clearly	Never	Sometimes	Often	Always
16. My child feels worthless	Never	Sometimes	Often	Always
17. My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
18. My child thinks about death	Never	Sometimes	Often	Always
19. My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
20. My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
21. My child is tired a lot	Never	Sometimes	Often	Always
22. My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
23. My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
24. My child feels restless	Never	Sometimes	Often	Always
25. My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always

KENT PSYCHOLOGICAL ASSOCIATES

Treatment of Minor Children

The initial appointment will be for the parental/legal guardian and the child. If you are divorced parents, we ask that you provide us with your court paperwork that indicates the custodianship agreement. If you are not the parent and are the legal guardian, please bring your court approved guardianship papers. If this documentation is not provided at the first appointment, or **if someone other than the parent or legal guardian brings the child to the first appointment, the appointment will be rescheduled.**

Per our ethics boards, it is best practice to inform both parents when a minor is in treatment. We ask that the parent who is consenting to treatment provide the other parent's information. The clinician seeing your child will attempt to reach out to inform them that their child is in treatment and to gather any further necessary information for the assessment and treatment of your child. Input from both parents is preferable as it increases the likelihood that both parents will view the therapist as a neutral party, and it helps to create a safe, balanced treatment environment for the child. Parents often have very divergent views about their child's problems and about what is in their child's best interests. It is ideal for both parents to meet with the therapist together to discuss their concerns about the child, so that both participate in formulating the child's treatment plan and goals.

*See ORC 4757-02 B(1-5) and 5122.04 A,B for Ohio laws regarding treatment of minors

Divorced or Separated Parents

It is not ethical for a treating mental health professional to offer an expert opinion regarding custody and visitation issues in court. Your child's therapist is a treating professional who is an expert on your child's mental health diagnosis and treatment. Any expert opinion regarding custody and visitation matters is properly performed by a court-appointed examining professional, who conducts a balanced child and parent evaluation separate from the child's treatment needs. In addition, a therapist's involvement in parental disputes creates potentially serious role conflicts that negatively impact a child's treatment.

Regarding Fees

With respect to payment for psychological services rendered to a child with divorced or separated parents, we have no standing in court actions which allocate financial responsibility for the child's health needs, and we are not in a position to enforce existing court orders. We prefer, when possible, that both parents attend the first session with the child to sign required financial agreement forms. If the parents do not initially appear together and concur on an arrangement for sharing these expenses, our policy is that the parent that brings the child to session will pay any applicable copay.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

KENT

Dear Client: Please list all of your medications below or provide the office with a copy of your current medication list. Many medications have side effects. It is important for your clinician to be aware of all of your medications (prescription, over-the-counter, and supplements) in order to determine if your medications may be contributing to any of the symptoms you are experiencing.

Medication List

Client name: _____ DOB: _____

Medication	Dosage	Frequency	Date Added/Discontinued *This column office use only.*

190 Currie Hall Parkway, Kent, Ohio 44240 • Office: 330.673.5812 Fax: 330.673.7162 • www.kentpsychological.com

Authorization for Release of Health Information Pursuant to HIPAA
Kent Psychological Associates, LLC

Dear Client: Your health insurance requires us to request consent to coordinate care with your primary care provider. We consider coordination of care an important part of providing high quality care. Please complete the following authorization that allows us to exchange information with your primary care provider. If you are uncomfortable with such exchange of information, please check the box below indicating your refusal to allow us to exchange information with your primary care provider.

☐ I prefer NOT to allow exchange of information between Kent Psychological Assoc. and my primary care provider.
☐ I do not have a primary care provider.

CLIENT _____ DOB _____ Last four SSN # _____

I THE UNDERSIGNED AUTHORIZE THE EXCHANGE OF INFORMATION BETWEEN:

My Behavioral Health Provider:
Kent Psychological Assoc. LLC
190 Currie Hall Parkway, Suite A
Kent, Ohio 44240
Phone: 330-673-5812 Fax: 330-673-7162

⇦ AND ⇨

My Primary Care Provider:
Name: _____
Street: _____
City: _____ State: Zip: _____
Phone: _____ Fax: _____

NFORMATION TO BE RELEASED BY KENT PSYCHOLOGICAL ASSOCIATES INCLUDES THE FOLLOWING:

)iagnosis
:ecommendations
)ischarge Summary
Service/Treatment Plan
Summary of Treatment

:EQUESTED INFORMATION FROM PRIMARY CARE PROVIDER INCLUDES THE FOLLOWING:

listory and Physical
ervice/Treatment Plan
'reatment/Office Visit Notes
Medical Evaluation
Current Medications/Medication History

'HE EXCHANGE OF INFORMATION IS FOR THE SPECIFIC PURPOSE OF:
nsuring proper coordination of care with your primary care provider.

IDERSTAND:

1. This authorization will expire on _____ (date, event, or condition not to exceed 1 year). If not dated, then this authorization will automatically expire 1 year from the date of signing.
2. I may revoke this authorization at any time by signing the "Revocation of Authorization" portion of this form, below, and providing a copy to the releasing party or by providing any other form of written revocation to the releasing party. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.
3. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
4. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.

xpressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of records signation above, which may include treatment for mental illness (ORC5122.31), alcohol/drug abuse (42 CRF Part 2), and/or Human Immune Deficiency irus (HIV) Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC3701.24.3).

_____ _____ _____
gnature of Client/Parent/Guardian Date Relationship to Client

EVOCATION OF CONSENT:
hereby withdraw my consent for any further release of information as of the date indicated below:

_____ _____ _____
gnature of Client/Parent/Guardian Date Relationship to Client

HE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further sure of this information except with the specific written consent of the person to whom it pertains. If you have received this information in error please / Kent Psychological Associates, LLC immediately.

KENT PSYCHOLOGICAL ASSOCIATES

Client Name: _____

DOB: _____

☐ I give my permission for Kent Psychological Associates to call and if necessary leave a reminder message for upcoming appointments.

I would like reminders by (choose one):

☐ Text to: _____

☐ Phone call to: _____

☐ Email to: _____

☐ I do not want reminder calls.

Reminder calls are a courtesy only. Any missed appointments remain the client's responsibility. Reminders are made the day before the appointment including Sundays.

_____ _____

Client/Guardian Signature Date

For your information:
Phone calls will come from 949-298-4668
Texts will come from 695-29
Emails will come from ValantApptReminder@reminderXchange.com
(You cannot reply back to these numbers.)

KENT PSYCHOLOGICAL ASSOCIATES

CRISIS RESOURCES

24 HOUR CRISIS HOTLINES

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555
- Town Hall II- (330) 678-HELP
- Akron Children's Hospital Psychiatric Intake Response Center (PIRC) (330) 543-7472
- Crisis Text Line: Text "4HOPE" to 741741 within Ohio. Free and confidential.

EMERGENCY:

- 911

PSYCHIATRIC EMERGENCY SERVICES (WALK-IN):

Portage County:

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555

Summit County:

- Summa Akron City Hospital Emergency Room- (330) 375-3361
- Akron General Medical Center Emergency Room- (330) 344-6611
- Akron Children's Hospital Behavioral Health Emergency Service - (330) 543-7472

ANSWERING SERVICE:

- Kent Psychological Associates- (330) 376-6801

  (Answering service will take your information for one of our clinicians to call you back.)