Informed Consent

Referral Source: You have been referred for a neuropsychological assessment (i.e., evaluation of your (or your child's) thinking abilities) by: _____(name of referral source).

Nature and Purpose of Assessment: The goal of neuropsychological assessment is to determine if any developmental influences exist or changes have occurred in your (or your child's) attention, sensori-motor development, memory, language, school achievement, problem solving, or other cognitive functions. A neuropsychological assessment may point to changes in brain function and suggest possible methods and treatments for rehabilitation. In addition to an interview where we will be asking you (or your child) questions about your background and current medical symptoms we may be using different techniques and standardized tests including but not limited to asking questions about your (or your child's) knowledge of certain topics, mood states, reading, drawing figures and shapes, listening to recorded audio files, viewing printed material, and manipulating objects. Other specific goals and anticipated uses of the information we gather today includes the following (check one):

- ☐ Assistance with medication and treatment planning
- ☐ Assistance with psychological, psychotherapeutic, behavioral intervention or counseling recommendations
- ☐ Assistance with educational recommendations, accommodations or placements
- ☐ Vocational recommendations
- ☐ Other _____

Foreseeable Risks, Discomforts, and Benefits: For some individuals assessments can cause fatigue, frustration, and anxiousness. Other anticipated risks, discomforts, and benefits associated with this assessment includes the following:

- Patients may disagree with the results.
- There is no guarantee evidence will be found to support your intended inquiry. For example, someone pursuing academic or vocational accommodations may not be determined to possess the disability in question.

Fees and Time Commitment: Assessments may take several hours or more of face-to-face testing and several additional hours for scoring, interpretation, and report preparation. This evaluation is estimated to take approximately ____6_____ hours of face-to-face assessment time. Though the fees may be covered by insurance, patients are responsible for any and all fees for the assessment as discussed in the payment contract.

Limits of Confidentiality: Information obtained during assessments is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults; and c) issuance of a subpoena from a court of law. Other foreseeable limits to confidentiality for this assessment include:

- It is implied and assumed by signing a release of information that the referral source will receive a complete unaltered written report documenting clinical information supporting the referral question.
- Often other relevant, sometimes sensitive information, for example substance use or risky behavior, will be included in the complete report.
- Children under the age of 18 will defer to their parents legal rights to the assessment information.

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian or Authorized Surrogate (if applicable) Date

_____ _____

Witness Signature Date

Laura Jansons, Psy.D.

Licensed Clinical Psychologist

3800 N. Wilke Rd. Suite 160 ◆ Arlington Heights, IL 60004

224-636-6333 ◆ 847-342-0378 (Fax)

PATIENT INFORMATION FORM

Date: _____

First Name: _____ Last Name: _____

Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Cell Phone: _____

Email: _____ Social Security #: _____

Birth Date: _____/_____/_____ Age: _____ Male ____ Female _____

Occupation: _____ Employer: _____

Employer Address: _____
Street *City* *State* *Zip*

Work Phone: _____

Person Responsible For Account If Other Than Patient

Name: _____ Relationship To Patient: _____

Date of Birth: _____

Address: _____
Street *City* *State* *Zip*

Phone: _____ email: _____

Occupation/Employer: _____

Employer Address: _____
Street *City* *State* *Zip*

Patient Was Referred By: _____

Patient's Physician: _____Phone : _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

Dr. Laura Jansons, Licensed Clinical Psychologist 3800 N Wilke Suite 160
Arlington Heights, IL 60004 224-636-6333 to

Release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ Dr. John Goldin-Mertdogan Institute for Personal Development
Fax: Morris: 815-941-0308/Romeoville (630) 226-9475

☐ Dr. Jonathan Gamze 3800 N Wilke Suite 160 Arlington Heights, IL 60004; 847-342-3030

☐ Dr. Douglas Neal Psychological Specialties 185 Heritage Dr, Crystal Lake, IL 60014; P:(815) 477-4727
F: (815) 356-8779

☐ Crossroads Counseling 1802 N. Division Street ~ Suite 509 Morris, IL 60450;
Phone: 815-941-3882 Fax: 815-941-3884

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ Psychological Evaluation including: interview data, history, psychological and neuropsychological findings, recommendations and conclusions.

☐ Other: _____

Regarding medical/psychological care given from dates: _____

The purpose of this release of information is: ☐ continuation of care. ☐ Psychological/Neuropsychological Testing

x Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Laura Jansons, Psy.D.

Licensed Clinical Psychologist

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INSURANCE INFORMATION FORM

All Information Must Be Completed And Form Signed In Order To Submit Charges To Blue Cross Blue Shield

PRIMARY INSURANCE (Note: Dr. Jansons is in network only with BCBS therefore secondary insurance is never billed)

Policy Holder's Name: _____

Address: _____
Street *City* *State* *Zip*

Phone: _____ Relationship To Patient: _____

Policy Holder's Birth Date: ____/____/____ Policy Holder's SSN: _____-_____-_____

Employer Of Policy Holder: _____

Employer Street Address: _____

City/State/Zip: _____

Insurance Company Name: Blue Cross Blue Shield

City/State/Zip: _____

Phone: _____

Insurance ID#: _____ Group #: _____

I/We authorize the release of any information necessary to process this claim. I/We also authorize the payment of benefits directly to Dr. Laura Jansons. It is understood that the undersigned has the responsibility for payment of services. Assignment of benefits does not release the undersigned from responsibility for payment.

SIGNATURE: _____ DATE: _____
Insured Person And/Or Patient

SIGNATURE: _____ DATE: _____
Patient, If Age 12 Or Older

Note: These questions are for both adult and child testing patients. Adult patients, please complete what is known.

DEVELOPMENTAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Birth date: _____ AGE: _____

Current School/Job: _____ Grade: _____

Person completing this: _____ Relationship _____

NATURE OF PROBLEM

Describe the problem or desired outcome for therapy or assessment:

PRENATAL HISTORY

How was your (or child's mother's) health during pregnancy?
Good ____(1) Fair _____(3) Poor _____(5) DK _____

Did you (or his/her mother) have any illness or complications during pregnancy with this child? What type?

How old were you (or child's mother) when (s)he was born? _____

Do you recall any of the following substances or medications being used during pregnancy?

Beer or wine ____ How many times? _____
Coffee or other caffeine (Cokes, etc.) _____ How many times? _____
Hard liquor? _____ How many times? _____
Cigarettes? _____ How many times? _____

Did mother ingest any of the following substances?

____ Valium (Librium, Xanax)
____ Tranquilizers
____ Anti-seizure medications (e.g., Dilantin)
____ Antibiotics (for viral infections)
____ Sleeping pills ____ Other (please specify) _____

Was there toxemia or eclampsia? No ___ (0) Yes ___(1) DK ___

Was there an Rh factor incompatibility? No ___ (0) Yes ___(1) DK ___

Was the pregnancy planned or unplanned? Wanted or unwanted?

Was there anything unusual about the delivery or birth?

Was (s)he born on schedule? If not how early or late?
Early _____ How many weeks total _____
Full Term 9 mos. ____
Late _____

What was the duration of labor?

Were you given any drugs to ease the pain during labor?

Name: _____ No ____
Yes____
DK____

Were there any signs of fetal distress during labor or birth? No ____
Yes____
DK____

Was the delivery: Normal? No_____ Yes____
Breech? No_____ Yes____
Caesarian? No____ Yes____
Forceps? No_____ Yes____
Induced? No_____ Yes____

What was the child's birth weight?_____

Were there any health complications following birth? Please describe:
No ____
Yes ____

POSTNATAL PERIOD AND INFANCY

Were there early infancy feeding problems? No____
Yes ____

Was the child colicky? No ____
Yes____

Were there early infancy sleep pattern difficulties? What type?

No____
Yes____

Were there problems with the infant's alertness? If so please describe.

No____
Yes____

Did the child experience any health problems during infancy? What type?

Did the child have any congenital problems? Please describe. No____
Yes ____

Was the child an easy baby? By that I mean did (s)he cry a lot? Did (s)he follow a schedule fairly well?

Very easy ____
Easy____
Average____
Difficult____
Very Difficult____

How did the baby behave with other people?
More sociable than average ____
Average sociability ____
Less sociable than average ____

When (s)he wanted something, how insistent was (s)he?
Very insistent ____
Pretty insistent ____
Average ____
Not very insistent ____
Not at all insistent____

How would you rate the activity level of the child as an infant / toddler?
Very active____
Active____
Average____
Less active____
Not active____

DEVELOPMENTAL MILESTONES

At what age did (s)he sit up?
3-6 mos. ____
7-9 mos. ____
DK ____

At what age did (s)he crawl?
6-12 mos. ____
13-18 mos. ____
Over 18 mos. ____
DK____

At what age did (s)he walk?
Under 1 yr____
1-2 yr____
2-3 yr____
DK____

At what age did (s)he speak single words (other than mama or dada)? _____

At what age did (s)he string two or more words together? _____

At what age was (s)he toilet trained (bladder control)? _____

At what age was (s)he toilet trained (bowel control)? _____

Approximately how much time did toilet training take from onset to completion? _____

CURRENT HEALTH STATUS:

How would you describe his/her health?
Very Good ____
Good ____
Fair ____
Poor ____
Very Poor ____

How is his/her hearing?
Good ____
Fair ____
Poor ____

How is his/her vision?
Good ____
Fair ____
Poor ____

How is his/her gross motor coordination (large muscle development – walking, running, jumping)?
Good ____
Fair ____
Poor ____

How is his/her fine motor coordination (small muscle development – finger/hand)?
Good ____
Fair ____
Poor ____

How is his/her speech articulation (speech and language development)?
Good ____
Fair ____
Poor ____

Has (s)he had any chronic health problems (e.g., asthma, diabetes, heart condition)?
No ____
Yes ____
If yes, please specify: _____

When was the onset of any chronic illness?

Which of the following illnesses has the child had?
Mumps ____
Chicken Pox ____
Measles ____
Whooping Cough____
Scarlet Fever ____
Pneumonia ____
Encephalitis ____
Otitis Media ____
Lead Poisoning ____
Seizures ____

Other diseases (specify)
_____

Has (s)he had any accidents resulting in the following? Please give date and cause of injury.
Broken Bones ____
Severe Lacerations____
Head Injury____
Severe Bruises____
Stomach Pumped____
Eye Injured____

Lost Teeth____
Sutures____
Other (specify)
_____

How many accidents? Please give age or date of injury.

Please provide age or date of surgery for any of the following conditions?
Tonsillitis____
Adenoids____
Hernia____
Appendicitis____
Eye, ear, nose & throat____.
Digestive disorder____
Urinary Tract____
Leg or arm____
Burns____
Other____

How many times did surgeries take place? _____

Duration of Hospitalization? _____

Is there any suspicion of alcohol or drug use? _____

Is there any history of physical/sexual abuse?_____

Does (s)he have any problems sleeping?
None____
Difficulty falling asleep____
Sleep continuity disturbance____
Early morning awakening____

Is (s)he a restless sleeper? _____

Does (s)he have bladder control problems at night?
If yes, how often? _____If yes, was (s)he ever continent? ____ During the day?_____

Does (s)he have bowel control problems at night?

If yes, how often? _____If yes, was (s)he ever continent? ____ During the day? _____

Does (s)he have any appetite control problems?
Overeats____
Average____
Under eats____

Please indicate if prescribed any of the following:) 0 = No; 1 = Yes) (Duration Coded in months)

Ritalin____	Duration of use____	
Concerta ____	Duration of use____	
Adderall ____	Duration of use____	
Strattera ____	Duration of use____	
Dexedrine____	Duration of use____	
Cylert____	Duration of use____	
Mood Stabilizer ____	Duration of use____	Name: _____
Antidepressant ____	Duration of use____	Name: _____
Antianxiety ____	Duration of use____	Name: _____
Tranquilizers____	Duration of use____	
Anticonvulsants____	Duration of use____	

Other prescription drugs:

Type_____	Duration of us ____
Type_____	Duration of us ____

Has (s)he ever had any of the following forms of psychological treatment? If so, please elaborate:

Individual psychotherapy____	Duration of therapy____
Group psychotherapy____	Duration of therapy____
Family therapy with child____	Duration of therapy____
Inpatient evaluation____	Type of evaluation: _____
Residential treatment____	Duration of placement____

Is there any self-care, feeding, dressing or grooming concerns?

PREVIOUS ATTEMPTS TO IMPROVE BEHAVIOR/OUTCOME:

What strategies have been implemented to address these problems or goals. (Check which have been successful)

Verbal reprimands____
Time out (isolation) ____
Removal or privileges____
Rewards____
Physical punishment____
Acquiescence to child____
Avoidance of child____
Other_____

On the average, what percentage of the time does (s)he comply with initial commands?
1-20%____

20-40%____
40-60%____
60-80%____
80-100%____

On the average, what percentage of the time does (s)he eventually comply with initial commands?
1-20%____
20-40%____
40-60%____
60-80%____
80-100%____

To what extent are you and your spouse consistent with respect to disciplinary strategies.
Most of the time____
Some of the time____
None of the time____

Have any of the following stress events occurred within the past 12 months?
Parents divorced or separated____
Family accident or illness____
Death in family____
Parent changed job____
Changed schools____
Family moved____
Family financial problems____
Other (please specify) ____

SCHOOL HISTORY

GRADE: _____ SCHOOL: _____TEACHER'S NAME: _____

SCHOOL COUNSELOR: _____ SCHOOL NURSE: _____

NUMBER OF SCHOOLS ATTENDED? _____

Please summarize the general school progress (e.g., academic, social, testing) within each of these grade levels. Please describe strengths as well as problem areas or weaknesses in cognitive/academic skills and behavioral control.

Preschool

Kindergarten

Grades 1 through 3

Grades 4 through 6

Grades 7 through 12

Has the (s)he ever been in any type of special educational program, and, if so, how long?
Learning disabilities class____ Duration _____
Behavioral/emotional disorders class____ Duration _____
Speech and language therapy____ Duration _____
Other (please specify)_____

Has the (s)he ever been? (Please describe reasons and give brief details):
Suspended from school____
Number of Suspensions____
Expelled from school____
Number of expulsions____

Retained in grade____
Number of retentions ____

Have any other instructional modifications been attempted?
None____
Behavior modification program____
Daily/weekly report card____
Other (please specify) ____

Does she/he have any communication or auditory processing problems? Please explain:_____
_____

Does she/he have any visual processing or dyslexia type problems? Please explain:
_____
_____

Does she/he have difficulty with problem solving or comprehension?

SOCIAL HISTORY

How does (s)he get along with his/her brothers/sisters?
Doesn't have any____
Better than average____
Average____
Worse than average ____

How does (s)he get along with peers?
Easier than average____
Average____
Worse than average____
DK ____

On average, how long does (s)he keep friendships?
Less than 6 months____
6 months - 1 year____
More than 1 year____
DK____

SYMPTOMS & BEHAVIORS OBSERVED:

Which of the following are considered to be a significant problem at the present time?
(Please make an entry for every item with 0 = No; 1 = Yes)
Fidgets____
Difficulty remaining seated____
Easily distracted____
Difficulty waiting turn____
Often blurts out answers to questions before they are completed____
Difficulty following instructions____
Difficulty sustaining attention____
Shifts from one activity to another____
Difficulty playing quietly____
Often talks excessively____
Often interrupts or intrudes on others____
Often does not listen____
Often loses things____
Work and materials are frequently disorganized compared to others the same age ____
Does not anticipate consequences of failure to complete tasks ____
Has difficulty initiating tasks ____
Has difficulty completing tasks ____
Has difficulty inhibiting inappropriate behaviors or actions ____
Frequently impulsive or acts before thinking ____
Often engages in physically dangerous activities ____

When did these problems begin? (specify age)_____

Which of the following are considered to be a significant problem at the present time?
(0 = No; 1 = Yes)
Often loses temper____
Often argues with adults____
Often actively defies or refuses adult requests or rules. ____
Often deliberately does things that annoy other people____
Often blames others for own mistakes____
Often touchy or is easily annoyed by others____
Often angry or resentful____
Often spiteful or vindictive____
Often swears or uses obscene language____

When did these problems begin? (specify age) _____

Which of the following are considered to be a significant problem at the present time?
(0 = No; 1 = Yes)
Stolen without confrontation____
Run away from home overnight at least twice____
Lies often____

Deliberate fire setting____
Often truant____
Breaking and entering____
Destroyed others' property____
Cruel to animals____
Forced someone else into sexual activity____
Used a weapon in a fight____
Often initiates physical fights____
Stolen with confrontation____
Physically cruel to people____

When did these problems begin? (specify age) _____

Which of the following are considered to be a significant problem at the present time?
(Please make an entry for each item with 0 = No; 1 = Yes)
Unrealistic and persistent worry about possible harm to attachment figures____
Unrealistic and persistent worry that a calamitous event will separate her/him from attachment figures. ____
Persistent school refusal____
Persistent refusal to sleep alone____
Repeated nightmares regarding separation from caregivers ____
Somatic complaints or often not feeling well ____
Excessive distress in anticipation of separation from attachment figure____
Excessive distress when separated from home or attachment figures____
Unrealistic worry about future events____
Unrealistic worry about appropriateness of past behavior____
Unrealistic concern about competence____
Marked self-consciousness____
Excessive need for reassurance____
Marked inability to relax____

When did these problems begin? (Specify age) _____

Which of the following are considered to be a significant problem at the present time?
(0 = No; 1 = Yes)
Depressed or irritable mood most of day, nearly every day____
Diminished pleasure in activities____
Decrease or increase in appetite assoc. with possible failure to make weight gain____
Difficulty initiating sleep at bedtime taking more than 30 minutes typically ____
Difficulty waking in the morning, i.e., feeling groggy or drowsy for more than five minutes after getting up ____
Insomnia or inability to maintain adequate sleep during the night ____
Hypersomnia or sleeping too much or more than typically expected ____
Psychomotor agitation or retardation____
Low energy, fatigue or loss of energy at times ____
Feeling of worthlessness or excessive inappropriate guilt____

Makes statements of not feeling good about life or not wanting to be alive at times ____
Suicidal ideation indicating thoughts about taking ones own life _____
Suicidal attempt in the past (indicate date(s) or age(s) ____
Threatens others ____
Poor appetite or overeating____
Low self-esteem____
Poor concentration or difficulty making decisions____
Feelings of hopelessness____
Never without symptom for 2 mos. over a 1 yr period____

When did these problems begin? (specify age) _____

Which of the following symptoms have been exhibited in the past or present?
(Please make an entry for each item with 0 = No; 1 = Yes)
Stereotyped mannerisms____
Odd posture____
Excessive reaction to noise or fails to react to loud noise____
Overreacts to touch____
Compulsive rituals____ Obsessive verbal themes _____
Motor tics____ Vocals Tics____ Tourette's Disorder _____

Loose thinking (e.g. tangential ideas, circumstantial speech____
Odd fascinations _____
Strange ideas _____
Going from one idea to another without reason _____
Many ideas at once _____
Delusions _____
Paranoia or fear or suspicion of being watched or hurt that is not realistic _____
Hallucinations____ Visual? _____ Auditory?_____

Inflated sense of self in speech _____
Inflated sense of self in behavior and actions _____
Refuses to accept adult authority _____
Refuses or inability to take responsibility for behavior _____
Frequent or unusually severe "melt downs" _____
Difficulty remembering own behaviors _____
Disoriented, confused, staring, or "spacey"____
Incoherent speech (mumbles, jargon, repetitive phrases or words) ____

Excessive lability w/o reference to environment____
Explosive temper with minimal provocation____
Excessive clinging, attachment, or dependence on adults____
Unusual fears____
Strange aversions____

Which of the following symptoms have been exhibited in the past or present?
(Please make an entry for each item with 0 = No; 1 = Yes)

(cont.)
Panic attacks____
Excessively restrictive or bland affect____
Situationally inappropriate emotions____

Little or no interest in peers____
Significantly indiscreet remarks____
Initiates or terminates interaction inappropriately.____
Qualitatively abnormal social behavior____
High or specialized interest in certain objects or things or topics _____
Excessive reaction to changes in routine_____
Interprets what others say literally _____
Fails to understand subtle intentions of others or jokes _____
Abnormalities of speech____
Self-harm in the past ____
Self-mutilation in the past ____
Self-mutilation currently occurring ____
Revised 7/1/2008

Please provide any information not addressed above that would help with assessment/treatment and/or help in understanding this child's/adolescent's needs.