Dennis W. Wallstrom, Ph.D.

Clinical and Forensic Psychology
PSY 13058
114 N. Indian Hill Blvd., Suite B
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(909) 603-9300, (909) 603-9301 FAX

New Patient Registration—Child/Adolescent

Welcome, and thank you for the opportunity to collaborate together for the mental, physical, spiritual, and social health of your child/adolescent. If you will take a few moments and provide information about him/her and your current concerns, it will help us focus treatment most effectively. Developmental, medical, and family history is important because physical issues can often affect psychological issues. Please feel free to bring any questions to the attention of Dr. Wallstrom.

Name____________________________________ Birthdate________________ Today's Date_______________

Address____ City, State, Zip____

Home Phone (OK to call?)___________________________ Cell Phone_____________________ E-mail______________

Gender:_____Female_____Male School Attending___________________________________ Grade_______________

Biological Mother's Name___________________________ Birthdate_________________ SS#________________

Address____ City, State, Zip____

Home Phone (OK to call?)___________________________ Driver's License________________ SS#________________

Work Phone (OK to call?)___________________________ Cell Phone_____________________ E-mail______________

Biological Father's Name___________________________ Birthdate_________________ SS#________________

Address____ City, State, Zip____

Home Phone (OK to call?)___________________________ Driver's License________________ SS#________________

Work Phone (OK to call?)___________________________ Cell Phone_____________________ E-mail______________

Parents Divorced?_____Yes_____No Legal Custody_____Joint_____Sole *If custody is joint legal, permission must be obtained from the other parent before treatment can proceed.*

Emergency Contact____
Name Relationship to Patient Phone

Primary Care Physician______________________________ Physician's Phone____

Other Persons in Household (Relationship to Patient): __________________________ ___________________________

__________________________ ___________________________

__________________________ ___________________________

How were you referred to Dr. Wallstrom?____

May we acknowledge contact?_____Yes_____No

Primary Insurance Plan________________________________ Payor/Health Plan_____________________________________

Policy/Group #________________________________ Psychiatric/Mental Health Plan____________________________

Insured Party________________________________ Insured Party SS#_____________________________________

Insured Party Birthdate________________________________ Patient's Relationship to Insured:
_____Self_____Spouse_____Dependent

Employer_____________________________________

What concerns about your child/adolescent have prompted you to see Dr. Wallstrom at this time?
____

What events or circumstances made these concerns surface?____

____

Please rate any problems or concerns about your child/adolescent according to their severity (rate 1-5):

NO PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM	EXTREME PROBLEM
1	2	3	4	5

_____Depressed Mood _____Lack of Friends _____Bedwetting/soiling

_____Anxiety _____Loneliness _____Sexuality/Sexual Issues

_____Stress _____Coping Difficulties _____Family Conflict

_____Loss of a Loved One _____Abuse/Victimization _____Behavioral Problems

_____School Difficulties _____Nightmares/Night Terrors _____Drug/Alcohol Use

_____Work Difficulties _____Legal Matters _____Illegal activities

_____Fighting _____Arguing _____Truancy

_____Anger _____Attention/Concentration _____Memory

_____Unusual Experiences____
(Describe)

_____Other____
(Please specify)

Current Medications: ____________________ ____________________ ____________________
(Name and Dosage)

____________________ ____________________ ____________________

Last Physical Exam? ____________________ ____________________
Date Doctor

Significant Findings? ____

Blood Test Results? ____
(include date)

Medical Conditions ____________________ ____________________ ____________________
Currently Being
Treated: ____________________ ____________________ ____________________

Does your child/adolescent experience any of the following? (Check all that apply)

_____Double or Poor Vision _____Excessive Thirst/Dry Mouth _____Difficulty Hearing

_____Indigestion, Gas Heartburn _____Fainting _____Stomach Pain

_____Blackouts _____Diarrhea or Constipation _____Convulsions

_____Vomiting/Vomiting Blood _____Blood in Stool _____Paralysis

_____Dizziness _____Change in Appetite/Eating Habits _____Headaches

_____Sleep Difficulties _____Thyroid Problems _____Sexual Difficulties

_____Coughing or Wheezing _____Difficulties with Memory, Attention, or Concentration

_____Chest Paine _____Weakness or Lack of Energy _____Shortness of Breath

_____Joint Pain _____Heart Palpitations or Irregularities _____Lumps Anywhere in Body

_____Swelling _____Weight Gain or Loss____
(Number of pounds over what period of time)

Describe what you know of your child's/adolescent's use of drugs or alcohol:

Substance	Amount	Frequency	Last Use

Has your child/adolescent ever been in trouble with the law because of using alcohol or illegal substances?
____

What mental health or substance abuse treatment has your child/adolescent received previously?
____

Please respond to the following lifestyle questions for your child/adolescent:

	Current Frequency	Highest Frequency	Last Use/Occasion
Caffeinated drinks			
Tobacco			
Alcohol			
Exercise and Sports			
Work			
Dating			
Religious Services			

Please answer the following questions about your child's/adolescent's development:

Any difficulties with the pregnancy?____________________Full term?______ Birthweight?____________

At what age did s/he walk?________Talk?_________

Behavioral or emotional difficulties at preschool?____

Any unusual fears?____

History of molestation or abuse?____

Typical hours of sleep?____

Attitude toward school?__________________________________Grades?________________

Special education (subjects)?____

Problems with homework?____

Suspensions or expulsions?____

Activities at school?____

What kind of serious medical illness has been in your family?____

____

What kind of mental health issues have been in your family?____

____

What kind of substance use problems have been in your family?_______________________________________

____

Policies and Agreements

Please read each item carefully and sign below. A copy of this agreement will be provided to you. Dr. Wallstrom will discuss with you any questions or concerns you may have.

TREATMENT APPROACH
Dr. Wallstrom will be working closely with you to identify clearly areas on which your treatment will focus, as well as goals of treatment and modes of treatment (e. g., individual therapy, couple/family therapy, EEG neurofeedback). Alleviating distress and making progress toward optimal mental, physical, spiritual, and social functioning , are my highest concerns. If you are involving your health plan, a case manager may be collaborating with us and making certification decisions. Your active involvement in your treatment, including "homework" assignments, will be essential for the best outcome of treatment.

CONFIDENTIALITY
All information disclosed by you to Dr. Wallstrom will be held in strictest confidence, unless court-ordered to release it, or:

--You authorize a release of information with your signature. *Parents/guardians sign releases for a child/adolescent.*
--You present a danger of physical harm to yourself or others.
--There is a reasonable suspicion of child or dependent adult abuse or neglect.

To protect others, law enforcement and potential victims may need to be contacted, according to the requirements of the law.

FINANCIAL TERMS
You (parents/guardians) will be responsible for the financial obligations of treatment. This will mean making payment for each session at the time of service (unless other arrangements are made), or fulfilling the applicable deductible amount and making co-payments. Co-payments must be made at the time of each session. If you are not eligible for benefits or your insurance company should not pay for any reason, you are responsible for full payment of services. Unpaid accounts may be sent to a collection agency, and a 40% service charge will be added to the balance assigned to the collection agency. INITIAL_______

CANCELLED OR MISSED APPOINTMENTS
This practice relies upon your responsibility for arriving at your appointments at the designated times. Of course, schedule changes and emergencies are inevitably a part of life. When making changes to appointments, please allow at least **24 hours notice**. Notification within less than 24 hours or not showing for an appointment will result in a **$70 fee**, which must be paid prior to your next appointment. Health plans do not cover charges for late cancellations or missed appointments. INITIAL_______

EMERGENCY PROCEDURES
You may contact Dr. Wallstrom outside of session at 909-603-9300, and leave a message at any time. Every effort will be made to respond to non-urgent messages the same day. If it is an urgent matter, you may contact Dr. Wallstrom on his mobile phone: 909-560-3905. Any life-threatening emergency should be addressed by calling 911, or by going immediately to the nearest hospital emergency room.

RELEASE OF INFORMATION TO YOUR HEALTH PLAN
If I am involving my health plan in my treatment, I authorize Dr. Wallstrom to release information regarding my care to my health plan for the payment of claims, certification and case management decisions, and other purposed related to the administration of my benefits.

CONSENT FOR TREATMENT
I authorize and request Dr. Wallstrom to carry out the assessments, diagnostic procedures, and treatments necessary during the course of treatment for my child/adolescent. I understand that the purpose of any facet of treatment will be explained to me and will be subject to my agreement. I also understand that the process of psychotherapy, while designed to facilitate recovery to optimal mental, physical, spiritual, and social functioning, may be challenging and difficult at times.

APPEALS AND GRIEVANCES
I acknowledge my right to request reconsideration in the event certification for my care is denied. To appeal, I understand I would request an appeal through Dr. Wallstrom, and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to Dr. Wallstrom at any time to register a complaint about any aspect of my care. And at any time, if I am not satisfied with the response I receive form an appeal or grievance, I may submit the complaint directly to my health plan.

I have read, understand, and agree to all of the above information.

____ ____________________
Patient (or Parent/Guardian)—PRINTED, then SIGNED Date

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I, ____, authorize my insurance company,

____, to send payment automatically to

Dennis W. Wallstrom, Ph.D., 114 N. Indian Hill Blvd., Suite B, Claremont, CA 91711.

Signed____ Date______________________