

Spectrus Psychological Services, PLLC

info@spectruspsych.com | www.SpectrusPsych.com

Youth History Form

Name: _____ Age: _____ Date of Birth: _____

Race & Ethnicity: _____ Religion: _____

Sexual Orientation: _____ Gender Identity: _____

Address: _____

Please describe the concerns or problems for which you are seeking services:

How did you hear about us?

Friend/Family Google Psychology Today Insurance Other

RELATIONSHIPS

Parent relationship status: Married Separated Divorced Single

Individuals with whom the patient lives (include pets):

Name	Relationship	Age

Patient's support network:

Family Partner/Spouse Friends Coworkers Professionals

BIRTH & DEVELOPMENT

Pregnancy

Planned pregnancy? Y /N Desired pregnancy? Y /N Prenatal care received? Y /N

Drug use during pregnancy: Y /N Which substance(s)?

Alcohol use during pregnancy: Y /N Which trimester: _____ Quantity? _____

Complications during pregnancy: _____

Length of pregnancy: _____

Complications during delivery: _____

Birth weight: _____ lbs. _____ oz Post-natal care in NICU: Y /N

Adopted: Y /N If yes, open or closed adoption? _____

PSYCHIATRIC HISTORY

Family Psychiatric History

Please indicate mental health problems experienced by members of your biological family:

Condition	Maternal/Paternal
Depression Disorders	M <input type="checkbox"/> /P <input type="checkbox"/>
Suicide Attempt or Suicide Completion	M <input type="checkbox"/> /P <input type="checkbox"/>
Anxiety Disorders / Panic Attacks	M <input type="checkbox"/> /P <input type="checkbox"/>
Obsessive Compulsive or Hoarding Disorders	M <input type="checkbox"/> /P <input type="checkbox"/>
Bipolar Disorder	M <input type="checkbox"/> /P <input type="checkbox"/>
Schizophrenia or Psychotic Disorders	M <input type="checkbox"/> /P <input type="checkbox"/>
History of abuse, neglect, or trauma	M <input type="checkbox"/> /P <input type="checkbox"/>
Posttraumatic Stress Disorder	M <input type="checkbox"/> /P <input type="checkbox"/>
Attention Deficit Hyperactivity Disorder	M <input type="checkbox"/> /P <input type="checkbox"/>
Learning Disorders	M <input type="checkbox"/> /P <input type="checkbox"/>
Autism Spectrum Disorder (including Asperger's)	M <input type="checkbox"/> /P <input type="checkbox"/>
Alcohol or Drug Abuse	M <input type="checkbox"/> /P <input type="checkbox"/>
Incarceration or arrests	M <input type="checkbox"/> /P <input type="checkbox"/>
Personality Disorder	M <input type="checkbox"/> /P <input type="checkbox"/>
Other:	M <input type="checkbox"/> /P <input type="checkbox"/>

Patient Psychiatric *HISTORY*

Condition	✓
Depression Disorders	<input type="checkbox"/>
Suicidality / Self - Harming	<input type="checkbox"/>
Anxiety Disorders / Panic Attacks	<input type="checkbox"/>
Obsessive Compulsive or Hoarding Disorders	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>
Schizophrenia or Psychotic Disorders	<input type="checkbox"/>
History of abuse, neglect, or trauma	<input type="checkbox"/>
Posttraumatic Stress Disorder	<input type="checkbox"/>
Attention Deficit Hyperactivity Disorder	<input type="checkbox"/>
Learning Disorder	<input type="checkbox"/>
Autism Spectrum Disorder (including Aspergers)	<input type="checkbox"/>
Alcohol or Drug Abuse	<input type="checkbox"/>
Incarceration or arrests	<input type="checkbox"/>
Personality Disorder	<input type="checkbox"/>
Other:	<input type="checkbox"/>

Patient CURRENT Concerns

Symptom	✓	Symptom	✓
Abandonment Fears	<input type="checkbox"/>	Hearing / Seeing Things	<input type="checkbox"/>
Academic/ Learning Difficulties	<input type="checkbox"/>	Hyperactivity/ Restlessness	<input type="checkbox"/>
Aggression (physical/verbal)	<input type="checkbox"/>	Hypervigilance	<input type="checkbox"/>
Alcohol / Drug Problems	<input type="checkbox"/>	Impulsivity / Risky Behaviors	<input type="checkbox"/>
Anger / Frustration / Irritability	<input type="checkbox"/>	Sleep Problems / Nightmares	<input type="checkbox"/>
Anxiety / Worry/Panic	<input type="checkbox"/>	Loss/ Grief	<input type="checkbox"/>
Attention / Concentration Problems	<input type="checkbox"/>	Lying	<input type="checkbox"/>
Body Image / Eating Problems	<input type="checkbox"/>	Memory difficulties	<input type="checkbox"/>
Communication / Speech Problems	<input type="checkbox"/>	Obsessions / Compulsions	<input type="checkbox"/>
Defiance/Rule Breaking	<input type="checkbox"/>	Odd Beliefs / Delusions	<input type="checkbox"/>
Discrimination/ Minority Stress	<input type="checkbox"/>	Poor hygiene	<input type="checkbox"/>
Depressed mood / Mood Swings	<input type="checkbox"/>	Relationship difficulties	<input type="checkbox"/>
Elevated mood/Mania	<input type="checkbox"/>	Self-Harming / Suicidality	<input type="checkbox"/>
Eye contact (poor/odd/infrequent)	<input type="checkbox"/>	Sensory Sensitivities	<input type="checkbox"/>
Gender identity / Sexual Orientation	<input type="checkbox"/>	Trauma Symptoms	<input type="checkbox"/>

Abuse & Trauma History

Natural disaster	<input type="checkbox"/>	Robbery or home invasion	<input type="checkbox"/>
Fire or explosion	<input type="checkbox"/>	Witnessed trauma or abuse	<input type="checkbox"/>
Car accident	<input type="checkbox"/>	Domestic violence	<input type="checkbox"/>
Physical assault	<input type="checkbox"/>	Childhood physical abuse	<input type="checkbox"/>
Sexual assault	<input type="checkbox"/>	Childhood sexual abuse	<input type="checkbox"/>
Unwanted sexual contact	<input type="checkbox"/>	Childhood verbal abuse	<input type="checkbox"/>
Combat or warzone exposure	<input type="checkbox"/>	Childhood emotional abuse	<input type="checkbox"/>
Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>

Was abuse or assault reported to police or other authorities: Y/N

Mental Health Treatment History

Outpatient and Inpatient Therapy Services

If the patient has ever received therapy services in the past, please provide relevant information below:

Assessment Services

If the patient has ever received an assessment in the past, please provide relevant information below:

Are you able to provide copy of past assessment report(s)? Y / N

Patient Strengths & Weaknesses

Patient Communication Preferences

I agree to receive communication from Spectrus Psychological Services, PLLC via the following methods:

Please provide ONLY the information for preferred methods of contact.

Cell Phone : _____

- YES, Spectrus may leave a voicemail at this number.
 NO, Spectrus may NOT leave a voicemail at this number.

Home Phone : _____

- YES, Spectrus may leave a voicemail at this number.
 NO, Spectrus may NOT leave a voicemail at this number.

Work Phone : _____

- YES, Spectrus may leave a voicemail at this number.
 NO, Spectrus may NOT leave a voicemail at this number.

I would like to receive email **communication** at the following email address.

Email : _____

I would like to receive email **appointment reminders** at the following email address.

Email : _____

Emergency Contact #1 _____
Name Relationship Phone

Street Address City State Zip

Emergency Contact #2 _____
Name Relationship Phone

Street Address City State Zip

Patient Name (printed)

Signature

Date

Signature of Authorized Representative

Date

Relationship to Patient

Insurance & Payment Information

In the event your insurance carrier does not cover the cost of services, the patient or the individual identified as the financially responsible party will be responsible for the full cost of services rendered.

Insurance Plan Information	
Insurance Company:	
Insurance Address:	
Insurance Phone Number:	
Member ID:	Group ID:
Information of the Insured Individual	
Relationship to Patient:	
Employer:	
Address:	
Phone Number:	DOB:

I authorize regularly scheduled charges to my Visa, MasterCard, American Express or Discover card. I Authorize **Jennifer S. Williams, PhD** to charge my card for missed appointment fees, late cancellation fees, the balance of fees denied by my insurance company, or not paid by my insurance company within 90 days of date of service, and insufficient check amounts plus insufficient check fee of \$30 per bad check. I authorize these charges to my card beginning ____/____/____ to the end of my treatment period. If I have questions about these charges, I agree to contact **Jennifer S. Williams, PhD**. The charges labeled on my credit card will not be my provider's name to preserve confidentiality. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Initial: _____

Please complete the information below:

I _____ authorize **Jennifer S. Williams, PhD** to
Name (as it appears on credit card)
 charge my credit card, indicated below, on or after the day in which I receive my therapy session. I understand that I will only receive a **5-day** advance notice of the charge if it exceeds **\$150.00**.

Billing Address _____ Phone# _____
 City, State, Zip _____ Email _____

Please make sure the following information is accurate.

Account Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Amex <input type="checkbox"/> Discover
Cardholder Name _____
Account Number _____
Expiration Date _____
CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Patient Name (printed)

Signature

Date

Signature of Authorized Representative

Date

Relationship to Patient