



This is to confirm \_\_\_\_\_'s appointment with  
Patient's Name

\_\_\_\_\_  
Provider Name

at our MK Plus office on \_\_\_\_\_, \_\_\_\_\_ at  
Day Date

\_\_\_\_\_  
Time

Our office is located at:

**31 Cambridge Lane Suite A  
Newtown, PA 18940**

Please do not hesitate to call us at **215-968-5151** should you require directions to our office. If you prefer, you can print directions from our website [www.mkplusnewtown.com](http://www.mkplusnewtown.com)

Prior to your visit, please review and complete the enclosed information and bring it with you to your appointment. Feel free to call our office 215-968-5151 should you have any questions prior to your visit.

If for any reason you need to cancel or reschedule your intake appointment, we ask that you provide our staff with as much notice as possible. **Please call our office 2159685151** and leave a message in our general mailbox and we will take care of notifying the provider.

We look forward to meeting you!



Father's Name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_  
 Highest level of Education: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Place of Employment: \_\_\_\_\_  
 Is father living in the home? \_\_\_\_\_  
 Amount and type of contact with child: \_\_\_\_\_

Child's brothers and sisters (Please list beginning with the oldest)

Name	Age	Living at home?	School or Occupation

List other relatives living in the home:

\_\_\_\_\_

Are there any activities that your family does together?

\_\_\_\_\_

What is the primary language spoken in the home?

\_\_\_\_\_

**DEVELOPMENTAL HISTORY**

**PREGNANCY**

Mother's health during the pregnancy:      (\_\_\_) Good      (\_\_\_) Fair

Any illnesses or complications during the pregnancy? (Explain)

\_\_\_\_\_

\_\_\_\_\_

List any medications taken during pregnancy: \_\_\_\_\_

**Drug use?** ( ) Mother ( ) Father **Alcohol Use?** ( ) Mother ( ) Father **Smoking?** ( ) Mother ( ) Father

Length of Pregnancy: \_\_\_\_\_ weeks Labor: \_\_\_\_\_ hours

Type of Delivery: ( ) Natural ( ) Cesarean ( ) Breech

What drugs were used during labor and delivery? \_\_\_\_\_

Birthweight: \_\_\_\_\_ pounds \_\_\_\_\_ ounces

Complications (if any):

Condition at birth: \_\_\_\_\_ APGAR score (if known): \_\_\_\_\_

Jaundiced? \_\_\_\_\_ Oxygen needed? \_\_\_\_\_ Incubator? \_\_\_\_\_

Transfusion needed? \_\_\_\_\_ Length of hospital stay: Infant \_\_\_\_\_ Mother \_\_\_\_\_

**EARLY DEVELOPMENT**

Who was the primary caretaker when your child was an infant?

\_\_\_\_\_

Any long separations from the mother? (Explain)

\_\_\_\_\_

\_\_\_\_\_

Were there any feeding problems? (Allergies to milk/formula- Please explain)

\_\_\_\_\_

\_\_\_\_\_

At what age did your child:

Sit without support? \_\_\_\_\_

Crawl? \_\_\_\_\_

Stand? \_\_\_\_\_

Walk? \_\_\_\_\_

Speak first word? \_\_\_\_\_

Speak in phrases? \_\_\_\_\_

Dress/undress self? \_\_\_\_\_



Describe any problems with speech/language:

At what age was toilet training initiated? \_\_\_\_\_ Completed? \_\_\_\_\_ Any accidents after that? \_\_\_\_\_

Is your child left or right handed? \_\_\_\_\_

Does your child sleep alone in his/her own bed? \_\_\_\_\_

**MEDICAL HISTORY**

Name of Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please check all the illnesses/conditions that your child has had. All checked boxes must include an approximate date in the space provided below:

- Measles             German Measles             Chicken Pox
- Mumps             Whooping Cough             Scarlet Fever
- Rheumatic Fever    Tonsillitis             Pneumonia
- Asthma             Epilepsy             Croup
- Ear Infection       Wax Build-up             Fever of  $\geq 102$  degrees
- Lead Poisoning    Loss of Consciousness    Convulsions/Seizures
- Allergies (Specify): \_\_\_\_\_

Please include date(s) for any illnesses checked above:

\_\_\_\_\_  
\_\_\_\_\_

Tubes in ears?  Which Ear(s)?  Left       Right       Both

When? \_\_\_\_\_

Other serious illness or injury? (Describe):

\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations?     Yes            When? \_\_\_\_\_ What for? \_\_\_\_\_  
                                  No

List any medications currently taking: \_\_\_\_\_

**FOR YOUNG WOMEN ONLY**

At what age did your daughter start to menstruate (get her period):

\_\_\_\_\_

Menstrual period experiences:

-How regular are they? \_\_\_\_\_

-How long do they last? \_\_\_\_\_

-Any Pain? \_\_\_\_\_

-How heavy are her periods? \_\_\_\_\_

-Other experiences during periods? \_\_\_\_\_

**HEALTH HABITS**

What kinds of physical exercise does your child get? \_\_\_\_\_

\_\_\_\_\_

How much coffee, cola, tea or other sources of caffeine does your child consume each day? \_\_\_\_\_

\_\_\_\_\_

Do you try to restrict your child's eating in any way? How? Why? \_\_\_\_\_

\_\_\_\_\_

Do you have any problems with your child getting enough sleep? \_\_\_\_\_

\_\_\_\_\_

**SOCIAL RELATIONSHIPS**

Does your child make friends easily?

\_\_\_\_\_

Does your child have many friends?

\_\_\_\_\_

In the neighborhood? \_\_\_\_\_ In school? \_\_\_\_\_

Does your child participate in organized activities? If yes, which ones? \_\_\_\_\_



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Does your child prefer to associate with older people, younger people, or those the same age?

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Does your child have difficulty keeping friends?

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How does your child get along with others in your family?

Parents? \_\_\_\_\_

Siblings? \_\_\_\_\_

How is your child disciplined? \_\_\_\_\_

**ACADEMIC HISTORY**

Describe your child's attitude, motivation and grades in school:

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Explain any current school problem(s) and any previous difficulties:

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Does your child currently have an IEP, a 504 or any other type of academic support?

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Has your child received any previous educational or neuropsychological testing? (Describe)

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List other family members who have had difficulties with school (Explain):

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**Areas of concern** (Check all that apply):

Aggressive Behavior

Getting along with sibling

Daydreaming

Getting along with others

Temper tantrums

Depression

- Low self esteem
- Anxiety
- Comprehending things said to child
- Completion of school work
- Failing grades/poor academic performance
- Saying what they want to say
- Fears (Explain fully): \_\_\_\_\_
- \_\_\_\_\_
- Other (Explain fully): \_\_\_\_\_
- Attention difficulties (Explain fully): \_\_\_\_\_
- \_\_\_\_\_
- Significant change in behavior (Explain fully): \_\_\_\_\_

Have there been upsetting events and/or significant losses in the life of your child or your family? (Explain):

\_\_\_\_\_

\_\_\_\_\_

To your knowledge, has your child ever been abused in any way (physically, verbally or sexually)? ( ) Yes  
 ( ) Not to my knowledge If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Describe your child's morning routine:

\_\_\_\_\_

\_\_\_\_\_

Describe your child's evening routine:

\_\_\_\_\_

\_\_\_\_\_

What are your child's strengths?

\_\_\_\_\_

\_\_\_\_\_

What do you see as his/her areas of need?

\_\_\_\_\_

\_\_\_\_\_

Has your child received any previous educational or psychological testing, therapy or remediation? (Describe)

\_\_\_\_\_

\_\_\_\_\_



Has your family or any family member had previous contact with a mental health agency, psychiatrist, or psychologist? (Describe)

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What other additional information would you like to include that may assist us with this evaluation?

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# PAYMENT POLICY

Two copies of this policy are being provided to you. Please review it carefully and sign one copy where indicated. Return the signed copy to our office at the time of your next appointment. The second copy is for you to retain for your reference.

Thank you for your cooperation.

MK Plus Behavioral Health Providers **do not** currently participate with any insurance plans.

MK Plus Behavioral Health services are provided on a payment-for-service basis.

All fees will be discussed and agreed to by you prior to the initiation of treatment.

Full payment is due at each visit and will be collected upon check-in for the appointment. Our office does not *bill* for any services rendered. The fee for these sessions with \_\_\_\_\_ are \_\_\_\_\_.

For the convenience of our clients, our office accepts the following credit cards: Master Card, Visa, American Express and Discover.

For your convenience, our office will retain your credit card information in a locked and secure file for the duration of the treatment and charge for visits as they occur.

Upon payment, each client will be provided with a receipt. This receipt will be appropriate for submission to your insurance company should you be entitled to any reimbursement for services provided.

**Our office requires 24 hours advance notification of any appointment that you wish to cancel and/or reschedule. If for any reason you need to cancel, please call our office at 215-968-5151 and leave us a message in our general mailbox. We will take care of notifying the provider. Out of courtesy to other clients waiting for appointments, please note that you will be charged for any appointment where you do not show up or you cancel the appointment less than 24 hours in advance.**

Your signature below acknowledges receipt and understanding of the above payment policies.

\_\_\_\_\_  
Client Name (Please Print)

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

(OFFICE COPY)



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\_\_\_\_\_  
Client Name (Please Print)

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

(CLIENT COPY)





## CREDIT CARD AUTHORIZATION

MKPlus requires that you provide your credit card to be retained on file in our secure electronic medical system. Please complete the information below and bring it with you to the next session. **NOTE: No charges will be made to the credit card unless you request to use this card for payment of services, or in the event of the non-payment of services, missed session, or cancellations within 24 hours.**

This authorization will be good for a period of twelve (12) months. -You authorize these charges to your credit card and understand that you will be provided a receipt for anything charged to your card. A receipt for each payment will be mailed to you and the charge will appear on your statement as "MKPlus." MKPlus accepts Visa, MasterCard, American Express, and Discover cards for payment of fees.

PATIENT'S INFORMATION			
Patient's Last Name:	First Name:	Middle:	OP ID:
PAYMENT METHOD INFORMATION			
Name as it appears on the card:			
Street Address:			
City:	State:	ZIP:	
Maximum Charge Amount: <u>(Charges up to the Patient's individual annual deductible will be charged unless other amount is listed.)</u>			
Please charge to the following:	<b>Credit card:</b> <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover	<b>Other:</b> <input type="checkbox"/> Health Savings Account <input type="checkbox"/> Flexible Spending Account	
Expiration Date:  ____ / ____	Last 4 Digits of Card Number: <u>(Must have card on hand in office to store securely)</u> <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <span>-</span> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <span>-</span> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <div style="border: 1px solid black; padding: 2px 5px;">X</div> <span>-</span> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>		
Card holder's signature:			
Date:	Phone number:		



**HIPAA Privacy Practices Acknowledgement Form**

I have received the Notice of Privacy Practices for MK Plus and I have been provided an opportunity to review it.

Patient name: \_\_\_\_\_

Name of person reviewing the information (if someone other than patient)

\_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ *Patient or*  
*Patient Representative* *Date*



## Parent Interview Form

Child's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Informant's Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Date: \_\_\_\_\_

1. What concerns do you have regarding your child's behavior?
2. What about those behaviors make them the most problematic?
3. Does the behavior occur when your child is with you? If so, when is the behavior likely to occur?
4. Are there times when you do not see occurrences of the behavior? If so, please describe times/circumstances when you are least likely to see the behavior?
5. What things have you identified that seem to cause your child to start or engage in the behavior?
6. What do you typically do at home when your child exhibits the behavior?
7. What strategies are you trying at home in an attempt to change or help manage your child's behavior?

8. Do you perceive an improvement, deterioration, or no change following the implementation of your management plan? Please describe.

9. What do you consider to be some of your child's strengths?

10. Are there any recent or on-going stressors that may impact on your child's functioning at school? Please describe.

11. List the names of medications that your child takes and describe if there are any side effects, which may affect your child (e.g. may cause sleepiness; decrease in appetite, etc.).

12. Does your child have any medical complications (if any) that may affect his/her behavior (e.g. asthma, allergies, sinus infections, seizures)?

13. Describe the sleep cycles of your child, and the extent to which these cycles may affect his/her behavior?

14. Describe the eating routines and diet of your child, and the extent to which these routines may affect his/her behavior?

15. Are there any other factors related to your child's behavior that are important for individuals working with your child to know?