595 Price Avenue, Suite 100
Redwood City, CA 94063
Phone (650) 322-5910
Fax (650) 322-7075
www.morrissey-compton.org

A not-for-profit 501(c)(3) corporation

Executive Director
John T. Brentar, Ph.D.

Board of Directors
Jeff Wiley (President)
Julie Cavanna-Jerbic
Allan Epstein
Michael Masia
Jack Morton
Linda Raggi
Karen Sparks
Jeanne B. Ware

Founders
Carolyn Compton, Ph.D.
Patricia J. Morrissey, Ed.D.

PARENT INFORMATION FORM

Please complete the following questions. Although detailed, your answers to these questions will assist us with your child's evaluation. ***All information is confidential****. Please PRINT your responses.*

Today's Date ___________________

Child's Name __________________________________Birthdate _____________ Age __________

Home Address ____________________________________Home Phone _____________________

City/Zip ___________________________________E-mail ____________________________________

Referred to Morrissey-Compton Educational Center by: _________________________________

____

Please explain your major reasons for seeking an evaluation at this time: What questions would you like addressed?

____

____

____

Note: If one purpose of this evaluation is to determine if the student is eligible for accommodations on standardized tests, in addition to this form, please fill out the attached Educational History form.

Parent 1 Name ______________________Address _______________________________________

Occupation __________________________Home Phone __________Work Phone ___________

Parent 2 Name ______________________Address (if different)_____________________________

Occupation _________________________ Home Phone ____________Work Phone____________

Marital status of parents: ___________________If divorced, do both biological parents know about the evaluation and give their consent: ____

Step-parents' Names ____

Address ____Phone__________

With whom does your child live? List all people living in household

____

____

Ages and genders of Siblings:

Name	Age	Gender

Is the child adopted? ____

Languages Spoken in the Home ____

EDUCATIONAL HISTORY:

Current School __________________________ Current Grade ______________

Teacher___________________________ Resource Specialist ______________

List all other schools child has attended, including dates.

School	Location	Date Attended

Has your child experienced difficulties in learning or acquiring basic academic skills? If so, what areas. ____

____

Has your child's behavior ever been considered a problem by the school? Yes _____ No _______

If yes, provide details. ____

____

Has your child ever been reluctant to attend school? Yes _____ No ______ If yes, describe.

____

Is your child currently being tutored? Yes ______ No ______ In the past? ____________________

Has your child ever been tested for special education services? Yes ____ No _____ If yes, when, by whom. What was the result? (Please include a copy of the evaluation if possible).

<u>Date</u>	<u>Agency or Individual</u>
___________________________	____
___________________________	____

What successes has your child experienced in learning? ___________________________________

____

Has your child received awards at school? If so, please specify age/grade and/or subject ______

____

Has your child ever repeated a grade or failed a subject? Yes_____ No_____ If yes, specify age, grade, and/or subject: ____

____

Is child's attention persistent? Does he/she have trouble concentrating? Yes _____ No ________

If yes, describe. ____

Please list any previous therapies your child has received (speech & language, occupational, physical, recreational, psychological, psychiatric).

____

____

DEVELOPMENTAL HISTORY

Were there any difficulties during pregnancy? Yes ______ No ______ If yes, please describe.

____

____

Did the mother take any medications or use any drugs/alcohol during pregnancy? Yes _______

No _______ If yes, please describe. ____

Describe your child's delivery. (e.g. if child was full-term or premature, vaginal or c-section, forceps, induced labor, etc.) ____

____

Child's birth weight _____________ During the first week of life, did the child have any of the following: Feeding trouble _____ Yellow jaundice _____Diarrhea _____ Excess vomiting _____ Blueness ______ Need of oxygen _____ Seizures ______ Breathing trouble ______

How old was the child when he/she first: (as best as you can recall)

Crawled ___________ Walked ___________ Spoke first words __________ Sentences ______

Completed toilet training ______________ Stayed dry at night ______________

Rode a bike ______

MEDICAL HISTORY

Place a check next to any illness/condition that your child has had.

______ Measles	______ Mumps	_______ Chicken Pox	______ Pneumonia
______ German Measles	______ Asthma	_______ Headaches	______ Dizziness
______ Broken Bones	______ Head Injury	_______ Diabetes	______ Whooping Cough
______ Seizures	______ Scarlet Fever	_______ High Fever	______ Exposure to TB
______ Anemia	______ Epilepsy	_______ Tiredness	______ Ear Infections
_____ Difficulty sleeping	______Difficulty eating	_____ Vision problems	____ Hearing Problems

Please provide details of any checked items, such as the date or age of child when illness occurred.

Date	Child's Age
______________________________	_______________________
______________________________	_______________________
______________________________	_______________________

Please list any previous surgeries or hospitalizations. _____________________________________

____

Is your child allergic to any medications, foods, or other substances? Yes _____ No ______ If yes, please describe. ____

If your child is under current medical supervision, please list names and phone numbers of doctors.

Doctor Name	Phone Number	Condition Treated

Please list any current medication (including dosage). Include any medication ADD/ADHD, depression, anxiety, etc.

Medication	Dosage	Date Started Taking Medication

Any past or current use of drugs such as alcohol, marijuana, cocaine? Yes _____ No ______ If yes, please describe and state by whom. ____

____

____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the family has had, noting the family member's relationship to the child (father, mother, brother, sister, aunt, uncle, etc.)

Learning Disability ___________________ Anxiety __________________________

Depression _________________________ Alcoholism _______________________

Manic Depression ____________________ Drug Addiction ____________________

Suicide _____________________________ Schizophrenia _____________________

Please describe all major transitions the child may have experienced (changes in residence or school, loss of loved ones through death or divorce, etc.) and his/her reaction. ___________

____

____

How does the child get along with others, including siblings, peers, and adults? __________

____

____

Please check all items that presently apply to your child's present condition:

_____ Nightmares _____ Headaches _____ Eating Disorder

_____ Loneliness _____ Hot or cold spells _____ Binge eating

_____ Worried _____ Dizziness _____ Vomiting after eating

_____ Weight change _____ Stomach problems _____ Use of diet pills

_____ Fearful _____ Constipation/Diarrhea _____ Use of laxatives

_____ Sexual problems _____ Fatigue _____ Use of cigarettes

_____ Thoughts of suicide _____Use of alcohol _____ Problems with stealing

_____ Relationship problems _____ Use of drugs _____ Problems with lying

_____ Trouble concentrating _____ Difficulty breathing _____ Problems with cheating

_____ Forgetfulness _____ Coordination problems _____ HIV positive

_____ Insomnia _____ Panicky feelings _____ Victim of physical abuse

_____ Confusion _____ Rapid heart beat _____ Victim of sexual abuse

_____ Obsessive thoughts _____ Strange experiences _____ Problems with temper

_____ Depression _____ Bedwetting _____ Daytime wetting

_____ Unhappiness _____ Trouble with the law _____ Profane language

_____ Feeling inferior _____ School related stress _____ Difficulty explaining self

_____ Overly slow _____ Tics _____ Overly active

_____ Falls often _____ Problems with mother _____ Problems with father

_____ Nail biting _____ Thumb sucking _____ Fussiness

_____ Fear of specific object or situation _____ Strong dislike of criticism

_____ Difficulty following directions _____ Poor fine motor skills

Please add any other information you feel is important regarding our assessment of your child. Please include your child's achievements. ____

____

____

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CONSENT TO TREAT AND DISCLOSURE STATEMENT

Clients Name: ____

Clients and legal guardians consent to receive assessment and/or treatment services at Morrissey-Compton Educational Center, Inc. and to enter into the following understanding:

1. Clients will be administered diagnostic and/or treatment procedures recommended by professional staff. Psychological Assistants are supervised by John T. Brentar, Ph.D., PSY13146. In the case of joint custody, both parents will need to sign and date this document.

2. The information provided during assessment and/or treatment services is confidential. Specific information is release to outside agencies or persons only after written consent of a parent(s) or legal guardian(s) is obtained. The only exceptions to confidentiality are as follows:

- When a client, family member, or collateral person states an intention to seriously harm him/herself or harm another person, Morrissey-Compton has the legal obligation to warn the individual's family, intended victim, and/or police
- When there is a reason to believe there is abuse or neglect of a child or vulnerable adult, the law requires a report be made to the police or other appropriate county agencies
- When an emergency condition occurs, Morrissey-Compton will communicate with family members or other appropriate persons
- By court order

3. Individuals and families have the right to access clinical information. You may request an information review with a Morrissey-Compton practitioner. However, in certain circumstances, if a Morrissey-Compton practitioner determines that reviewing such information may be deemed harmful, the practitioner may instead provide a summary of the clinical information.

4. Fees and financial arrangements will be discussed by the first appointment and a financial agreement will be signed at the onset of the services. When pursuing an evaluation, the total fee is due at the first visit. Scheduled appointments require a 24-hour cancellation notice. If notice is not received, clients may be charged a fee of $150. If an evaluation is cancelled after the full payment has been received, the full payment, less the intake fee and/or any cancellation fees for missed appointments, will be refunded.

5. It is understood that Morrissey-Compton does not bill insurance companies directly and each family is responsible for pursuing their own insurance reimbursement for services.

6. Morrissey-Compton routinely provides a copy of the written report to your child's pediatrician. Please inform your clinician if you do not wish to have a copy mailed to the doctor.

By signing below, I agree to the terms and conditions outlined above and authorize Morrissey-Compton to provide assessment and/or treatment services to my child and/or family. I also agree to be financial responsible for those services.

Parent/Guardian:____ Date: ___________

Parent/Guardian:____ Date: ___________

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Client's Rights to Privacy Notice

The Morrissey-Compton Educational Center, Inc. is committed to preserving the privacy of your confidential information and records or that of your child. In fact, we are required by law to protect the privacy of the information you share with us as well as the information we gather from an evaluation conducted at this agency. In addition, the law requires the Center to provide you with this notice describing how the information will be used, when and how this information would be disclosed and how you can access this information.

It is our policy as well as the law to have your written consent before the Center uses or discloses information we have about you or your child. This would include schools, other agencies or professionals, as well as insurance companies. We may, however be required by law o disclose information about you or your child without your consent in response to a court order, subpoena, warrant, or summons subject to legal requirements. At any time, you may revoke your consent that allows us to disclose information by giving us written notice. Your revocation will be effective upon receipt of notice.

You have the right to inspect the information we have in our files about you or your child including billing information. If you do wish to inspect the files, please call and make an appointment with the clinician with whom you have been working so that that individual may be of service to you in this matter. If you have a child who was evaluated at this agency who is now at least 18 of age, we will need that individual's written consent before reviewing the files. If you believe that the information in our files is either incorrect or incomplete, you may ask us to amend the information. Test scores, clinical observations during the evaluation as well as diagnoses will not be changed.

If you believe that your privacy rights have been violated, you may file a complaint with us or with:

The Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Our Board of Directors as well as the Director will review any complaints filed.

Please sign below to indicate that you have received the Privacy Notice

_______________________________ _______________________________

(Please print name) (please sign name)

____

(date)

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PHOTOGRAPHY CONSENT FORM

Client Name: ____

Clients and legal guardians consent to have their photograph taken before one of their evaluations appointments begins. And to enter into the following understanding:

1) The photograph provided is confidential and will remain in the client's file folder and used solely for the resource of the professional staff working with them on evaluations, tutoring services or therapy services.
2) The photograph is intended to provide the professional staff member with a visual reference of their client during current and future evaluations.
3) The photograph will remain in the client file and be updated at re-evaluation (if applicable).
4) As an alternative, clients and legal guardians are welcome to submit their own photographs for the clinicians' reference. If one is not provided with other intake packet information, we will take a headshot before one of the client's evaluation appointments.
5) The photograph is not intended for advertising purposes and will not be released in any way.
6) Once the case is completed, the images will be stored in a secure (locked) location in the client file, and only authorized staff will have access to them.
7) All information in the client file will be kept as long as it is relevant and after that time destroyed or archived.

____________________________________ ____________________

Parent/Client Signature Date

____________________________________ ____________________

Parent/Client Signature Date

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AUTHORIZATION TO EXCHANGE INFORMATION

To maximize the effectiveness of our evaluations, we would like to have the ability to contact other professionals working with your child.

I hereby authorize:

Pediatrician:____

Name/Telephone/Fax

Therapist/Psychologist:______________________________________

Name/Telephone/Fax

School (Teacher, School Psychologist):__________________________

____

Name/Telephone/Fax

Other: ____

Name/Telephone/Fax

To release and/or exchange any or all pertinent information relating to

_______________________to the Morrissey-Compton Educational Center

Child's Name

____

Parent/Guardian

____

Date