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

Board of Directors
Michael Masia (President)
Julie Cavanna-Jerbic
Allan Epstein
Jack Morton
Karen Sparks
Jeff Wiley

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

Executive Director
John T. Brentar, Ph.D.

CLIENT INFORMATION FORM

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

Today's Date ___________________

Name __________________________________ Birthdate _____________ Age __________

Home Address ____________________________________ Phone Number_____________________

City/Zip ___________________________________ E-mail ____________________________________

Occupation___________________ Employer_________________ Work Phone_________________

Languages Spoken ____

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?

____

____

____

EDUCATIONAL HISTORY:

List all schools child has attended, including dates.

School	Location	Date Attended

Do you have a history of learning difficulties or acquiring basic academic skills? If so, what areas. ____

____

Have you been evaluated before (Please include a copy of the evaluation if possible)?

Yes _____ No _______

If yes, provide details. ____

____

Did you ever receive any special education services in school or private tutoring?

Yes _____ No ______ If yes, describe.

____

MEDICAL HISTORY

Do you have or have you had any medical illness or condition? Please describe:

____

____

Please list any previous therapies you have received (speech & language, occupational, physical, recreational, psychological, psychiatric).

____

____

Place a check next to any illness/condition that you have 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 when illness occurred.

Date	Age
______________________________	_______________________
______________________________	_______________________
______________________________	_______________________

Please list any previous surgeries or hospitalizations. _____________________________________

____

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

If you are 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. ____

____

____

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 (father, mother, brother, sister, aunt, uncle, etc.)

Learning Disability ___________________ Anxiety __________________________

Depression _________________________ Alcoholism _______________________

Manic Depression ____________________ Drug Addiction ____________________

Suicide _____________________________ Schizophrenia _____________________

Please check all items that presently apply to your 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 for us to know as we begin our assessment. ____

____

____

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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.

Client:____ 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.

____________________________________ ________________

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 you.

I hereby authorize:

Doctor:____

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

Client Name

____

Client

____

Date