

**Judith Marsh, Ph.D.
Licensed Psychologist**

**Midstep Centers for Child Development
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Email JM@midstep.com**

Dear Parent/Guardian: Thank you for selecting Midstep for the services you are seeking for your child. Please complete the form below and bring it with you to your first meeting with Dr. Marsh. If you have questions or are unsure of what a question is asking, please skip that and we will complete this at the first visit. I am looking forward to meeting you and your family. *Dr. Judy Marsh*

Demographics

Date of First Interview

Patient's Address

Patient Name

DOB

Age

Phone (Home)

Race

Phone (Cell)

Religion

Phone (Work)

Parent/Caregivers Names, Ages, Occupations, Level of Education

Sibling Names, Ages, Grade, School

Insurance Information

Referral Information

Source of Referral

Reason for Referral/Parental Concerns

School/Educational History of Child

Current grade

School

Type of Educational Program (e.g. special education, gifted, etc.)

Other Services Provided by School (e.g. speech, etc.)

Was Child Ever Seen by School Psychologist? If yes, Findings

Previous Psychological/Psychoeducational Testing? If Yes, Findings

Academic Difficulties/Strengths of Child

Behavioral Difficulties/Strengths of Child

Other Concerns of Teachers/School

Extracurricular Activities

Other School Information

Developmental History of Child

Birth History (please note if this history was “normal” or “typical” or if there were problems. If there were difficulties please describe them.

Developmental Milestones

Other Developmental Information

Medical History of Child

Current Health/Problems/Conditions

Past and Current Medical Conditions/Health Problems

Names and Addresses of Child’s Physician(s)

Current Medications for Medical Condition(s)

Other Medical Concerns

Family Medical History

Current Health of Parents, Siblings, Other Important Figures

Past Major Health Problems of Family Members

Other Family Medical Concerns

Mental Health of Child you are bring for services

Has Child Been Seen in The Past for Mental Health/Behavioral Concerns?

If Yes to Above, Name and Address of Clinician(s)

Previous Treatment for Mental Health/Behavioral Concerns?

If Yes to Above, Name and Address of Treating Clinicians

Current Medications for Mental Health/Behavioral Reasons

Past Medications for Mental Health/Behavioral Reasons

Family Mental Health

Past or Current Issues/Medications for Mental Health Issues/Mother:

Past or Current Issues/Medications for Mental Health Issues/Father:

Past or Current Issues/Medications for Mental Health Issues/Siblings:

Past or Current Issues/Medications for Mental Health Issues/Grandparents:

Past or Current Issues/Medications for Mental Health Issues /Aunts, Uncles, Cousins

Parental Methods of Discipline

Do Parents Agree on Methods of Discipline?

Would You Like Help with Discipline?

Parent Goals/Hopes for Therapy

Child Goals/Hopes for Therapy

Other Information You Would Like Dr. Marsh to Know

Consent for Treatment

I _____ acknowledge mine/my child's

(Name) _____ voluntary participation in

treatment with Judith Marsh, Ph.D. who will be the sole professional responsible

for the progress of treatment.

- I understand that I/we may discontinue treatment at any time.
- I understand that I/we may review the contents of my treatment record with my therapist and that, upon written request, I may receive copies of those records generated by Judith Marsh, Ph.D.
- I understand that my records or information about myself/my child may not be released to outside parties without my written consent from me/my child (if over the age of 14).
- I understand that the co-payment required by my insurance company set for my treatment with Judith Marsh, Ph.D will be \$_____ for each 50 minute session and that I am responsible for a "missed appointment fee of \$25 unless 24 hours advance notice of cancellation has been given.

Other Comments:

Parent Signature: _____ Date: _____

Child/Adolescent Signature: _____ Date: _____
(for children 14 and older)

Therapist/Witness: _____ Date: _____

Consent to Release Information

Name of Primary Physician: _____

Address: _____

Phone: _____

Date of last Visit: _____

Name of School: _____

Address: _____

Phone: _____

Contact Person(s): _____

Name of Additional Mental Health Professionals Your Child Has Seen:

Name: _____ Phone: _____

Approximate Date of Last Visit: _____

Name: _____ Phone: _____

Approximate Date of Last Visit: _____

Other: _____

I, _____ give permission to Judith Marsh, Ph.D. to discuss my child _____ with the above persons. I also give permission for Judith Marsh, Ph.D. to release written reports to the above persons and to receive written reports from the above persons. I also understand that I have the right to refuse the release of any information about my child and that such refusal will have no bearing on my child's treatment by Judith Marsh, Ph.D.

After Reading, Initial of Parent and Child _____

Consent to Above Granted:

Parent Signature _____ Date: _____

Child/Adolescent Signature _____ Date: _____
(for children 14 and older)

Therapist/Witness _____ Date: _____

(Revised 2/19/02)