

PATRICIA KOCH, Ph.D., LICENSED PSYCHOLOGIST  
3103 Bee Cave Road, Suite 101, Austin, TX 78746

(512) 371-7221 (office/fax) (512) 773-3923 (cell) wellbeing@drpatkoch.com

**CHILD AND ADOLESCENT HISTORY FORM**  
(To be filled out by parents of children and adolescents)  
*Please return with accompanying paperwork at or before first visit.*

Name of Child \_\_\_\_\_ Today's Date \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

School attending \_\_\_\_\_ Grade \_\_\_\_\_

Father (biological/adoptive) \_\_\_\_\_ Occupation \_\_\_\_\_

Yrs. of Education \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Mother (biological/adoptive) \_\_\_\_\_ Occupation \_\_\_\_\_

Yrs. Of Education \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Is your child adopted? \_\_\_\_\_ Age of child when adopted \_\_\_\_\_

Do child's parents currently live together? \_\_\_\_\_

Are parents: divorced? \_\_\_ separated? \_\_\_ widowed? \_\_\_

If parents live apart, how old was your child when parents began living apart? \_\_\_\_\_

Please describe custody and visitation arrangements. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any other adults who live in the home, including step-parents:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

—

Name \_\_\_\_\_ Relationship \_\_\_\_\_

—

Please list other children in the home:

Name \_\_\_\_\_ Age \_\_\_\_\_  
Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_  
Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_  
Relationship \_\_\_\_\_

If the child has brothers or sisters who do not live in the home now, please list:

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Please list the name and locations of grandparents who interact often with the child (either in person or by mail and visits):

Grandparent(s) \_\_\_\_\_ Location \_\_\_\_\_

Grandparents(s) \_\_\_\_\_ Location \_\_\_\_\_

Please describe your goal in making this appointment. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did the problem(s) begin? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List anything you did to improve the problem. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PRENATAL HISTORY**

Were there any significant problems in the pregnancy? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please specify. \_\_\_\_\_

\_\_\_\_\_

Were alcohol, medications, and/or street drugs used? \_\_\_\_\_

Length of : Pregnancy \_\_\_\_\_ Labor and  
delivery \_\_\_\_\_

Medications during labor and delivery: \_\_\_\_\_

Were there any complications in labor/delivery? Yes \_\_\_ No \_\_\_.

Please specify: \_\_\_\_\_

\_\_\_\_\_

**NEONATAL HISTORY**

Birthweight: \_\_\_\_\_. Were there any significant problems for the child at birth or in the newborn phase? Yes \_\_\_ No \_\_\_. Please specify \_\_\_\_\_

\_\_\_\_\_

**INFANCY (0 to 12 months)**

Check if applicable, any significant problems, delays, and/or difficulties your child had in the 1st year:

- |                |                                |                                |
|----------------|--------------------------------|--------------------------------|
| _____ feeding  | _____ sleeping                 | _____ breathing                |
| _____ colic    | _____ bowel/urinary habits     | _____ intolerance of affection |
| _____ crawling | _____ inability to be consoled | _____ sitting unassisted       |
|                | _____ emotional responsiveness |                                |

Please specify any other significant problems during this period: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who cared for child during the first year? \_\_\_\_\_

\_\_\_\_\_

**TODDLERHOOD (12 to 36 months)**

Check if applicable, any significant problems, delays, and/or difficulties:

- |                              |                       |                         |
|------------------------------|-----------------------|-------------------------|
| _____ walking unassisted     | _____ feeding self    | _____ first words       |
| _____ severe temper tantrums | _____ using sentences | _____ entertaining self |

self destructive behavior       toilet training       overactivity  
 stranger anxiety

Please specify any other significant problems: \_\_\_\_\_

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Did your child attend daycare?  yes  no. If so at what ages? \_\_\_\_\_

Did your child attend preschool?  yes  no. If so at what ages? \_\_\_\_\_

### **CHILDHOOD (3 to 11 years old)**

Check if applicable, any significant problems, delays, and/or difficulties:

<input type="checkbox"/> impulsive	<input type="checkbox"/> reading skills
<input type="checkbox"/> nervous/fearful	<input type="checkbox"/> writing skills
<input type="checkbox"/> severe temper tantrums	<input type="checkbox"/> math skills
<input type="checkbox"/> destroying property	<input type="checkbox"/> school failure
<input type="checkbox"/> self-destructive habits	<input type="checkbox"/> completing tasks
<input type="checkbox"/> overactivity	<input type="checkbox"/> cooperating in group activities
<input type="checkbox"/> obeying	<input type="checkbox"/> very shy
<input type="checkbox"/> bowel/urinary habits	<input type="checkbox"/> aggressive
<input type="checkbox"/> prolonged sadness or irritability	

Please specify any other significant problems: \_\_\_\_\_

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### **ADOLESCENCE (12 to 18 years old)**

Check if applicable, any significant problems, delays, and/or difficulties:

<input type="checkbox"/> prolonged sadness or irritability	<input type="checkbox"/> truancy	<input type="checkbox"/> delinquency
<input type="checkbox"/> gang membership	<input type="checkbox"/> aggressive	<input type="checkbox"/> social isolation
<input type="checkbox"/> academic failure	<input type="checkbox"/> impulsive	<input type="checkbox"/> pregnancy
<input type="checkbox"/> drug and alcohol use	<input type="checkbox"/> sexually active	<input type="checkbox"/> running away
<input type="checkbox"/> temper outbursts	<input type="checkbox"/> fighting	

Please specify any other significant problems: \_\_\_\_\_

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### **MEDICAL/HEALTH HISTORY**

Check if applicable any of the following health problems your child has had:

<input type="checkbox"/> ear infections	<input type="checkbox"/> rashes or skin problems	<input type="checkbox"/> meningitis	<input type="checkbox"/> seizures
<input type="checkbox"/> pneumonia	<input type="checkbox"/> trouble with eyes/vision	<input type="checkbox"/> asthma	<input type="checkbox"/> anemia
<input type="checkbox"/> high fevers	<input type="checkbox"/> bowel problems	<input type="checkbox"/> surgeries*	
<input type="checkbox"/> serious injuries*		<input type="checkbox"/> allergies*	
<input type="checkbox"/> slow weight gain			
<input type="checkbox"/> lead poisoning	<input type="checkbox"/> heart problems	<input type="checkbox"/> kidney problems	
<input type="checkbox"/> drug overdose	<input type="checkbox"/> child physical or sexual abuse	<input type="checkbox"/> suicide attempt	<input type="checkbox"/> headaches
<input type="checkbox"/> trouble with ears/hearing		<input type="checkbox"/> hospitalization*	

\*Please give  
details: \_\_\_\_\_

\_\_\_\_\_  
List medications used over several  
months/years: \_\_\_\_\_

\_\_\_\_\_  
Primary Care Physician or Pediatrician and other treating medical doctors (e.g.,  
psychiatrists): \_\_\_\_\_

**SOCIAL HISTORY**

Were/are both parents involved in the child's care?

\_\_\_\_\_  
Who stays with the child when the child is ill?

\_\_\_\_\_  
Does your child require much scolding or discipline? \_\_\_\_\_ Please  
explain. \_\_\_\_\_

\_\_\_\_\_  
What forms of discipline/guidance do you use?

\_\_\_\_\_  
What is your child's reaction to discipline/guidance?

\_\_\_\_\_  
Do parents usually agree on discipline/guidance? If no, please  
explain. \_\_\_\_\_

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Do you have extended family or friends in the community to help with the child?

Describe. \_\_\_\_\_

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Does the child have a close relationship with an adult not presently living at home?

\_\_\_\_\_

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Have brothers or sisters of the child experienced any learning or behavioral problems?

\_\_\_\_\_

If so,

explain: \_\_\_\_\_

\_\_\_\_\_

Have other family members, including parents, experienced any learning, behavioral, or emotional problems? If so, please

explain: \_\_\_\_\_

\_\_\_\_\_

Are you satisfied with your child's progress in school?

\_\_\_\_\_

\_\_\_\_\_

What does your child say about school?

\_\_\_\_\_

\_\_\_\_\_

What activities does the child do when not in school?

\_\_\_\_\_

\_\_\_\_\_

What activities does the family do together?

\_\_\_\_\_

\_\_\_\_\_

Have there been any important changes in the family during the last year (examples: job changes, moves, births, deaths, separation or divorce)?

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How does the child get along with others (family, neighbors, peers)?

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Does your child have any habits which concern you (nail-biting, bedwetting, drugs, truancy, etc.)?

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Who watches your child after school hours?

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What kinds of jobs or household responsibilities does your child have?

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Does he/she do them willingly?\_\_\_\_\_Without prompting?

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Has your child ever received special services and/or special education or been hospitalized for behavioral or emotional reasons?\_\_\_\_\_ Please explain and provide records\_\_\_\_\_

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Please list the names and addresses of any doctors, psychologists, speech therapists, or other professionals who have evaluated your child. Please note if your child receives Special Education.

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At this stage of your child's development, please discuss those aspects of your child's development (mental, social, physical, or emotional) about which you feel pleased--areas of the child's strengths.

If you would care to, please discuss your aspirations for this child--what you hope or expect him/her to become as an adult.

Please feel free to add any information you feel will add to my understanding of your child.

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### OFFICE INFORMATION

- I appreciate the opportunity to work together with you. My goal is to provide effective and efficient help for the problems you are experiencing. Below is information about my office policies.
- My intention is for my office to feel comfort and safe. Please let me know if there is anything I can do to help you feel more comfortable.
- The first appointment is generally an **Initial Evaluation** and lasts approximately one to one and a quarter hours. Prior to the first visit, please complete the appropriate forms as they provide information for the first meeting. You can send those forms back or bring them with you on your first visit.
- The information you share with me is confidential and this information will not be discussed with anyone without written consent, except in the following situations: 1.) If you share information that indicates that you are a danger to yourself or others; 2.) If abuse of a minor, elderly, or disabled person is suspected, or if you provide information about such abuse; 3.) To insurers for claims payment; 4.) To mental health professionals who are in association with the psychologist for purposes of "covering" for me when I am unavailable or for purposes of hospitalization or for emergency psychiatric services; 5.) As required by state law; 6.) If I were appointed by the court to evaluate/provide service to you; 7.) If you were to file a suit against me for breach of duty.
- Please notify me as soon as possible and within 24 hours when canceling or rescheduling an appointment. The reason for doing this is that we have agreed to meet at a specific time and this time slot is reserved for you. Missed appointments or those canceled with less than 24-hour notice carry a charge of 75% of full fee. This fee is payable before or at the time of the next appointment. The client, not the insurance carrier, is responsible for this charge. Payment is expected at the time of service. I accept cash, checks, and Visa and Mastercard credit cards.
- You are responsible for knowing your insurance benefits, including knowing whether a mental health provider is on your plan, and the type of services covered by your plan. The services you receive may exceed the benefits provided in your insurance or managed care benefits package. Managed care/insurance plans are often complicated, and I share what I know to help guide you in understanding what services and costs your plan accepts. Ultimately, it is your responsibility to know and manage your benefits. Accounts due for over 30 days are considered overdue. Delinquent accounts may be turned over to a collection agency and a surcharge will be added.
- I check my voice mail throughout the day and return calls as soon as possible, usually within a couple of hours or at the end of my work day. For urgent matters feel free to contact me on my business cell phone (512) 773-3923. In a life threatening situation contact your doctor, psychiatrist, the mental health hotline 472-4357, or go to the nearest emergency room.
- Please let me know if you have any questions or problem with my services. It is most productive to work out concerns at the time they occur. The ethical guidelines and practice standards published by the American Psychological Association and the American Association of Marriage and Family Therapists are adhered to in my practice. Questions about consumers' rights may be addressed to the Texas State Board of Examiners of Psychology (512/305-7700) and The Texas State Board of Examiners for Marriage and Family Therapists (512/834-6657)..

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**Keep a copy of this for your records**

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**Fee Information**

The following is a list of my fees for psychological services:

Diagnostic Assessment/Intake Assessment	(90791)	\$150
Individual Therapy 45 minutes	(90834)	\$125
Family/Couples Therapy 50 minutes	(90847)	\$130
Individual Therapy 30 minutes	(90832)	\$ 90
Individual Therapy 60 minutes	(90808)	\$140
Individual/Family Therapy 90 minutes		\$175
Group Therapy 90 minutes	(90853)	\$ 50
Neurofeedback in 10 session packets		\$1200
Coaching 60 minutes		\$130
Reports, letters up to 20 minutes		\$ 50
Reports, letters up to 45 minutes		\$100
Telephone Contact < 15 minutes		\$ 35
Telephone Contact < 30 minutes		\$ 60
Telephone Contact < 45 minutes		\$ 85
Court or Deposition Services (per hour)		\$250
No Call/No Show w/out 24 hour notice (Insurance does not cover this cost)		75 % of full fee

These fees do not reflect any contracted discounts with managed care plans or individuals. The total fee, or the agreed upon co-payments are due at the time of service unless alternative arrangements have been made.

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**My signature attests to the following: 1) I have read the Office Information and Fee Information forms, and I consent to engage in psychological services; 2) I authorize Patricia Koch, Ph.D. to release any pertinent information acquired in the course of my evaluation and treatment to my insurance company; 3) If pertinent, I authorize my insurance benefits to be paid directly to Patricia Koch, Ph.D., and I understand I am financially responsible for non-covered services; 4) I understand that Patricia Koch, Ph.D. is not "on-call" after office hours or on weekends; 5) I understand that Dr. Koch is a sole practitioner in independent practice and is not part of a group practice.**

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Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Client)

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Client)

**Keep one copy of this contract for your records.  
Return one copy to me.**

REGISTRATION INFORMATION

Please Print

Date \_\_\_\_\_

Last Name		First Name		MI
Street Address	Apt. No.	City	State	Zip
Social Security No.	Sex	Date of Birth	Home Phone	Cell Phone
Employer	Occupation	Work Phone	E-mail	

PRIMARY INSURANCE INFORMATION

Insurance Company/Plan		Group No.	Member Identification Number		
Insurance Claim Address		Insurance Phone No.		Effective Dates	
			Self	Spouse	Dependent Other
Policyholder Last Name	First Name	MI	Relationship to Policyholder		
Policy holder Street. Address	Apt. No.	City	State	Zip	
Policyholder Employer	Occupation	Date of Birth	Sex		
Policyholder Home Phone	Policyholder Work Phone		Other Phone		

SECONDARY INSURANCE INFORMATION

Insurance Company/Plan		Group No.	Member Identification Number		
Insurance Claim Address		Insurance Phone No.		Effective Dates	
			Self	Spouse	Dependent Other
Policyholder Last Name	First Name	MI	Relationship to Policyholder		
Policy holder Street. Address	Apt. No.	City	State	Zip	
Policyholder Employer	Occupation	Date of Birth	Sex		
Policyholder Home Phone	Policyholder Work Phone		Other Phone		

EMERGENCY CONTACT

Last Name	First Name	Home Phone No.	Work Phone No.	Other Phone	
Street Address	Apt. No.	City	State	Zip	

Patricia Koch, Ph.D. Licensed Psychologist  
HIPAA Notice of Privacy

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**THIS NOTICE DESCRIBES HOW YOUR PRIVATE HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Private Health Information may be used and disclosed in the following circumstances:

1. When required for public health issues such as workman's compensation.
2. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
3. When required by any state or federal law, including abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservist, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits.

You as the patient have rights to your private Health Information, including,

1. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored within 30-60 days.
2. The right to request information of any party that has requested information pertaining to your private health information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing, however, this will not affect any information already disclosed.

I, as a private practitioner have the responsibility to:

1. Make each patient aware of the Privacy Notice.
2. At any time make the necessary changes to Privacy Notice that are required by law.

If you as the patient feel your privacy has been violated you have the right to complain by filing a written complaint with the Secretary of Health and Human Services in Washington, D.C.

I \_\_\_\_\_, hereby authorize Patricia Koch, Ph.D. to release private health information on my behalf to the following person(s): \_\_\_\_\_

\_\_\_\_\_  
Patient/Legal Guardian/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Patricia K. Koch, Ph.D.  
Licensed Psychologist

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR  
TREATMENT, PAYMENT, & OPERATION**

I understand that as part of my healthcare, Patricia Koch, Ph.D. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means for communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third-party payer can verify that services billed were provided.
- A tool for routine operations such as assessing quality of care.

I understand and have been provided with a HIPAA Notice of Privacy that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Patricia Koch, Ph.D. reserves the right to change her notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that my health information will not be used for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment or payment. I understand that I may revoke this consent in writing, except to the extent that Patricia Koch, Ph.D. has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

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

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Patricia K. Koch, Ph.D.  
Licensed Psychologist

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**Consent to E-Mail**

In order to comply with HIPAA law, I am required to inform you that while my computer is password protected, my E-mail is not considered to be secure. If you would like to communicate with me via my E-mail, you are required to provide informed consent.

I understand that my E-mail communications with Patricia Koch, Ph.D. are not considered secure. However I would like to communicate with her via E-mail.

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Patient/Legal Guardian

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Date

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Witness

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Date