

CHILD GUIDANCE CLINIC

DESCRIPTION OF SERVICES, PROCEDURES AND CONFIDENTIALITY

The Child Guidance Clinic is a community service for children and families and is part of the County Health Department. The services provide early detection, diagnosis and treatment for children and families who have developed behavioral, emotional, social, speech, language, hearing, and intellectual and communication problems; and provides intervention services, which enhance the development of children. Adults or children identified as needing services not available in the Child Guidance Clinic are provided with appropriate referrals. Services will be provided based on the needs of the client and availability of specific staff. Individual cases are reviewed by a team of staff members for thoroughness.

CHILD GUIDANCE CLINICS MAY CONSIST OF THE FOLLOWING SERVICES:

Parent Education Services:

Child Development Specialists offer programs which focus on the prevention of developmental and behavioral problems by providing assessment, education and intervention services to parents and young children; administer developmental screenings and assessments to children birth through age eight; provide parent consultation with regard to their child's growth, development and behavior; teach parent study groups to enhance parenting skills and strengthen family interaction. It is not the intent of educational services to remediate or treat mental health and/or behavioral problems in children or adults.

Psychosocial Services:

Psychology staff offer services to promote, maintain or restore mental health to children and families in coordination with developmental and physical health services. Psychosocial staff assess, diagnose and treat mental health problems and promote healthy interactions in the prevention of mental disorders.

Speech, Language, Hearing Services:

Speech-language pathologists evaluate children's speech and language abilities. Following evaluation, parents are counseled regarding their child's development in the areas of language, articulation, fluency and voice. Hearing acuity is screened and additional tests may be administered to assess the efficiency with which the child is able to understand and use what he hears. If treatment of a problem area is indicated, a variety of methods may be used to help the child improve his skills, including involvement of parents in a home program. Parents are often included in the sessions to encourage positive parent-child interaction and increase language stimulation.

Screenings:

A screening is not a complete evaluation. It is a method used to check for possible problems in development, speech, language, hearing, social, emotional and/or behavioral skills. Not passing a screening does not necessarily indicate a disorder, but rather is an indication for referral for more in-depth testing. Due to the limited nature of a screening, certain problems may not be entirely ruled out even if a screening is passed.

General Information:

Information is collected as part of the service process for assessment, intervention planning and supervision purposes. Most of the information will be recorded in written form and, as appropriate, some information is recorded on audio and/or videotapes. All information is kept confidential and cannot be released without your written permission. There are, however, special situations under which confidential information could be revealed. These include:

- A "duty to warn" ethic allows a clinician to break confidentiality when danger exists to the client and/or others.
- Under special circumstances, the court may subpoena a client's records and may order a clinician to give testimony during a court hearing.

The fees charged are based on a sliding scale and are determined by the annual gross income and size of your family. No one is refused services because of an inability to pay.

If you cannot come to an appointment or group session, please let the Child Guidance Clinic know at least 24 hours ahead of time.

PREVIOUS EVALUATIONS:

HAS THIS CHILD EVER HAD A/AN

- A. PSYCHOLOGICAL OR PSYCHIATRIC EXAMINATION? _____ DATE: _____
FINDINGS: _____
- B. SPEECH EXAMINATION? _____ DATE: _____
FINDINGS: _____
- C. VISION AND/OR HEARING EXAMINATION? _____ DATE: _____
FINDINGS: _____
- D. EDUCATIONAL EVALUATION: _____ DATE: _____
FINDINGS: _____
- E. OTHER EXAMINATIONS: _____ DATE: _____

DEVELOPMENTAL HISTORY:

AT WHAT AGE DID YOUR CHILD

- A. SMILE AT PARENTS? _____
- B. SIT ALONE? _____
- C. CRAWL? _____
- D. WALK ALONE? _____
- E. GAIN BOWEL CONTROL? _____
- F. GAIN BLADDER CONTROL? _____
- G. SAY FIRST WORDS? _____
- H. USE SMALL SENTENCES? _____

ANY CONCERNS ABOUT THIS CHILD'S DEVELOPMENT? _____

SCHOOL HISTORY:

IF THIS IS A SCHOOL REFERRAL STATE REASON FOR REFERRAL: _____

CURRENT SCHOOL: _____

IS CHILD CURRENTLY ENROLLED IN A PRE-SCHOOL OR CHILD CARE CENTER? _____

IF SO, HOW MANY PRE-SCHOOLS OR CHILD CARE CENTERS HAS THIS CHILD ATTENDED? _____

NUMBER OF SCHOOLS ATTENDED SINCE 1ST GRADE? _____

NAME OF CENTER: _____

HAS THIS CHILD EVER

- A. BEEN PLACED IN A SPECIAL CLASS? _____ WHAT KIND? _____
- B. RECEIVED REMEDIAL INSTRUCTION? _____ WHAT SUBJECT? _____
- C. REPEATED ANY GRADES? _____ WHICH GRADE? _____
- D. RECEIVED TUTORING? _____ WHICH SUBJECTS? _____
- E. RECEIVED SPEECH THERAPY? _____ WHEN? _____ HOW LONG? _____
- F. BEEN TESTED BY SCHOOL COUNSELOR? _____ WHEN? _____
- G. BEEN EXPELLED FROM SCHOOL? _____ WHEN? _____ REASON? _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SCHOOL PERFORMANCE? _____

SPEECH, LANGUAGE AND HEARING:

DO YOU HAVE ANY CONCERNS ABOUT THIS CHILD'S SPEECH, LANGUAGE OR HEARING? _____

ADDITIONAL INFORMATION:

IS THERE ADDITIONAL INFORMATION WHICH WOULD HELP US TO BETTER UNDERSTAND YOUR CHILD'S/FAMILY'S NEEDS?

SIGNATURE OF PERSON COMPLETING APPLICATION

TO BE COMPLETED BY PARENT/GUARDIAN

| | | | |
|-------------|---------|------|---------------|
| NAME (Last) | (First) | (MI) | DATE OF BIRTH |
|-------------|---------|------|---------------|

FAMILY HISTORY: List relatives (mother, father, brothers, sisters, aunts, uncles, grandparents) who have or have had any conditions.

| CONDITION | YES | CONDITION | YES | CONDITION | YES |
|---|-----|---|-----|--------------------------|-----|
| Allergy to Medication, Food, Pollen, Etc. | | Drug/Alcohol Abuse | | Physical Abuse | |
| Anemia/Sickle Cell Trait | | Eye/Ear Disorders | | Psychiatric Conditions | |
| Arthritis/Joint Disease | | Heart Disease | | Rheumatic Fever | |
| Asthma, Emphysema | | High Blood Pressure | | Sexual Abuse | |
| Birth Defects | | Kidney/Urinary Tract Disease | | T.B., Other Lung Disease | |
| Blood Disease | | Mental Retardation | | Thyroid Disease | |
| Cancer: Specify | | Muscle/Bone Disease | | Venereal Disease | |
| | | Nerve Disorder: Epilepsy, Cerebral Palsy, Etc. | | Other: | |
| | | | | | |
| Diabetes | | | | | |

DOES EITHER PARENT OR PERSON CARING FOR THE CHILD HAVE ANY SERIOUS OR CONTINUING HEALTH PROBLEMS? YES NO
 EXPLAIN: _____

MOTHER'S PRENATAL HISTORY: Check or give answer to each question.

| | | |
|-----------------|---|---|
| PRENATAL | NUMBER OF PREGNANCIES? _____ | HOW MANY LIVING CHILDREN DO YOU HAVE? _____ |
| | WAS THIS A PLANNED PREGNANCY? <input type="radio"/> NO <input type="checkbox"/> YES | |
| | DATE OF PREVIOUS PREGNANCY: _____ | |
| | DID YOU RECEIVE PRENATAL CARE DURING YOUR PREGNANCY? <input type="radio"/> NO <input type="checkbox"/> YES | |
| | IF SO, WHERE? _____ | <input type="checkbox"/> DOCTOR <input type="checkbox"/> CLINIC <input type="checkbox"/> MIDWIFE <input type="checkbox"/> 10 OR MORE <input type="checkbox"/> YES |
| | NUMBER OF VISITS FOR CARE? _____ | <input type="radio"/> 1-3 <input type="radio"/> 4-9 <input type="checkbox"/> NO |
| | WERE YOU ON THE WIC PROGRAM WHILE PREGNANT? _____ | |
| | HOW MUCH WEIGHT DID YOU GAIN WHILE PREGNANT? _____ | |
| | DID YOU HAVE ANY HEALTH PROBLEMS BEFORE THIS PREGNANCY? <input type="radio"/> YES <input type="checkbox"/> NO | |
| | DID ANY OF THE FOLLOWING OCCUR WHILE YOU WERE PREGNANT? <input type="radio"/> Bleeding <input type="radio"/> High Blood Pressure <input type="radio"/> Surgery <input type="radio"/> Anemia <input type="checkbox"/> NONE | |
| | <input type="radio"/> Urinary Tract Infection <input type="radio"/> Accidents <input type="radio"/> Swelling of Hands or Face <input type="radio"/> Other Infections <input type="radio"/> Other (specify) _____ | |

CHILD'S BIRTH HISTORY: Check or give answer to each question

| | |
|-----------------|---|
| DELIVERY | WHERE WAS THE BABY BORN? <input type="radio"/> Home <input type="radio"/> Other (Specify) _____ <input type="checkbox"/> Hospital |
| | WHO DELIVERED THE BABY? <input type="radio"/> Midwife (Specify) _____ <input type="radio"/> Other (Specify) _____ <input type="checkbox"/> Doctor |
| | HOW MANY HOURS WERE YOU IN LABOR? _____ |
| | WHAT TYPE OF DELIVERY? <input type="radio"/> Caesarean Section <input type="radio"/> Breech <input type="checkbox"/> Normal |
| | DID YOU RECEIVE ANY MEDICATION OR ANESTHETIC DURING LABOR? <input type="radio"/> YES <input type="checkbox"/> NO |
| | COMMENTS: _____ |
| | WERE THERE ANY COMPLICATIONS DURING LABOR AND DELIVERY? <input type="radio"/> YES <input type="checkbox"/> NO |
| | COMMENTS: _____ |
| | HOW OLD WERE YOU WHEN THIS BABY WAS BORN? _____ |
| | WAS THIS A MULTIPLE BIRTH (TWIN, TRIPLET)? <input type="radio"/> Yes <input type="checkbox"/> No |

| | | |
|-------------|---|------------------------------|
| BABY | HOW MUCH DID THE BABY WEIGH? _____ | HOW LONG WAS THE BABY? _____ |
| | DID THE BABY HAVE ANY PROBLEMS? <input type="radio"/> YES <input type="checkbox"/> NO | |
| | IF YES, WHAT? <input type="radio"/> Breathing <input type="radio"/> Color <input type="radio"/> Other _____ | |
| | DID THE BABY HAVE AN LV. OR OXYGEN? <input type="radio"/> YES <input type="checkbox"/> NO | |
| | WAS THE BABY IN AN INCUBATOR? <input type="radio"/> YES <input type="checkbox"/> NO | |

CHILD'S HEALTH HISTORY: HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING PROBLEMS? IF SO, PLEASE GIVE AGE.

| | | | | |
|-----------------------------|---|--|------------------------|-----------------------|
| PAST MEDICAL HISTORY | ALLERGIC RHINITIS _____ | CONSTIPATION _____ | KIDNEY INFECTION _____ | RHEUMATIC FEVER _____ |
| | ANEMIA _____ | CONVULSIONS _____ | LEUKEMIA _____ | RUBELLA _____ |
| | ASTHMA _____ | DIARRHEA _____ | LYMPHOMA _____ | SCARLET FEVER _____ |
| | BLEEDING _____ | EAR PROBLEMS _____ | MEASLES _____ | SICKLE CELL _____ |
| | CANCER _____ | EYE PROBLEMS _____ | MUMPS _____ | TONSILLITIS _____ |
| | CHICKENPOX _____ | FRACTURES _____ | PNEUMONIA _____ | WHOOPING COUGH _____ |
| | | | | OTHER _____ |
| | HOSPITALIZATIONS _____ | EMERGENCY ROOM VISITS _____ | | |
| | DOES YOUR CHILD SEEM TO BE DEVELOPING NORMALLY? _____ | DO YOU UNDERSTAND WHAT YOUR CHILD SAYS TO YOU? _____ | | |
| | DOES YOUR CHILD HEAR WELL? _____ | | | |

Reviewer's Signature _____ Date _____