8 Myrtle Avenue
Westport, CT 06880
(203) 908-5603

Mark Beitel, Ph.D.

Licensed Clinical Psychologist

3 Sylvan Road South, Box 10 **Westport, CT 06880** **203.644.0798**

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Background Information

Identifying Data

Name of patient: _____
Address: _____
Telephone: _____
Date of Birth: _____
Age: _____
School: _____
Grade: _____
Today's Date: _____

Reason for Referral

Who referred the patient: _____
What is the purpose of the referral: _____
Please write five words that describe the patient: _____
_____
Please list the patient's current problems: _____
_____
_____
Problems eating (if yes, describe): _____
Problems sleeping (if yes, describe): _____
Problems with self-esteem (if yes, describe): _____
Problems with academic self-esteem (if yes, describe): _____
Problems with body image (if yes, describe): _____
Problems with speech/language (if yes, describe): _____
_____
Problems with sensory integration (if yes, describe): _____
Problems with vision (if yes, describe): _____
Problems with auditory processing (if yes, describe): _____
Chronic illnesses (please describe): _____
Alcohol / Substance use (if yes, list each substance, note severity, and date of first use): _____
_____
_____
Rate the patient's fine motor skills (circle one): Below Average Average Above Average

Rate the patient's gross motor skills (circle one): Below Average Average Above Average
Has the patient received OT services (if so, list dates): _____
How is the patient doing in school: _____
How does the patient feel about school: _____
Does the patient have accommodations in school (if so, describe): _____
_____
Rate the patient's social skills (circle one): Below Average Average Above Average
Please list the patient's current strengths: _____
_____
What does the patient do for fun: _____
What does the patient do for exercise: _____

Developmental and Medical History

Is the patient adopted (circle one): Yes No
Was conception complicated? If so, how: _____
Was labor complicated? If so, how: _____
Was delivery complicated? If so, how: _____
Length at birth: _____ If unknown, circle one of the following: Normal Abnormal
Weight at birth: _____ If unknown, circle one of the following: Normal Abnormal
Head circumference at birth: _____ If unknown, circle one: Normal Abnormal
At what age did the patient roll over: _____
At what age did the patient first sit up: _____
At what age did the patient crawl: _____
At what age did the patient walk: _____
At what age did the patient talk: _____
Who is the patient's physician: _____ Town: _____
Current height: _____ weight: _____
Please list major or recurrent illnesses (and dates of onset/duration): _____
_____
_____
_____
Does the patient have allergies (if yes, describe): _____
Has the patient seen a psychotherapist (if yes, name provider and give dates/duration/frequency of sessions): _____
_____
Has the patient seen a psychiatrist (if yes, name provider and give dates): _____
_____
Has the patient seen a neurologist (if yes, name provider and give dates): _____
_____
Please provide medication history (include dates, doses, and prescriber): _____
_____
_____
Please list current medications (include dates, doses, and prescriber): _____
_____
When was the patient's last physical examination: _____
When was the patient's last dental examination: _____
Please list any dental problems: _____
When was the patient's last eye exam: _____
Please list vision problems: _____

Does the patient wear corrective lenses (circle one): Yes No
When was the patient's last hearing test: _____
Please list hearing problems: _____

Family and Social History

Where does the patient live: _____
Has the patient moved houses: Yes No If so: when and where: _____
Who lives with the patient (include age and sex of siblings): _____
Are the patient's parents married (if divorced, provide date of separation): _____
Is the family religious (if so, which religion): _____
If religious, does the family attend services (if so, where and how frequently): _____
_____
Has the patient participated in religious education (if so, any problems?): _____
_____
Does the patient have close relationships (circle one): Yes No
How many close friends does the patient have: __
Does the patient socialize with peers outside of school (if so, how frequently): _____
_____

Educational History

Please describe the patient's academic difficulties (if any): _____
_____
_____
Please list all educational institutions attended to date (including preschool): _____
_____
_____
_____
_____
_____

Please list problems and services by grade:

Preschool	
Kindergarten	
1st grade	
2nd grade	
3rd grade	
4th grade	
5th grade	
6th grade	
7th grade	
8th grade	
9th grade	
10th grade	
11th grade	
12th grade	

Current 504 Plan: Yes or No (Circle one)
Ever had an 504 Plan: Yes or No (Circle one)
If Yes, date of 504 Plan implementation: _____ and end date _____

Current IEP: Yes or No (Circle one)
Ever had an IEP: Yes or No (Circle one)
If Yes, date of IEP implementation: _____ and end date _____

Please list previous evaluations:

Date	Type	Examiner	Purpose	Findings

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Estimate for Psychological Testing

Service	Estimated Time (in hours)
Intake Interview	1
Record Review	0-1
Face-to-Face Testing	5-8
Write-Up Time	5-7
Feedback	1

The fee for the psychological testing-related services listed above is $7000.00. Additional services are provided at an hourly rate of $700.00 (such as attendance at a meeting beyond the feedback meeting). Testing costs might be insurance reimbursable. However, patients are responsible for navigating this process. It is important to note that psychological testing has some risks and benefits. Testing can help clarify the diagnostic picture, identify psychological and academic strengths and weaknesses, and more. We examine cognitive function, academic achievement, fine-motor skill, attention, and psychological symptoms.

One potential risk is that the examinee might experience stress and/or fatigue from the testing process. Also, the examiner creates a test report based upon findings and clinical impression. The findings/impression might be at odds with stakeholder's expectations. It is important to note that the report will not be changed substantively after it is written (unless there is an obvious error of fact). Please note that the person or entity who pays for the report owns it. Additionally, the findings might be subject to use in legal proceedings.

I _____ hereby acknowledge that I have received this estimate for psychological testing.

_____ _____
Signature Date

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Release of Confidential Information

I, _____, hereby request the release of confidential information about clinical care, which might involve information related to psychological assessment and/or psychotherapy. Specifically, I have requested that Mark Beitel, Ph.D. communicate with _____ _____ about my case for the purposes of treatment coordination and planning. This release shall remain in effect 180 days from the date signed.

Signed: _____ Date: _____

Please Print: _____