

**Thomas H. White, Ph.D.**  
Child, Adolescent, Adult and Family Psychology  
Licensed Psychologist

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**WELCOME TO THE OFFICE**

Enclosed you will find a questionnaire. This questionnaire is to assist us in better understanding your situation/problem. We recognize that there are a lot of questions, so if you do not understand a particular question or feel uncomfortable answering a question, feel free to leave it blank. We will review this questionnaire and discuss it thoroughly with you in our first appointment. We ask that you bring this packet with you to your first appointment along with your insurance card.

Please arrive 10 minutes early to check in with our reception staff. If you are unable to keep this appointment, we ask that you please call our staff so that they can assist you with re-scheduling or canceling the appointment.

Treatment with our office is voluntary and can be terminated at any time without penalty. Our goal is to be as helpful to you as possible and to assist you in most effectively dealing with your current problems. If at any time you have questions, concerns or ways we might improve our services, we would appreciate your input.

I understand that, in all cases, strict standards of confidentiality and professional ethics will be maintained. I give my permission to be treated by this office.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

(Parent/Guardian if client is a minor)

Dr. Thomas H. White, Ph.D., is a licensed psychologist who has been in private practice since 1984. Prior to entering private practice, Dr. White was the school psychologist and special education coordinator for the Franklin County School System, and later the Buford City School System. He was a member of the committee that re-wrote the Georgia Department of Education Guidelines for the Learning Disabilities program. He received his Masters and Doctoral degrees from the University of Georgia in Educational Psychology, and then continued his training in Clinical Psychology through internships at Georgia Baptist Medical Center and Atlanta Area Psychological Services.



## FINANCIAL POLICY

It is the policy of this office to request payment for services at the time the service is rendered. If it would be more helpful for you to pay the deductible and co-payment, we will be glad as a service to file your insurance for you. However, we cannot guarantee payment in part or in full by any insurance company or other party, and therefore, you are ultimately responsible for any charges you incurred. Co-payments are requested at the time of service. We also accept payments by Visa/MasterCard.

We want to be sensitive to financial hardships that you may have and we will be glad to develop alternative methods of payment. Please discuss this with us and we will be glad to work with you in any way possible. However, if you fail to follow the mutually agreed to method of payment, we will consider the charges to be delinquent and will take appropriate action to receive payment for the charges incurred.

### **MISSED APPOINTMENTS AND CANCELLATIONS:**

We require a 24-hour notice of cancellation if you are unable to keep your scheduled appointment. There will be a charge for any appointment, which is not canceled with a 24-hour notice. Please be aware that your insurance company will not reimburse for missed appointments. If you have two consecutive missed appointments without 24-hour notification, you will not be rescheduled.

### **FORMS AND LETTERS:**

A fee will be incurred for the completion of forms and letters. Your doctor and/or therapist can inform your of the specific charge.

**NOTE:** In cases of divorce and/or separation, the parent who originally brought the child in for services is responsible for paying this office, regardless of which parent is legally responsible for insurance coverage and medical bills, as established by a divorce or any other agreement. Assignment from the non-custodial parents insurance carrier will be accepted only after this office has his/her signature on file.

**I HAVE READ AND UNDERSTAND THE ABOVE BILLING POLICY. I AGREE TO PAY FOR SERVICES UNDER THE CONDITIONS AND SPECIFICATIONS SET FORTH IN THIS BILLING POLICY AND ACKNOWLEDGE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES PROVIDED, REGARDLESS OF INSURANCE COVERAGE.**

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of person responsible for bill after insurance

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # (home): \_\_\_\_\_ (work) \_\_\_\_\_

Who referred you to our office: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

School (if child): \_\_\_\_\_ Grade: \_\_\_\_\_

I. Describe in one sentence what prompted you to schedule this appointment: \_\_\_\_\_

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

What problems are you currently experiencing?	How long has this been present?	Is this worsening, improving or unchanged?
1.		
2.		
3.		
4.		
5.		

Please circle all that apply:

Decreased appetite  
 Increased appetite  
 Low energy  
 High energy  
 Withdrawal from others  
 Decreased ability to enjoy things  
 Excessive worrying  
 Explosive temper  
 Self-criticism  
 Tearfulness

Frequent crying  
 Impulsivity  
 Distractibility  
 Decreased concentration  
 Sleeping too much  
 Decreased sleep  
 Trouble waking too early  
 Violence  
 Aggression  
 Nightmares

Visual hallucinations  
 Auditory hallucinations  
 Intrusive thoughts  
 Bothersome thoughts  
 Inability to hold a job  
 Relationship problems  
 Sexual problems  
 Alcohol or drug problems  
 Legal problems

If the patient is a child, please circle symptoms that apply:

History of ADHD  
 Decline in grades  
 Stealing  
 Avoidance of school  
 Cruelty to animals  
 Drug use  
 Bedwetting  
 Lack of respect for authority

Learning disabilities  
 Fire setting  
 Lying  
 Runaway  
 Skipping school  
 Alcohol use  
 Developmental disabilities  
 Problems getting along with friends

School failure  
 Explosive behavior  
 Unusual fears  
 Sexual activity  
 Tics  
 Tobacco use  
 Problems with the law

Significant stressors experienced in the past year:

___ Major losses:	
___ Moves:	
___ Work:	
___ Family:	
___ Other:	

**II. Past Psychiatric History:**

Previous Outpatient Treatment	Treatment Dates	Treatment Provider	Reason for Treatment	Results
Psychiatric Hospitalizations				

Prior medication for depression, anxiety, etc...

Date	Name	Dosage	Response

**III. Past Substance Abuse History:**

Substance Used Alcohol/Drugs	Age Started	Time Period of Use	Amount Used	Date of Last Use	Effect/Consequences	Treatment

**IV. Medical History Problems:**

Medical problems: (if you have or have ever had a problem, please circle)

- |                     |                    |               |                    |
|---------------------|--------------------|---------------|--------------------|
| Diabetes            | Rapid heart rate   | Stroke        | Kidney problems    |
| Thyroid problems    | Breathing problems | Back problems | Migraine headaches |
| High blood pressure | Asthma             | Head injury   | Meningitis         |
| Heart problems      | Seizures           | Anemia        | Dizziness          |
| Other _____         |                    |               |                    |
| Other _____         |                    |               |                    |

Surgeries/Major Illnesses	Time Period	Physician

Current Primary Care Physician: \_\_\_\_\_

Permission to communicate with Primary Care Doctor? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you seeing any other physicians (family doctor or specialist) or therapist? If so please list current medications:

Medication	Dosage	When Started	Reason	Prescribing Physician

Medication allergies: yes \_\_\_\_\_ no \_\_\_\_\_

If yes – medication allergy \_\_\_\_\_

**V. Family History**

In your immediate or extended family, has anyone experienced problems with:

	Relation
___ Depression	
___ Excessive Anxiety	
___ Manic/Depression	
___ Schizophrenia	
___ Suicide	
___ Drug/Alcohol Problems	
___ Abuse	

**VI. Psychosocial History;**

Who currently lives in your household?

Name	Age	Relation

Marital status of self or for child (parents): \_\_\_\_\_

Number of marriages: \_\_\_\_\_ Length of present marriage: \_\_\_\_\_

Dates of previous marriages: \_\_\_\_\_

**Work History:**

\_\_\_ Employed                      \_\_\_ Unemployed                      \_\_\_ Disabled                      \_\_\_ Retired

Current job: \_\_\_\_\_ Length of employment: \_\_\_\_\_

Work related concerns: \_\_\_\_\_

**Educational Background:**

Adult – Last completed grade: \_\_\_\_\_

Child – Current grade: \_\_\_\_\_ School: \_\_\_\_\_

School changes: \_\_\_\_\_

School concerns: \_\_\_\_\_

**Legal Background:**

Adult – Past or present legal problems: \_\_\_\_\_

Child – Legal problems: \_\_\_\_\_

Custody information: \_\_\_\_\_

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**Support System:**

Number of close friends/family members: \_\_\_\_\_

Changes with relationship to friends: \_\_\_\_\_

Hobbies/interests: \_\_\_\_\_

Religious preference/beliefs: \_\_\_\_\_