Warner Family Counseling
Kaylene Warner LCSW
ADD/ADHD Evaluation

The charge for this service is $160.00. Payment is expected at time services are rendered. The evaluation process begins with a written and verbal assessment. At the conclusion of this process Ms. Warner will score the written assessment and complete a written summary. Contact will then be made with your physician by Ms. Warner. She will provide the findings from this assessment, recommendations for medications and further treatment if warranted and fax a copy of the summary for your medical record. Please allow *7-10 business days* for case management to be completed. At this time please contact your physician to discuss a treatment plan.

Name _____ Date of Birth: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip Code: _____
Employer: _____ Occupation: _____
Best Phone Number to Reach You: _____
Is it okay to leave a message at these numbers? Y N
Email Address: _____

Family Information

Child Name	Sex	Age	With whom does child live

List any other individuals living in the home:

_____

Is there any family history of mental illness or substance abuse? Please explain.

_____

Presenting Problem

Please list the reasons that bring you here today. This may include certain problems, issues, significant losses or changes that are causing you stress.

1. _____
2. _____
3. _____

4. _____

Medical History & Information

Are you being treated by a physician for any medical treatments? Please describe.

_____

_____

Are you currently taking any medications? List medication and dosage.

_____

_____

Have you ever been treated for ADD/ADHD in the past? IF so when and with what means of treatment. _____

Who is your physician? _____

Last visit? _____Follow up date: _____

Referral Source

How did you learn about this office? _____

Release of Information

I, _____whose date of birth is _____authorize Kaylene Warner LCSW to disclose and and/or obtain to/from _____

Whose contact information is as follows_____

Regarding:

__Assessment

__Diagnosis

__Psychological Evaluation

__ Medication Management

__Treatment Plan or Summary

__ Medical Information

__Progress in treatment

__ Other. Please specify _____

Expiration

Unless sooner revoked, this consent expires one year from date of signature.

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date