GARIN D. VICK, PSY.D.

CLINICAL & FORENSIC PSYCHOLOGY

Welcome, Thank you for allowing me to help your family.

Prior to the start of Reunification Therapy / Family Integration Therapy (RT/FIT), we will need the **Court Order for Reunification Therapy / Family Integration Therapy. Dr. Vick is required to respond to the Court and, if applicable, your attorney upon receipt of this document. RT/FIT cannot begin until this process is completed.*

We have included a packet of important information to be completed prior to your first session with Dr. Vick. Please call our office at (813) 689-2525 if you have any questions or concerns. Dr. Vick will review the paperwork with you at the beginning of your first session.

Please deliver the completed packet to our office prior to the first session. However, if you are unable to deliver the completed packet before the first session, we ask you to arrive to the session **30-minutes** early with your paperwork to allow Dr. Vick time to review your documents and completed questionnaires.

ALL PAPERWORK HAS TO BE COMPLETED AND SIGNED PRIOR TO MEETING WITH DR. VICK. IF NOT, YOUR SCHEDULED SESSION TIME WILL BE USED FOR YOU TO COMPLETE MISSING AND/OR UNFINISHED PAPERWORK. FOLLOWING THE COMPLETION OF YOUR PAPERWORK, DR. VICK WILL MEET WITH YOU FOR THE TIME REMAINING OF YOUR SCHEDULE APPOINTMENT.

PLEASE NOTE: Failure to complete all the enclosed paperwork will result in the need to reschedule your appointment and a charge of $400.00 for the (2 hour) scheduled session time that would have to be cancelled.

Thank you,

Dr. Vick

1463 Oakfield Drive, Suite136, Brandon, FL 33511 / (813) 689-2525 / (813) 689-4433 fax
Drgvick@gmail.com / www.Drgvick.com

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CLINICAL & FORENSIC PSYCHOLOGY

REUNIFICATION / FAMILY INTEGRATION THERAPY SERVICES AGREEMENT

Thank you for the opportunity to work with your family. Please excuse the length of this form. However, the complexity of these services necessitates detailed coverage of my policies and procedures.

This Document contains information on the Reunification/Family Reintegration Therapy (RT/FRT) process I have been retained to conduct upon order of the court, or upon stipulation of both parties and their attorneys, and retained by the court. As a psychologist licensed under Florida Statutes 491 and Qualified under Florida Statutes 61.125, I am trained, experienced, and legally qualified to conduct the services defined in this document.

Reunification Therapy (RT) is a clinical intervention employed when a parent and child have become estranged. It is **child-centered** and conducted by a mental health professional, who has specialized training in this type of family therapy. RT in a legal context implies that a cohesive family unit existed prior to the estrangement.

RT differs from a medical doctor visit in that it requires active participation and work from all parties involved. RT can be a challenging process for families, as family members often have varying perspectives of a conflict or event. However, the ease and success of RT can be increased if all parties involved are engaged, honest, and forthcoming with their emotions, perceptions, and experiences, as well as open to hearing the perceptions of others and feedback from the provider. All parents who have or want to have a significant role in the life of the child are required to participate in the Reunification Therapy, as co-parenting education is a significant aspect of RT.

The rigor of RT has both benefits and risks. RT will almost certainly involve discussing unpleasant memories or events and processing difficult emotions, such as sadness, anger, frustration, guilt, or insecurity. RT can be particularly difficult for parents, as the therapeutic process requires that each parent put aside any hurt feelings, old conflict, or manipulation to work towards what is best for the joint child or children. It would not be appropriate to view RT as time to be used to convince the provider of who is right, wrong, or the best parent. Rather, parents should strive for a relationship where their joint child(ren) feel free to build a healthy relationship with both parents without threat of interference or negative influence.

When successful, RT results in healthier relationships, reduced conflict, and lower stress parenting. However, there are no guarantees in this process and much of the outcome will be dependent on the work that the family is willing to put in. Families should be fully aware that RT does not always end in the reunification of the estranged party with their child or children. Goals and progress are continually assessed by the provider and if progress appears unlikely for any reason, the provider

may terminate services and refer for alternative services. Such alternative services include, but are not limited to, support groups, domestic violence treatment, chemical dependency treatment, group therapy, or individual therapy.

It should be noted that these services may be recommended by the provider to be completed before RT begins or to coincide with RT. In this event, the provider will direct the family to appropriate referrals. Even though others besides the child(ren) may also be clients in RT, providers are committed to addressing each case from a child-centered perspective. It is expected that parents, guardians, and other caregivers involved will commit to this perspective as well. All efforts will be made to proceed at an appropriate pace for the child(ren), which is different for each child. This does not mean that it is exclusively at the child or children's discretion to choose when contact with the estranged parent will resume. It is not uncommon for children to be fearful, apprehensive, or uncertain about reunification after an extended estrangement, but children can expect to process these difficult feelings as a part of therapy. This process in and of itself may be uncomfortable, but providers will make their best efforts to prepare children for these challenges and assess for their emotional preparedness. It will ultimately be at the provider's discretion to decide if the child(ren) are psychologically prepared to reunite with their estranged parent.

☐ ***The Role of the Reunification Therapist***

The relationship between the Reunification Therapist and the family participating in therapy is considered a professional one where the therapist is considered the "provider" and the family is considered the "client." While Dr. Vick cares deeply for his clients and work hard to provide high quality care, this relationship should not be considered personal or that of a friendship. Per the code of ethics, it would cross professional boundaries to interact with clients on social media or in the community in the context of a personal relationship. Even after the termination of therapy services, it would be considered unethical to have a personal relationship with a client. The provider should not be confused with Custody Evaluators, Parenting Time Expeditors, or Parent Consultants or other 3rd party mental health providers. Therefore, providers do not evaluate or make recommendations for parenting time, custody arrangements, or other similar legal matters, as this would be outside of their scope of practice. Dr. Vick is only qualified to make therapeutic recommendations pertaining to the Reunification Therapy process. as court appearances are not billable to insurance. Should Dr. Vick be called to testify in court regarding the reunification process, the party who has subpoenaed Dr. Vick will be responsible for all the costs charged by Dr. Vick for this service (a more detailed description of costs is listed under the "*Professional Fees*" section of this document).

This document also contains important information about my professional services and business policies. We also comply with the Health Insurance Portability and Accountability Act (HIPAA), a recent federal law that provides new privacy protections and new client rights about the use and disclosure of your Protected Health Information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. This notice, which is attached to this contract, explains HIPAA and its application to your personal health information in detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. When you sign this document, it also represents an agreement between us. Please read it carefully and note any questions that you might have so we can discuss them at our next meeting. Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms during our professional relationship. In addition, you agree that you have read and understood my "Notice of Privacy Practices" and agree to participate in treatment under the terms set forth.

REUNIFICATION / FAMILY INTEGRATION SERVICES

☐ ***Role and Responsibilities of Each Parent***

Although the focus and pace of treatment is based on the needs and well-being of the child, both parents are a part of the treatment; hence reunification therapy is considered treatment of the family system, and a specialized form of family therapy.

Reunification calls for a very active effort on the part of both parents. In order for therapy to be successful, both parents must work towards goals designed to help build or re-build the child's comfort level with the non-preferred parent. These goals are identified with the help of the reunification therapist.

☐ **Therapeutic work requires genuine effort on the part of each parent.**

- Both parents must deeply examine their attitudes and behaviors, and work hard on shifting those that contribute to the child's reactions.
- Each parent is expected to support and encourage the child in the therapeutic endeavor, refrain from questioning the child about his/her individual sessions or time spent with the other parent, and to be as open-minded as possible about making changes of attitude.
- Each parent is expected to make treatment a priority and to work on helping their child make it a priority.

- Continuity of services is crucial to success, especially in the beginning. Frequent or long interruptions in attendance will undermine the effectiveness of the treatment. Generally, you can expect that there will be weekly sessions, tapering to less frequent sessions as soon as it is indicated.
- It is the responsibility of the parents to ensure that the child is present and on time for sessions. Each parent is expected to cooperate with the therapist's recommendations for how transportation to the sessions will be structured. It is sometimes requested that neither parent brings the child to sessions.
- The parent who is aligned with the child will be urged to encourage the child to engage fully in the process. This parent is asked to model cooperation and openness by supporting the child in taking steps that may feel risky to the child. This parent will be urged to keep his or her own fears and resistances in check as the child engages in therapy. This parent often feels that the process is advancing too quickly, especially when the child is observed to be dealing with the discomfort of approaching a previously avoided source of stress.
- The parent who is the target of the child's resistance will be urged to be patient with the process, as this parent frequently feels the process is too slow. This parent will be urged to keep his or her needs for a speedy reunification in check, understanding that the therapy will move at a pace that is appropriate to the child's needs and readiness. This parent will be urged to concentrate on restoring the parent-child relationship as opposed to restoring parenting time.
- Both parents will be responsible for obtaining help and support for their own reactions to the process, and the reunification therapist will assist with providing that support and will refer you to other therapists or support services as indicated.

☐ ***Role and Responsibilities of the Child***

It is common for children to be reluctant or resistant to participating in RT, especially if one parent is opposed to it and/or the court has ordered it. The child will receive a high level of support and encouragement by the therapist. Great effort will be made by the therapist to hear the child and understand his or her experience. The pace of the therapy will be in accordance with the needs and readiness of the child, although that does not mean that the child will never experience discomfort or feel some degree of pressure. The child's responsibility, like both parents', will be to make family therapy a priority. The child will be expected to attend sessions and engage in child-centered ways of exploring family relationships, putting forth an effort to try new ways of dealing with problems. In most cases, when both parents are committed to the process, children are likely to engage in it as well.

Role and Responsibilities of the Therapist

Dr. Vick will conduct a family assessment. If evaluations have already occurred, he will review previous reports and other relevant documents and records as part of this process. Dr. Vick will work primarily with the child, but also with each parent to address how their behavior may be contributing to the problem. Dr. Vick strives to work in a time and cost-efficient manner but paces the process in accordance with the needs of the child. With proper releases (please note consent is mandatory requirement to engage in reunification therapy with Dr. Vick), Dr. Vick may issue therapeutic progress reports to both attorneys, both parents or the court in which the following information may be included: descriptions of the cooperation of all parties, including the disclosure of any resistance, alienation, or undermining that is observed or believed to be occurring; the general therapeutic issues that are being addressed, and the progress being made toward goals.

Role of Court

In RT, the Court not only defines the order for RT but also provides oversight of the reunification process and intervenes, as needed, to appoint professionals to address the needs of the family. The judge or magistrate will most likely schedule status conferences to review the progress of the therapy. The court may also elect to assign a case manager or parent coordinator to oversee the therapy, especially if there are several therapists involved and services need to be coordinated. **The court will decide issues such as parenting time, not the reunification therapist.**

Dr. Vick utilizes models of RT that have been shown to be effective with families navigating high conflict and complicated clinical issues. These protocols are structured to allow all parties to understand expectations for frequency of services, attendance, and content of sessions. Each family is unique, and flexibility is required in the therapeutic process. With that in mind, listed below are the typical goals of RT.

Why a Court Order for RT is Required

The Court order is the foundation for RT. A detailed court order defines the plan to move a parent from whatever level of contact they are currently at to whatever level of contact the court sets as the desired endpoint. The court order will identify what professionals will be involved in your case and clear expectations of each family member involved including, but not limited to, who will attend sessions, the frequency of sessions, and the duration of treatment. Often these plans detail discrete levels of access, or steps towards the endpoint, and thus are referred to as “stair step schedules.” Sometimes movement between the steps, forward or backward, is automatic, based on various conditions, while at other times transitions might only occur after an assessment of progress on some

factor or combination of factors. The reunification therapist will have the ability to set and refine goals, treatment plans, and format of the sessions.

What Happens After the Court Orders Reunification Therapy?

After a court order is received appointing Dr. Vick as your reunification therapist, he will:

- Have an initial intake appointment with co-parents either separately or together to thoroughly review the court order, the reunification process, limits to confidentiality, the scope of my role as the reunification therapist, and next steps in the process.
- Have additional individual appointments with each parent to gather history and each parent's view of the problem.
- Have an initial intake appointment with the child or children without the parents present.
- Consult with other therapists who may already be working with the family.
- Review documents relevant to RT.
- Develop a stair step approach to achieving clear goals for the specific schedule already identified in the court order.
- Identify the therapeutic needs for the family and set the agenda for the first meeting between the resisted parent and the child to set clear expectations.
- Continue to consider the needs of the family members. If individual issues are present for a parent or a child that are interfering with the success of reunification, it is important to be able to refer for individual therapy.
- Provide updates to the referring attorneys and possibly to the Court as appropriate.
- Continue to work with the child and resisted parent, with periodic individual appointments with the preferred parent as appropriate, to provide feedback and redirection as needed to assist them in supporting the relationship with the child and the resisted parent.

Goals of Reunification Therapy

In RT the focus is to heal the relationship between the parent and child, and help parents reconnect and reunite with child(ren) who are estranged in a controlled and therapeutic manner. With the long-term goal of reconnecting the parent and child for a long-lasting bond. Although the process will look different based on the unique needs of the family and reasons a parent and child have become estranged, the overall goals for RT include fostering healthy child adjustment, and improving parent functioning and roles, as well as the following:

- To restore contact between the resisted parent and his/her child(ren).
- To work with each parent and their child(ren) to identify and separate the child's needs and views from each parent's needs and views.
- To improve each parent's ability to fully understand the needs of each child, and the negative repercussions for the child(ren) of a severed or compromised relationship with a parent in their young lives and as adults.
- To work with each family member to form more appropriate parent-parent and parent-child roles and boundaries.
- To address distortions/irrational beliefs and replace with more realistic perceptions that reflect the child(ren)'s actual experience with both parents.
- To improve the child(ren)'s ability to differentiate himself/herself in his/her emotional development in age-appropriate ways.
- To help each parent differentiate valid concerns from overly negative, critical, and generalized views relating to the other parent.
- To assist the parents in resolving relevant parent-child conflicts.
- To improve each parent's parenting skills and family communication skills

Professional Fees

My fee for RT/FIT services is two hundred and seventy five dollars **($275.00)** per hour, payable via cash, check, cashiers check, or credit card. Time is billed in 15-minute increments. This rate shall apply to my time involved in all sessions, phone calls, interviews and discussions with collateral contacts, reading and writing of any pertinent documentations or emails, participating in case conferences, preparation of parenting plans, preparation of reports and recommendations, any required collection action or related litigation, and any and all other time spent on your behalf. As such, a retainer of **$3000.00** is required or by signing a credit card authorization form before this process is begun. This deposit can be paid by including a check with this signed agreement, by calling my office and making a credit card payment, or by personally delivering a cash deposit to my office. If you choose to provide a retainer then, as more time is required, you agree to pay an additional retainer upon request. Any unused portion of any retainer shall be returned upon completion of my services as a Reunification / Family Integration Therapist. **You will be supplied an accounting of hours accrued upon request.**

If Dr. Vick becomes involved in litigation (including any subpoena), which requires his professional participation, I accept I will be required to pay for the professional time required (including phone calls), even if Dr. Vick is compelled to testify by another party. I acknowledge professional fees will apply to any service that relies on Dr. Vick's professional training, is for my benefit, and for which I am liable. I understand charges will be based on **$400.00** hourly rate; billing will be charged by the minute; and charges for depositions or court appearances will be portal to portal.

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CLINICAL & FORENSIC PSYCHOLOGY

Appearance in court involves your permission to testify, OR the court's permission to allow my testimony. If requested by the court, or if I myself request to testify for any reason, you agree to pay my standard fee of **$400.00/hour** at the percentage ordered by the court, for any and all time expended in preparation, travel, or testimony. In the event that I serve as a witness, expert witness or any other role in any litigation or hearing or other legal proceeding, you agree to pay my standard fee of **$400.00/hour** for any time expended in such testimony. This includes preparation time, travel, testimony time, or time waiting to testify, whether or not my testimony is actually taken. You agree not to request or subpoena for any reason any of my personal notes, interview summaries, records, drafts, or any documents used in the course of your or your child(s) treatment. Should any signatory of this agreement seeks to compel me to provide information in a court proceeding or elsewhere, you agree in advance that this person will compensate me, at the rate of **$400.00/hour**, for any and all time expended in response to this request for release or subpoena of information, including preparation and court time, document review and phone calls, all travel time (portal to portal), all time expended invoicing, correspondence, etc…plus the cost of all legal services which I may employ to defend the integrity of this process. If requested to testify by the court or any party to this case, you authorize me to testify to the court regarding any and all specifics contained within my case file and/or the process of reaching my conclusions and recommendations. You agree to pay my normal compensation fee of **$400.00/hour**, which shall include any and all time expended in the course of any and all court appearances associated with this process.

You also understand and agree that any court appearance will require receipt of additional daily retainer of **$3200.00 for each day subpoenaed by the requested party before I will appear to testify.** This daily retainer of $3200.00 will need to be received **48-hours** in advanced of the court appearance. If additional time not covered by this retainer is required in the course of any court appearance, you agree to compensate me for all additional time expended, at my normal fee of $400/hour, upon presentation of final invoice. If both parties request my presence in court, the retainer fee and any additional fees can be split according to percentage agreed upon between the parties or as ordered by the court. Any unused portion of the retainer will be returned to appropriate party or parties upon completion of all court action.

☐ **Missed Appointments**

Once an appointment has been scheduled, you will be expected to pay for it unless you provide a 24-hour advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). Charges for missed appointments or late cancellations will be paid by the client/parent missing/canceling the appointment, despite the Court's order regarding payment for RT services.

1463 Oakfield Drive, Suite 136, Brandon, FL 33511 / (813) 689-2525 / (813) 689-4433 fax
Drgvick@gmail.com / www.Drgvick.com

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise. I do not allow clients to maintain balances. If I am unable to charge your credit card for services rendered or your retainer is not replenished, services will be paused until the unpaid balance is paid or you have made payment arrangements with Dr. Vick. Payment scheduled for other services will be agreed to at the time these services are requested. If your account is more than 60 days in arrears and suitable agreements have not been made, I have the option of using legal means to secure payment, including collection agencies or small claims court. In most cases, the only information which I release about a client's treatment would be the client's name, the nature of services provided and the amount due.

Cash or checks accepted, please make checks payable to Youth Psychological Assessment & Therapy Center, Inc. or Dr. Garin Vick. A $25.00 fee will be charged for returned checks.

Contacting your RT/FIT Therapist

I am not immediately available by phone. When I am unavailable, our telephones are answered by my office assistant or an answering machine which we monitor at least daily. We will make every effort to return your call on the same day you make it with the exception of holidays. It is important to note that we do not provide crisis services. Should you require after-hours services due to mental or emotional distress, please contact your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. If we are unavailable for an extended time, we will provide you with the name of a trusted colleague whom you can contact, if necessary.

Professional Boundaries

I understand that Dr. Vick's role as the reunification therapist is a professional relationship. Though he cares deeply about the families he works with, the relationship is different from a friendship. This means Dr. Vick will not be friends with his clients on social media or interact with them outside of sessions simply because the professional boundaries for mental health providers do not allow for it. In additional, ethical boundaries prevent Dr. Vick from having both concurrent personal and professional relationships with me and/or my family members or from having a personal relationship with me following the termination of our work together in RT.

Professional Records

You should be aware that pursuant to HIPAA, we keep PHI about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking services, a description of the ways in which our problem impacts your life, your diagnosis, the goals we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone,

including reports sent to your insurance carrier. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (other than the health care provider) and we believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your Clinical Records, you have a right of review, which we will discuss with you upon request. In addition, for some services, I also keep a set of Psychotherapy Notes. The Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. As such, your Psychotherapy Notes are not available to you and cannot be sent to anyone else.

☐ **Minors and Parents**

Minors and Parents Reunification therapy usually involves minor children. Consent for their participation is given by the parent, and it is understood that they often would not consent to participate if they were asked. Clients under 18 years of age who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to diagnosis and treatment in a crisis situation. Since privacy in psychotherapy is often crucial to successful progress, and parental involvement is also essential, it is usually my policy to request and agreement with minors and their parents about access to information. This agreement provides that during treatment, we will provide parents only with general information about the progress of treatment, and the client's attendance as scheduled sessions. We can also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else. In this case, we will inform the parents of our concern.

☐ **Limits to Confidentiality**

In general, the confidentiality of all communications between a client and a psychologist is protected by law, and Dr. Vick can only release information about his work with you to others with the written permission of his clients. However, court-ordered RT/FIT is a **non-confidential process** that will not only require/allow Dr. Vick to provide testimony, but any or all notes, electronic correspondence,

observations, and recommendations may be disclosed to the court by the Reunification Therapist. They will not be disclosed to the parties without a Court's order. Additionally, all parties need to sign any and all releases requested by Dr. Vick that are necessary to obtain reports from relevant professionals (e.g. psychiatrist, psychologist, social worker's, teachers school officials, pediatricians, hospitals etc.). This includes past records as well as current records.

As a licensed psychologist, I am a mandated reporter and as such there are some situations (not all listed) where I am legally obligated to take action to protect and share information about treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency. If you and/or a family member/significant other report to me that you have stated a threat of serious bodily harm to an identifiable person, I am required to take protective actions which include notifying the potential victim, contacting the police, and/or seeking hospitalization for you. If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact family members who can help provide protection.

Confidentiality The law protects the privacy of all communications between a patient and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form.

There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- It is necessary to talk to both parents in the course of reunification therapy. Your agreement for such contact is required for participating in reunification therapy and understood by your consent below.
- I will need to communicate with your attorneys and the court, at my discretion.
- I may need to consult with other health and mental health professionals involved in your case.
- You should be aware that I employ an administrative assistant. In most cases, I need to share confidential information with this individual for both clinical and administrative purposes, such as scheduling, billing and quality assurance. My assistant is bound by the same rules of confidentiality and has been given training about protecting your privacy and have agreed not to release any information outside of the practice without my permission.
- I also have formal business associate contracts with Therapy Notes (for billing and business filings). These contracts require Therapy Notes to maintain the confidentiality of these data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with a model copy of my business associate contract.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the appropriate parties, the patient's employer, the workers' compensation insurance carrier or the Labor Commission.
- There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are uncommon in my practice.
- Child Abuse: If I have reason to believe that a child has been or is likely to be subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, the law requires that I immediately notify the Division of Child and Family Services or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.
- Abuse of Vulnerable Adult: If I have reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment, or exploitation, I am required to immediately notify Adult Protective Services intake. Once such a report is filed, I may be required to provide additional information.
- Harm to others: If a patient communicates an actual threat of physical violence against an identifiable victim, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the patient.

☐ **Audio/Video Recording**

To protect the privacy of all clients in the office, absolutely no audio or video recording by clients is allowed, whether overt or in secret, on any device, including a smart phone. Florida's wiretapping law is a "two-party consent" law. Florida makes it a crime to intercept or record a "wire, oral, or electronic communication" in Florida, unless all parties to the communication consent. (See Fla Stat. Ch. 934.03). In addition to subjecting, you to criminal prosecution, violating the Florida wiretapping law can expose you to a civil lawsuit for damages by an injured party. Dr. Vick may require adult/child clients to leave their cell phones outside of the room he is providing RT/FIT.

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☐ **Courtesy Call Policy**

We would like to know if you want to be on our courtesy call/message list. Please place your name, and number to call below. The only information disclosed will be the clinician's name, and the date and time of the appointment. Please fill out the following below: Please check whether you'd like to receive a courtesy call/message prior to your appointment:

Yes ☐ No ☐ Phone Number:

Be aware that by signing this form you are releasing us from any liability associated with leaving information regarding your or your child's appointment.

Name (print): _____ Signature: _____

Please list all family members who will be participating in the RT/FIT Therapy with Dr. Vick.

CHILDREN'(S) NAMES (please print):

_____ _____ _____

_____ _____ _____

Your signature below indicates:

1. You have read and understand the information in this document and that you consent to you and your child(ren) participating in reunification therapy with Dr. Vick.

2. You agree to abide by the terms outlined in this document.

PARENT'S/GUARDIAN'S NAME (please print): _____

_____ _____

Signature of Client or Parent/Guardian Date

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TELETHERAPY INFORMED CONSENT FORM

I _____ hereby consent to engage in teletherapy/coaching with Garin D. Vick, Psy.D. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy/coaching also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Psychotherapy Services Agreement I received with this consent form.

3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Dr. Vick, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if Dr. Vick believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not be improve, and in some cases may even get worse.

5. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

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6. I accept that teletherapy does not provide emergency services. During our first session, Dr. Vick and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

8. I understand that while email may be used to communicate with Dr. Vick, confidentiality of emails cannot be guaranteed.

9. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand, and agree to the information provided above.

Printed Name

Client (or Guardian's) Signature

Date

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GARIN D. VICK, PSY.D.
CLINICAL & FORENSIC PSYCHOLOGY

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

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I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Website

I have a website www.Drgvick.com that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

Be aware that by signing this form you are releasing us from any liability associated with electronic communication.

Name (print): _____

Signature: _____ Date: _____

GARIN D. VICK, PSY.D.
CLINICAL & FORENSIC PSYCHOLOGY

Effective: 04/18/2022

New Office Policy Re: Cancelled or Missed Appointments:

We understand that from time to time our clients need to cancel sessions due to schedule conflicts or illnesses. However, canceling appointments can lead to scheduling problems for other clients, as well as difficulties for the office due to the inability to bill insurance for missed or cancelled appointments. Additionally, missed appointments or appointments cancelled without sufficient notice can negatively impact your treatment goals. For these reasons, we have instituted the following policy with regard to cancellations:

Once an appointment is scheduled, you will be expected to pay **($275.00)** for the missed session or **($550.00)** for 2-hour sessions unless you provide a **48-hour** notice of cancellation. For insurance clients if you **are 30-minutes late to your appointment, you will be charged for a missed appointment of $275.00 per hour, as Dr. Vick cannot bill your insurance company for the remaining time. Self-pay clients who are late have the choice to see Dr. Vick for the remaining time of their appointment, but the appointment can not be extended into another client's scheduled time. You will still be responsible for the full session fee of $275.00.**

If you are calling in to cancel and cannot reach someone directly, you are asked to leave a message on the voicemail system, which automatically logs the time and date of the call. (813) 689-2525.

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In some cases, we may waive your missed appointment fee. Dr. Vick makes this determination on a case-by-case basis.

Client or Parent/Guardian Signature

Date

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GARIN D. VICK, PSY.D.
CLINICAL & FORENSIC PSYCHOLOGY

NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP and you may have a copy of this to read and refer to it for more information. However, not all possible situations can be covered, so please ask Dr. Vick, about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read the NPP we will ask you to sign a consent form to let us use and share your information. If you do not consent and sign this form, we cannot evaluate/treat you or your child.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you to sign an authorization form to allow this.

Of course, we will keep your health information private but there are sometimes when the laws require us to use or share it. For example:

- When there is serious threat to your child's health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
- Some lawsuits and legal or court proceedings
- If a law enforcement official requires us to do so
- For Workers Compensation and similar benefit programs

There are some other situations like these but which do not happen very often. They are described in the longer version of the NPP. Your rights regarding your health information

- You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

- You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
- You have the right to look at the health information we have about you such as your medical and billing records. *You can even get a copy of these records, but we may charge you. Contact Dr. Vick to arrange how to see your records. See below
- If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You must make this request in writing and sent it to Dr. Vick. You must tell us the reasons you want to make the changes.
- You have a right to a copy of this notice. If we change this NPP we will post the new version in our waiting area, and you can always get a copy from Dr. Vick.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with Dr. Vick and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Vick by phone at (813) 689-2525.

The effective date of this notice is April 30, 2022.

Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. I will be happy to discuss these situations with you now or as they arise.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, have received a copy of this office's notice of privacy practices.

Patient name: _____

Signature: _____ Date: _____

***It is your right to refuse to sign this document.**

GARIN D. VICK, PSY.D.
CLINICAL & FORENSIC PSYCHOLOGY

CREDIT CARD AUTHORIZATION FORM

By signing this form, I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by Dr. Vick, including fees associated with late cancellations (after 24-hours of appointment) or no cancellation of my appointment(s). For your convenience, after visits are discontinued, any remaining balances will be charged to your credit card on file.

By signing this form, I certify that the information provided on this form is true and correct to the best of my knowledge. I am also authorizing Dr. Vick to charge my credit card, listed below, for any of the above-noted charges.

I understand that I may revoke this agreement, at any time, by providing a request in writing.

Client's Name: _____ D.O.B.: _____

Card Holder's Name: _____

Card Holder's Address: _____

Visa ☐ MC ☐ Discover ☐ Expiration Date: _____ Zip Code: _____

Account Number: _____ 3 Digits # on _____

Signature: _____ Date: _____

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CLINICAL & FORENSIC PSYCHOLOGY

CLIENT DATA FORM – ADULT

This a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Full Name: _____ **Today's Date:** _____

Sex: ☐ **M** ☐ **F** **Date of Birth:** _____ **Place of Birth:** _____

Primary Address: _____

Street City State Zip Code

Home Phone Number: _____ **Okay to Leave a message?** _____

Emergency Contact: _____ **Phone:** _____

Relationship with Emergency Contact: _____

Referral Source: _____

May I have your permission to thank this person for the referral? ☐ **Yes** ☐ **No**

Briefly describe the presenting problem(s): _____

Briefly explain what has been tried to resolve the problem(s): _____

Education: Highest Degree or Grade Level _____

Did you serve in the military? ☐ **Yes** ☐ **No** **Branch** _____

Honorable Discharge ☐ **Yes** ☐ **No**

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Occupational Status: Employed___ Unemployed___ Retired___ Disability___

Occupation:_____ **Employer:** _____

Your place in birth order: #___**of**___**children. List brothers and sisters in order, with ages.**

1._____ **3.** _____

2._____ **4.** _____

Relationship Status: Single___**Married**___**Divorced**___**Widowed**___**Cohabitating**___**Date Met:** _____

Date Married/Cohabitating:_____ **Partner/Spouse: Name**_____

Former Spouses/Partners Name Date Met Date Married/Cohabitating Date Ended Reason

1. _____

2. _____

3. _____

Children: Name Age Gender Where resides Problems in the Relationship?

1. _____ **Yes No**

2. _____ **Yes No**

3. _____ **Yes No**

4. _____ **Yes No**

5. _____ **Yes No**

Significant Changes (death, separations, financial, or home instability): _____

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Adult Checklist of Concerns and History:

Please mark all of the items below that apply. Add notes or details in the space next to the concerns checked.

- ☐ Abuse: physical, sexual, emotional, neglect, cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription meds, over-the-counter meds, etc.
- ☐ Eating problems—over or undereating, appetite, vomiting
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems

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- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Other concerns or issues:
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital problems
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsion
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Parenting issues
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination,work inhibitions, laziness
- ❑ Relationship problems
- ❑ School problems
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues

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- ❑ Stress _____
- ❑ Suspiciousness, distrust _____
- ❑ Suicidal thoughts _____
- ❑ Temper problems _____
- ❑ Thought disorganization and confusion _____
- ❑ Threats, violence _____
- ❑ Trauma Experience _____
- ❑ Weight and diet issues _____
- ❑ Withdrawal, isolating _____
- ❑ Work problems _____

Have you ever been diagnosed with depression, anxiety, or any mental illness? ☐ Yes ☐ No
Has your doctor ever prescribed antidepressants, tranquilizers, or "nerve" medications? ☐ Yes ☐ No
Have you ever attempted suicide or physically harmed yourself? ☐ Yes ☐ No
Have you ever been physically assaulted? ☐ Yes ☐ No
Have you ever been raped or sexually abused? ☐ Yes ☐ No
Do you have any physical, cognitive, or emotional difficulties? ☐ Yes ☐ No
Do you have a religious affiliation or spiritual practice? ☐ Yes ☐ No

List the names, field of practice, address and phone number of the medical and mental health professionals the child has seen in the past as well as those presently seen for treatment:

NAME OF PROVIDER	TYPE OF TREATMENT	DATES OF TREATMENT	PHONE NUMBER

Does any relatives have a history of mental illness, suicide, alcoholism, or trouble with the law? ☐ Yes ☐ No

If yes, list: _____

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List past and/or present medications:

NAME	DOSAGE	OUTCOME

Please describe all hospitalizations (Where, When, How Long, For What Problem(s), and Type of Treatment Received):

List all serious illness that you have had with dates and outcome:

Appetite:	☐ excellent	☐ good	☐ fair	☐ poor	☐ recent changes
Sleep:	☐ excellent	☐ good	☐ fair	☐ poor	☐ recent changes
Energy level:	☐ excellent	☐ good	☐ fair	☐ poor	☐ recent changes
Mood:	☐ excellent	☐ good	☐ fair	☐ poor	☐ recent changes
Affect:	☐ excellent	☐ good	☐ fair	☐ poor	☐ recent changes

Substance Use History

How much tobacco do/did you smoke (or chew) per day? Packs per day_____ Date/Age Started
Date quite if applicable
How many servings of caffeinated beverages do you drink/day? Type: Amount:
How much beer, wine, and hard liquor do you consume each week, on average?
Your preferred alcoholic beverage

Are you currently drug or alcohol dependent?	☐ **Yes**	☐ **No**
Have you ever felt the need to cut down on your drinking?	☐ **Yes**	☐ **No**
Have you ever felt annoyed by criticism of your drinking?	☐ **Yes**	☐ **No**

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Have you ever felt guilty about your drinking? ☐ Yes ☐ No
Have you ever been in substance abuse treatment? ☐ Yes ☐ No

Drug/alcohol use:

Substance	Tried	Daily	Weekly	Monthly	Never Tried
Beer	☐	☐	☐	☐	☐
Wine	☐	☐	☐	☐	☐
Liquor	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Cocaine or Crack	☐	☐	☐	☐	☐
Speed, Ice, or Crank	☐	☐	☐	☐	☐
Heroin	☐	☐	☐	☐	☐
Inhaled glue or whippets	☐	☐	☐	☐	☐
LSD, PCP, or Peyote	☐	☐	☐	☐	☐
Mushrooms	☐	☐	☐	☐	☐
Vicodin/other pain medications	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐
Ecstasy	☐	☐	☐	☐	☐
Non-prescribed drugs	☐	☐	☐	☐	☐

Other: _____

Legal History

Do you currently have legal charges pending against you? ☐ Yes ☐ No
Is your reason for coming to see me related to an accident or injury? ☐ Yes ☐ No
you required by a court, the police, or a probation/parole officer to have this appointment? ☐ Yes ☐ No
Are you a registered sex offender? ☐ Yes ☐ No
Are you presently suing anyone or thinking of suing anyone or engaged in a custody battle? ☐ Yes ☐ No

If you answered yes to any of the above, please explain: _____

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Your Attorney: _____ **Phone:** _____

List all previous arrests/contacts with the police, courts, and jails/prisons you have including DUI charges:

Date	Charge	Sentence

Other comments, questions, or information: _____

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CLIENT DATA FORM - CHILD

Today's Date: _____ Child's Full Name: _____ Date of Birth: _____ Age: _____

Place of Birth: _____ Referral Source: _____

Mother's Name: _____ Marital Status: _____

Father's Name: _____ Marital Status: _____

Child's Primary Address: _____
Street City State Zip Code

School: _____ Grade: _____

Pediatrician: _____ Telephone: _____

Address: _____
Street City State Zip Code

Mother's Employer: _____ Father's Employer: _____

Home phone: _____ Home phone: _____

Work phone: _____ Work phone: _____

Cell phone: _____ Cell phone: _____

To (re)schedule appointments, where may we call?

Home: Yes ☐ No ☐ Work: Yes ☐ No ☐ Cell: Yes ☐ No ☐

May I leave a message on the answering machine? Yes ☐ No ☐

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May I leave a message with someone at this number? Yes ☐ No ☐

Please list any restrictions: _____

Whom may I contact in case of an emergency?

Name: _____ Relationship to child: _____

Phone: _____ Alternate phone: _____

Parent's marital status: _____ Date married (if applicable): _____

Step-mother: _____ Step-father: _____

Current custody arrangement/Weekly schedule (if applicable): _____

_____

_____

Are you the child's legal guardian? Yes ☐ No ☐

If no, please list the following information for the legal guardian or other parent/legal guardian:

Name: _____ Relation to Child: _____

Address: _____

(Street) (City) (State) (Zip code)

Phone: _____ Alternate phone: _____

Briefly describe/explain the presenting problem(s): _____

_____

_____

_____

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Briefly explain what has been tried to resolve the problem(s): _____

Family Information:

List the members of the child's family (use the back of this form if necessary):

NAME/ IN HOME	SEX	AGE	RELATIONSHIP	LIVING	GRADE	OCCUPATION

Other people living in the home: _____

Non-residential adults involved with your child on a regular basis (e.g., babysitter):

Legal History:

List the names, field of practice, address and phone number of the medical and mental health professionals the child has seen in the past as well as those presently seen for treatment:

NAME OF PROVIDER	TYPE OF TREATMENT	DATES OF TREATMENT	PHONE NUMBER

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Please describe the reason(s) for ending treatment (i.e., therapy):

CURRENT MEDICATION(S): DOSAGE OUTCOME

PREVIOUS MEDICATION(S): DOSAGE OUTCOME

Child's Strengths:

Child's Needs:

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CLINICAL & FORENSIC PSYCHOLOGY

Please list hobbies, sports, recreational, TV, and toy preferences; any special skills or talents:

Has your child experienced any of the following?

	Relationship to the Individual	Child's age during event
Death of a significant person:		
Physical abuse:		
Sexual abuse:		
Emotional abuse:		
Violence between family members:		
Other significant events:		

Please use the scale below to indicate your child's current level of distress with the following items:

	No Concern	Some	Moderate	Urgent
Academic problems	0	1	2	3
Aggressive behavior	0	1	2	3
Anxiety/fears/worries	0	1	2	3
Attention/concentration difficulties	0	1	2	3
Bedwetting	0	1	2	3
Behavior problems	0	1	2	3
Change in family constellation (e.g. divorce or remarriage)	0	1	2	3
Depression	0	1	2	3
Eating problems	0	1	2	3
Feelings over a recent loss/death	0	1	2	3
Losing contact with reality	0	1	2	3
Relationship with family	0	1	2	3
Relationship with peers	0	1	2	3
Problems with alcohol/drugs	0	1	2	3
Sexual behaviors	0	1	2	3
Sleep problems	0	1	2	3

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Suicidal feelings/behaviors	0	☐	1	☐	2	☐	3 ☐
Trauma/Physical or sexual abuse	0	☐	1	☐	2	☐	3 ☐

Family History: (put an X for each person with the problem)

	Mother	Father	Sibling	Relative	Explain
Academic Problems in School	☐	☐	☐	☐	
Attention deficits/hyperactivity	☐	☐	☐	☐	
Behavior Problems in School	☐	☐	☐	☐	
Speech/Language Problems	☐	☐	☐	☐	
Developmental Disorders	☐	☐	☐	☐	
Medical Problems	☐	☐	☐	☐	
Depression/Bipolar	☐	☐	☐	☐	
Anxiety or Panic Attacks	☐	☐	☐	☐	
Schizophrenia/Hallucinations	☐	☐	☐	☐	
Alcohol or Substance Abuse	☐	☐	☐	☐	
Suicide	☐	☐	☐	☐	
Mental Health Treatment	☐	☐	☐	☐	
Sensory Impairment	☐	☐	☐	☐	
Sexual Abuse	☐	☐	☐	☐	
Physical Abuse	☐	☐	☐	☐	
Incarcerations	☐	☐	☐	☐	
Domestic Violence	☐	☐	☐	☐	

PREGNANCY AND BIRTH

Birth weight? _____lbs. _____oz. Length of Pregnancy: _____Full Term _____wks.

☐ Bleeding during first three months
☐ Bleeding during second three months
☐ Bleeding during last three months
☐ Smoked 1+packs of cigarettes a day
☐ Toxemia/pre-eclampsia
☐ Vomited often
☐ Labor lasted less than two hours
☐ Labor lasted longer than 12 hours
☐ Infections
☐ Premature baby(ies)
☐ Taking medications
☐ Labor induced
☐ Difficult delivery
☐ Gained less than 15 lbs.
☐ Put to sleep for Delivery
☐ Miscarriages
☐ Preterm labor
☐ Hurt or injured
☐ Drug use/abuse
☐ Alcohol use/abuse
☐ Cesarean section

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Elaborate on items or list any other pregnancy problems: _____

_____

NEWBORN PROBLEMS (check all that apply)

- ☐ cord around neck
- ☐ injured during birth
- ☐ trouble breathing
- ☐ turned yellow
- ☐ heart defect
- ☐ infection
- ☐ skin problems
- ☐ ventilator
- ☐ transfusion
- ☐ seizures
- ☐ gagged often
- ☐ turned blue
- ☐ twin/triplet
- ☐ trouble sucking
- ☐ diarrhea
- ☐ inhaled merconium
- ☐ hospitalized time _____
- ☐ jittery
- ☐ vomited often
- ☐ other defect(s)
- ☐ given medication
- ☐ needed oxygen

HEALTH PROBLEMS AND TREATMENTS (please indicate all that apply)

General Health (circle one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of most recent physical exam: _____ Reason for Exam: _____

Has your child ever had a concussion or serious head trauma? ☐ Yes ☐ No

Has your child ever had a seizure? ☐ Yes ☐ No

Please list any medical conditions: _____

_____

_____

Is your child on a special diet? : ☐ Yes ☐ No

If yes, please explain: _____

_____

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☐ asthma	☐ orthopedic problem	☐ skin problem	☐ allergies
☐ vision problem	☐ hearing problem	☐ heart problem	☐ arthritis
☐ immune deficiency	☐ kidney problem	☐ ear infections	☐ headaches
☐ anemia	☐ motor movements	☐ had surgery	☐ enuresis
☐ other blood diseases	☐ physical therapy	☐ lead poisoning	☐ encopresis
☐ persistent high fever	☐ hospitalizations	☐ speech therapy	☐ head injury
☐ outpatient therapy	☐ occupational therapy	☐ tics	☐ seizures

Appetite:	☐ excellent	☐ good	☐ fair	☐ poor	☐ recent changes
Sleep:	☐ excellent	☐ good	☐ fair	☐ poor	☐ recent changes
Energy level:	☐ excellent	☐ good	☐ fair	☐ poor	☐ recent changes
Mood:	☐ excellent	☐ good	☐ fair	☐ poor	☐ recent changes

Please explain any recent changes listed above: _____

_____

_____

Please describe all hospitalizations (Where, When, How Long, For What Problem(s), and Type of Treatment Received):

_____

_____

_____

List all serious illness that the child has had with dates and outcome: _____

_____

_____

Developmental Milestones

	2m	4m	6m	9m	12m	15m	18m	2y	3y	4y	5y	6y	No
Sat without help	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crawled	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walked alone (10-12 steps)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walked up stairs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rode a tricycle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Caught a big ball	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Spoke first words													
Put words together													
Spoke 2-3 word sentences													
Spoke clearly													
Used fingers to feed self													
Used a spoon													
Fully bladder trained													
Fully bowel trained													
Able to dress self													
Able to tie shoe laces													

PRESCHOOL CONCERNS (check all that apply)

- ☐ trouble learning numbers and letters
- ☐ difficulty drawing or coloring
- ☐ difficulty sitting to listen to story
- ☐ behavior problems
- ☐ trouble understanding more, less, big, small, etc.
- ☐ difficulty with feeding or dressing skills
- ☐ not interested in books or reading

Additional Preschool Concerns: _____

SCHOOL AGE LEARNING PROBLEMS (check all that apply)

- ☐ difficulty learning to read
- ☐ difficulty spelling
- ☐ reading comprehension problem
- ☐ difficulty writing
- ☐ handwriting problems
- ☐ difficulty understanding directions
- ☐ difficulty with speech/expressing self
- ☐ gross motor difficulties
- ☐ clumsy
- ☐ difficulty learning math calculations
- ☐ difficulty learning math concepts
- ☐ problem completing homework
- ☐ repeated grade
- ☐ difficulty remembering instructions
- ☐ remedial/summer school
- ☐ poor motivation
- ☐ fine motor difficulties
- ☐ school avoidance

Any speech, hearing, or learning difficulties? ☐ Yes ☐ No

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Has your child ever received services from a speech pathologist? ☐ Yes ☐ No

Has your child ever been evaluated for a special education or Section 504 plan? ☐ Yes ☐ No
If yes, does your child have an IEP? ☐ Yes ☐ No Date of most recent review: _____

Additional School Age Learning Problems: _____

_____

BEHAVIOR PROBLEMS (check if a consistent problem for more than 6 months)

☐ fidgety, overactive
☐ risk taker
☐ hard to satisfy
☐ aggressive
☐ compulsive, has rituals
☐ demanding, wants to be center of attention
☐ trouble making or keeping friends
☐ plays with things in unusual ways
☐ impulsive, acts without thinking/poor self control
☐ trouble concentrating for long
☐ disorganized
☐ doesn't recognize danger
☐ sad or depressed
☐ doesn't finish things
☐ mood swings
☐ trouble with self- control
☐ angry
☐ poor eye contact
☐ difficulty with changes
☐ odd/bizarre behavior
☐ motor movements/tics

Additional Behavioral Problems: _____

_____

_____

What methods have been used in disciplining your child? (Check all that apply)

☐ time out
☐ use hand
☐ spanking
☐ verbal threats
☐ slap face
☐ threats
☐ withhold privileges
☐ grab hair
☐ redirecting
☐ push
☐ physical threats
☐ shaking
☐ belts/other objects
☐ shove
☐ grab arm
☐ food restrictions

How does your child express his/her angry feelings?

☐ hurts adults
☐ yells/curses/threatens

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- ☐ hurts children
- ☐ cries
- ☐ talks to someone
- ☐ does not express feelings
- ☐ throws/breaks things
- ☐ argues
- ☐ tells others that s/he is angry
- ☐ other: _____

Does your child currently show any of the following behaviors:

	YES	NO
Is your child a loner	☐	☐
Prefer being with younger children	☐	☐
Prefer older children	☐	☐
Prefer adults over children own age	☐	☐
Avoid being a leader	☐	☐
Avoid being a follower	☐	☐
Frequently fight with peers	☐	☐
Frequently fight with adults	☐	☐
If yes with whom_____		
Frequently fights with siblings	☐	☐
Breakup up of important relationship	☐	☐
Trouble picking up social cues	☐	☐
Trouble making or keeping friends	☐	☐
Self-destructive behavior	☐	☐
Self-mutilation behaviors (i.e., cutting)	☐	☐
Preoccupation with death	☐	☐
Suicidal thoughts or attempts	☐	☐
Obsessive thoughts	☐	☐
Compulsive behaviors	☐	☐
Low Energy	☐	☐
High Energy	☐	☐
Concerns about weight	☐	☐
Body image problems	☐	☐
Sexual identity issues	☐	☐
Low self-confidence	☐	☐
Low self-esteem	☐	☐

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	YES	NO
Is the child fearful	☐	☐
Anxious/worries	☐	☐
Nervous habits	☐	☐
Does the child engage in much fantasy	☐	☐
Much daydreaming	☐	☐
Hallucinations	☐	☐
Poor attention/concentration	☐	☐
Difficulty following instructions	☐	☐
Difficulty solving problems	☐	☐
Confusion about date, time, place, who s/he is	☐	☐
Poor memory	☐	☐
Poor coordination	☐	☐
Stuttering	☐	☐
Can't seem to stop talking	☐	☐
Echoing (repeating) what others say	☐	☐
No speech or refuses to talk	☐	☐
Verbal aggression	☐	☐
Physical aggression	☐	☐
Oppositional/defiant	☐	☐
Breaks rules	☐	☐
Poor impulse control	☐	☐
Cruelty to animals	☐	☐
Lying	☐	☐
Stealing	☐	☐

Other behaviors (please describe): _____

_____

_____

_____

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RELATIONSHIPS WITH OTHERS

Parents:	☐ excellent	☐ good	☐ fair	☐ poor
Siblings:	☐ excellent	☐ good	☐ fair	☐ poor
Peers in neighborhood:	☐ excellent	☐ good	☐ fair	☐ poor
Peers in school:	☐ excellent	☐ good	☐ fair	☐ poor
Teachers:	☐ excellent	☐ good	☐ fair	☐ poor
Other adults:	☐ excellent	☐ good	☐ fair	☐ poor
Younger children:	☐ excellent	☐ good	☐ fair	☐ poor
Animals:	☐ excellent	☐ good	☐ fair	☐ poor

DRUG/ALCOHOL USE:

Substance	Has tried	Daily	Weekly	Monthly	Never tried
Beer	☐	☐	☐	☐	☐
Wine	☐	☐	☐	☐	☐
Liquor	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Cocaine or Crack	☐	☐	☐	☐	☐
Speed, Ice, or Crank	☐	☐	☐	☐	☐
Heroin	☐	☐	☐	☐	☐
Inhaled glue or whippets	☐	☐	☐	☐	☐

Substance	Has tried	Daily	Weekly	Monthly	Never tried
LSD, PCP, or Peyote	☐	☐	☐	☐	☐
Mushrooms	☐	☐	☐	☐	☐
Vicodin/other pain medications	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐
Ecstasy	☐	☐	☐	☐	☐
Non-prescribed drugs	☐	☐	☐	☐	☐

Other: _____

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Please list any other concerns or relevant information: _____

_____

_____

What goals do you have regarding your child's treatment? _____

_____

_____

The information contained in this self-report was reviewed with the client and/or parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Name (please print): _____

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Co-Parenting Questionnaire

Name:

Parent's Name:

Please list the names and ages of your children.

Name:	Age:

How would you describe each child?

What makes each child special?

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Have there been any changes in behavior since the separation or divorce?

Have the children expressed preferences for the future?

How does each child react to change?

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What strategies help each child handle change?

Who else is important in your child(ren)'s lives?

Please list step-parents and other significant care-givers for the child(ren).

Name:	Relationship to Child(ren):

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What do you and your child(ren) like to do together?

What are your plans and wishes for your child(ren)?

How do you and your child(ren) handle and resolve conflict? Discipline?

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HISTORY OF RELATIONSHIP/MARRIAGE & DIVORCE/SEPARATION:

Date of marriage:

Date of separation:

Date of divorce:

Have you or anyone in your family participated in custody or parenting plan evaluations? If so, please provide name of evaluator and dates of evaluation.

Name of Evaluator	Dates of Evaluation

Have any post-judgment agreements been reached? Yes ____ No ____

Is there any pending litigation? Yes ____ No ____ If yest, please describe.

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Has there been any post-judgment litigation? Yes ☐ No ☐

Is there any pending litigation? Yes ☐ No ☐ If yes, please describe.

PARENTING AGREEMENT:

How was your parenting agreement reached? (i.e., mediation, stipulated agreement, decided by a judge.)

Please provide any additional information about how your parenting agreement was reached that you feel relevant.

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Please check any of the following that are of concern.

- ☐ Who pays for what
- ☐ Discipline
- ☐ Schedule changes
- ☐ School functions
- ☐ Homework
- ☐ Holidays
- ☐ Gifts
- ☐ Summer Vacations
- ☐ Interpreting the time-share agreement
- ☐ Exchanges
- ☐ Bedtime
- ☐ Religion
- ☐ Wanting more flexibility
- ☐ Medical Issues
- ☐ Decision-making
- ☐ Attendance at extracurricular activities
- ☐ Extended family relationships
- ☐ Transportation
- ☐ School
- ☐ Step-parents
- ☐ Wanting more structure
- ☐ Dating
- ☐ Family gatherings

Please explain your selections above in greater detail

Please explain any concerns not listed above.

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CONTACT SCHEDULE:

Each parent's work schedule.

Please describe the current contact schedule for the child(ren).

Where do the exchanges of the child(ren) take place?

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Who provides transportation?

How satisfied are you with the current contact schedule?

What are your concerns about the contact schedule?

How well are your child(ren) adjusting to the contact schedule?

Child(ren)'s schedules of activities, special needs, and interests [such as school, religious training, and after school activities]:

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Does either parent have plans to move?

Does either parent have a new relationship or plan to remarry?

Are there any adult relatives or friends with whom the child(ren) should or should not have close contact?

Is counseling needed for the child(ren), parents or the family?

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Are there any special medical needs of the child(ren), parent, or family?

CO-PARENTING RELATIONSHIP:

How would you describe your relationship with your co-parent?

What are the strengths of your co-parenting relationship?

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What are the primary means you and your co-parent use to communicate? (i.e., in person, telephone, text, email, co-parenting software).

How satisfied are you with your co-parenting communication?

Where would you like to see improvement in your co-parenting communication?

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How do you deal with conflict in your relationship with your co-parent?

How does your co-parent deal with conflict?

Where are the areas you would like to see improvement in your co-parenting relationship?

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Please place an "X" by the areas you would like to improve on and circle the areas you feel are your strengths.

___ Staying child focused
___ Shielding my child(ren) from adult issues
___ Choosing my "battles" wisely
___ Respecting boundaries with my co-parent
___ Managing my stress level
___ Respecting my co-parent
___ Shielding my child(ren) from co-parenting conflict
___ Helping my child develop positive self-esteem
___ Providing my co-parent with parent information
___ Respecting my child(ren)'s privacy
___ Avoiding conflict with my co-parent
___ Feeling comfortable attending my child(ren)'s events when my co-parent also attends
___ Supporting a positive relationship between my child(ren) and their other parent.

What are your parenting strengths?

What are your parenting weaknesses?

What do you think are your co-parent's parenting strengths?

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What do you think are your parenting strengths?

What do your children think are your parenting weaknesses?

What do your children think are your co-parenting strengths?

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What do your children think are your co-parent's parenting weaknesses?

SELF-CARE:

How do you manage co-parenting stress?

What activities do you engage in to take care of yourself?

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Do you have social/family support? Yes ☐ No ☐ If yes, please describe.

DOMESTIC VIOLENCE:

Is there any history of domestic violence in this co-parenting relationship? Yes ☐ No ☐

If yes, please describe the type(s) of domestic violence, frequency and last incident.

Have your children witnessed any acts of domestic violence? Yes ☐ No ☐

Has the Department of Children and Families or law enforcement been involved with your family? Yes ☐ No ☐ If yes, please explain.

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Any other concerns or information you would like to discuss?

Name (please print)

Signature

Date

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REUNIFICATION / FAMILY INTEGRATION THERAPY HISTORY FORM

DATE: _____ REFERRED BY: _____

It is important that you complete the following questionnaire as fully and accurately as possible. This form is intended to alert the REUNIFICATION THERAPIST to issues that deserve special attention. This questionnaire is confidential between you and the parenting coordinator.

NAME: _____ RELATIONSHIP TO CHILD(REN): _____

HOME ADDRESS: _____

TELEPHONE: (H) _____ (W) _____ (C) _____

COURTESY CALL POLICY: We would like to know if you want to be on our courtesy call / message list. Please place your name, and number to call below. The only information disclosed will be the clinician's name, and the date and time of the appointment. Please fill out the following below:

Please check whether you'd like to receive a courtesy call/message prior to your appointment:

☐ Yes ☐ No Number: _____

Be aware that by signing this form you are releasing us from any liability associated with leaving information regarding your appointment and sending invoices to the below email.

EMAIL: _____

NAME (print): _____

SIGNATURE: _____ DATE: _____

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ATTORNEY:

ATTORNEY'S FULL ADDRESS (POSTAL CODE) AND TELEPHONE:

OCCUPATION: FULL TIME ☐ PART TIME ☐ HOURS

NUMBER OF YEARS AT PRESENT PLACE OF EMPLOYMENT:

AGE & DATE OF BIRTH: PLACE OF BIRTH:

RELIGION: OBSERVANT:

EDUCATION:

MARITAL STATUS: ☐ MARRIED ☐ COMMON LAW ☐ SEPARATED ☐ DIVORCED

☐ WIDOWED ☐ SINGLE

NAME ALL PERSONS WITH WHOM YOU RESIDE (INCLUDING CHILDREN, PARTNERS, ROOMATES, RELATIVES, CAREGIVERS, ETC.)

ARE YOU AND THE OTHER PARENT PHYSICALLY SEPARATED?

DATE MARRIAGE/RELATIONSHIP: CITY OF MARRIAGE:

DATE OF FINAL SEPARATION:

DATES OF PREVIOUS SEPARATIONS/RECONCILIATIONS (BE SPECIFIC):

HAS THE DIVORCE PETITION BEEN FILED? ☐ YES ☐ NO (IF YES, BY WHOM)

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HAVE YOU BEEN MARRIED/COMMON-LAW BEFORE? ☐ YES ☐ NO

IF YES, DATES OF PREVIOUS MARRIAGE(S) AND DIVORCE(S):

CHILDREN: (Indicate from which marriage. Put * by child(ren) relevant to this process.)

NAME	AGE	SEX	DOB	RESIDING WITH	GRADE	SCHOOL

CURRENT LEGAL CUSTODY (pertaining to major decisions) BY SEPARATION AGREEMENT OR COURT ORDER (Please supply copy of Parenting Plan and/or Order)

CURRENT PARENTING TIME SCHEDULE:

CURRENT CHILD SUPPORT ARRANGEMENTS

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RECENT MAJOR LIFE EVENTS -- POSITIVE AND NEGATIVE? (EG., LOSSES, ACCIDENTS, CHANGE OF EMPLOYMENT, BIRTH OF CHILD, MARRIAGE, ETC.(PLEASE LIST AND THESE WILL BE DISCUSSED ON AN INDIVUDAL BASIS.)

WHAT ARE THE CURRENT ISSUES AND IMPLEMENTATION PROBLEMS?

WHAT DO YOU AND THE OTHER PARENT DO BEST AS PARENTS?

WHAT ARE YOUR SIGNIFICANT CONCERNS ABOUT PARENTING?

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WHAT ARE YOUR HOPES/GOALS FOR PARENTING IN THE FUTURE?

WHAT ARE YOUR SIGNIFICANT CONCERNS ABOUT YOUR RELATIONSHIP WITH THE OTHER PARENT?

WHAT ARE YOUR SIGNIFICANT HOPES/GOALS FOR YOUR RELATIONSHIP WITH THE OTHER PARENT?

ARE YOU ABLE TO DISCUSS FAMILY ISSUES OPENLY WITH EACH OTHER? ☐ YES ☐ NO

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COMMENTS REGARDING WHETHER OR NOT YOU AND THE OTHER PARENT ARE ABLE TO MAKE DECISIONS COOPERATIVELY ABOUT THE CHILDREN:

DURING THE RELATIONSHIP WITH THE OTHER PARENT, IMPORTANT DECISIONS WERE MADE ABOUT:

		BY OTHER PARENT	BY ME	JOINTLY
A)	Household Finances	☐	☐	☐
B)	Purchases of Family Property	☐	☐	☐
C)	Children's Education	☐	☐	☐
D)	Children Health Care	☐	☐	☐
E)	Children's Religious Training	☐	☐	☐
F)	Children's Extra Curricular Activities	☐	☐	☐

HAVE THERE BEEN ANY INCIDENTS OF VERBAL AND/OR EMOTIONAL ABUSE?

☐ YES ☐ NO

IN THE PAST SIX MONTHS? ☐ YES ☐ NO

OR AT ANY TIME IN THE RELATIONSHIP? ☐ YES ☐ NO

HAVE THERE BEEN ANY INCIDENTS OF SPOUSAL VIOLENCE? ☐ YES ☐ NO

IN THE PAST SIX MONTHS? ☐ YES ☐ NO

OR AT ANY TIME IN THE RELATIONSHIP? ☐ YES ☐ NO

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GIVE SPECIFICS ON THE ABOVE:

HAVE THE CHILDREN WITNESSED ANY INCIDENTS OF PHYSICAL, VERBAL OR EMOTIONAL ABUSE? GIVE SPECIFICS ON THE ABOVE

HAVE THERE BEEN ANY INCIDENTS OF PHYSICAL, VERBAL OR EMOTIONAL ABUSE AGAINST THE CHILD(REN)? IF YES, GIVE SPECIFICS.

ARE YOU FEARFUL OF THE OTHER PARENT FOR ANY REASON?

HAS THE OTHER PARENT EVER THREATENED TO HURT YOU IN ANY WAY?

HAS THE OTHER PARENT EVER HIT YOU OR USED ANY OTHER TYPE OF PHYSICAL FORCE TOWARDS YOU?

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HAS THE OTHER PARENT EMOTIONALLY OR SEXUALLY ABUSED YOU?

HAVE YOU OR THE OTHER PARENT ABUSED ALCOHOL OR DRUGS?

HAVE YOU EVER CALLED THE POLICE, REQUESTED A PROTECTION ORDER, OR SOUGHT HELP FOR YOURSELF AS A RESULT OF ABUSE BY THE OTHER PARENT?

HAS THE OTHER PARENT EVER THREATENED TO DENY YOU ACCESS TO YOUR CHILDREN?

DO YOU HAVE ANY CONCERNS ABOUT THE CHILDREN'S EMOTIONAL OR PHYSICAL SAFETY WITH YOU OR THE OTHER PARENT?

WHAT WOULD YOU SAY ABOUT YOUR RELATIONSHIP WITH THE OTHER PARENT?

Excellent_☐_ Good _☐_ Fair _☐_ Poor_☐_ Couldn't be worse_☐_

WHAT EFFECT DO YOU THINK THIS RELATIONSHIP HAS ON THE CHILDREN?

A great deal_☐_ Some_☐_ A little_☐_ None at all__☐__

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WHAT DO YOU THINK IT WOULD TAKE TO IMPROVE THIS SITUATION?

PRESENT USE OF ALCOHOL (INCLUDING BEER, WINE, LIQUOR)

Daily☐ Once or twice a week☐ Once or twice a month☐ None☐

HAVE YOU EVER BEEN ARRESTED FOR AN ALCOHOL RELATED CRIME? ☐YES ☐NO If yes, please explain.

HAVE YOU EVER UNDERGONE TREATMENT FOR SUBSTANCE ABUSE? ☐YES ☐NO

IF YES, PLEASE INDICATE WHEN

PLEASE RATE THE EFFECTIVENESS OF THIS TREATMENT:

Very effective ☐ Helpful ☐ Waste of time ☐

ARE YOU NOW OR HAVE YOU EVER BEEN ON PROBATION OR PAROLE? ☐YES ☐NO IF YES, PLEASE EXPLAIN:

HAVE YOU EVER HAD A RESTRAINING ORDER FILED AGAINST YOU?

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IS THERE A RESTRAINING ORDER IN EFFECT RIGHT NOW THAT YOU ARE INVOLVED IN?

HAVE YOU OR THE OTHER PARENT PARTICIPATED IN DOMESTIC VIOLENCE CLASSES, BATTERER'S INTERVENTION, ANGER MANAGEMENT?

WHEN AND WHERE?

IF YES, PLEASE RATE THE EFFECTIVENESS OF THESE CLASSES IN ELIMINATING ABUSIVE BEHAVIOUR.

Very effective _____ Helpful _____ Waste of time _____

HAVE THERE EVER BEEN CHARGES FILED AGAINST YOU FOR PHYSICAL ASSAULT, BATTERY, DOMESTIC VIOLENCE OR STALKING?

SPECIFICALLY, WHAT CAN YOU DO TO BRING OUT THE BEST IN THE OTHER PARENT?

DISCUSS ANY ADDITIONAL CONCERNS:

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PREVIOUS AND CURRENT COLLATERAL SOURCES (E.G., SOCIAL WORKERS, PSYCHOLOGISTS, PSYCHIATRISTS, SCHOOL, BOARDS OF EDUCATION, FAMILY DOCTORS, PEDIATRICIANS, HOSPITALS, CAS, CCAS, JF&CS, OTHER RELEVANT AGENCIES OR SOURCES):

SOURCE/CONTACT	PHONE	DATES	LOCATION

IN CASE OF AN EMERGENCY WHO SHOULD BE NOTIFIED?

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