VRAELYS/QUESTIONNAIRE

StrengVertroulik/Strictly Confidential

Voltooiasseblief so volledig as moontlik Please fill out the questionnaire

Evaluasie Datum Date of Assessment

1. PERSOON VERANTWOORDELIK VIR REKENING / PERSON RESPONSIBLE FOR ACCOUNT

Van / Surname

Dr Mnr Mev Mej / Dr Mr Mrs Miss

Voorname / First Names

I D Nommer / I D Number

Woonadres / Home Address

Kode/Code

Werkgewer / Employer

Werksadres / WorkAddress

Kode/Code

Tel (H) Tel (B) Sel/Cell

E-pos/E-mail

2. MEDIESE FONDS/MEDICAL AID

Naam / Name Nommer / Number

Hooflid se Naam / Name of Main Member I D Nr / I D No

Tel. (H) Tel. (B) Sel/Cell

3. OUERS: AGTERGRONDGESKIEDENIS / PARENTS: BACKGROUND HISTORY

VADER / FATHER

- Naam/Name
- Hoërskool / High School Jaar /Year
- Hoogstegraadgeslaag / Highest grade passed Jaar/Year
- Naskoolse Opleiding/TertiaryTraining Jaar/Year
- (Instansie/Institution)
- Beroep/ Occupation Werkgewer / Employer

Mediesegeskiedenis / Medical History

- Allergieë / Allergies
- SkolastieseProbleme / Learning Disabilities

Rianie de Bruin, Educational Psychologist, 326 Wynandskraal Street, Erasmusrand/999 Haarhoff Street-East, Villieria, Pretoria.Website: elizabethhefer.co.za, E-mail rianiedb@gmail.com
GPS Co-ordinates: -25,807344 28,283430

MOEDER / MOTHER

- Naam/Name
- Hoërskool / High School — Jaar /Year
- Hoogstegraadgeslaag / Highest grade passed — Jaar/Year
- Naskoolse Opleiding/TertiaryTraining — Jaar/Year
- (Instansie/Institution)
- Beroep/ Occupation — Werkgewer /Employer

MedieseGeskiedenis/Medical History

- Allergieë/Allergies
- Skolastieseprobleme/Learning disabilities

GESINSAMESTELLING/SIBLINGS

Naam en ouderdom:

4. KLIËNT/CLIENT

Van /Surname

Naam / Name

Geboortedatum/Date of birth — Geslag/Sex — Ouderdom/Age

Skool/School — Graad/Grade

Graadherhaal / Grade failed

Klasonderwyser en tel nr

Class teacher and tel no

Prinsipaal / Principal

Verwysdeur/

Referred by

Hoofklagte/

Main complaint

5. AGTERGRONDGESKIEDENIS VAN KLIËNT/BACKGROUND HISTORY OF CLIENT

Gesondheid met swangerskap/Health during pregnancy

Swangerskapsduur/Duration of pregnancy

Geboorteprosedure: Normaal — Tyd in kraam (ure) — Keisersnee

Birth procedure: Normal — Duration of labour — Caeserian Section

Naelstringomnek/Umbilical cord around neck — Refluks/Reflux — Koliek/Colic

Borsvoeding/Breastfed

Geboortegewig/Birth weight — Bottel/Bottle

Allergieë/Allergies

Ontwikkelingsmylpale **(ouderdom in maande)**
Developmental Milestones **(age in months)**

• Sit	
• Kruip/Crawl	
• Loop/Walk	
• Woorde/Words	
• Sinne/Sentences	
• Toilet gebruik op/Potty trained at	
• Van doekeaf/Off diapers	

Siektegeskiedenis/Childhood Diseases/Sickness

• Koorsstuipe/Fever fits							
• Kindersiektes/Child diseases (ouderdom/age)							
• Ander siektes/Other diseases (ouderdom/age)							
• Hoofbeserings/Head injuries (ouderdom/age)							
• EEG	Y/N		Date				
• MRI	Y/N		Date				
• Medieseverslae/Medical reports							
• Hospitalisasie	Ja/Nee		Datum		Rede		
• Hospitalization	Yes/No		Date		Reason		
• Operasies	Ja/Nee		Datum		Rede		
• Operations	Yes/No		Date		Reason		
• Oorinfeksies	Ja/Nee		Datum				
• Ear infections	Yes/No		Date				
• Visie: Oogtoets	Ja/Nee		Ouderdom		Disfunksie		
• Vision: Eye test	Yes/No		Age		Dysfunction		

Eetgewoontes/Eating habits

Eetlus/Appetite

Slaappatroon/Sleeping pattern

Gewoontes/Habits

• Duimsuig/Thumb sucking (ouderdom/age)	
• Naelbyt/Nailbiting (ouderdom/age)	
• Kopstamp/Head banging (ouderdom/age)	
• Trekkings, Obsessies/Tics, Obsessions (age/ouderdom)	

Gedrag	Huis		Skool	
Behaviour	Home		School	

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6. SKOLASTIESE AGTERGROND/SCHOLASTIC BACKGROUND

Speelgroep/Dagmoeder Playgroup/Day care: Name Age
Skooltaal/School Language:

Kleuterskool/Nursery School: Name Age

Skooltaal/SchoolLanguage

Pre-PrimêreSkool/Pre-Primary School Name
Age
Skooltaal/School Language

PrimêreSkool/Primary School Name Grade
Skooltaal/School Language

Hoërskool/High School Name Grade
Skooltaal/School Language

TersiêreOpleiding: Naam Kursus
Tertiary Training: Name Course Year

SkoolWeiering/Fobia
School Refusal/Phobia

Sport:Soort/Type Ouderdom/Age

7. VORIGE EVALUASIES/PREVIOUS ASSESSMENTS

Fisioterapie/Physiotherapy:
Terapeut/Therapist Ouderdom/Age

Arbeidsterapie/Occupational Therapy:
Terapeut/Therapist Ouderdom/Age

Spraakterapie/Speech therapy:
Terapeut/Therapist Ouderdom/Age

Neuro-ontwikkelingspediater/Neuro-developmental Paediatrician

Dr Ouderdom van kind/Child's age
Ander/Others: Name Ouderdom van kind/Child's age

8. VORIGE TERAPIE/PREVIOUS THERAPY

Fisioterapie/Physiotherapy Ja/Nee Yes/No

Tydsduur Duration

Arbeidsterapie/Occupational therapy Ja/Nee Yes/No

Tydsduur Duration

Spraak/taalterapie/ Speech/language therapy Ja/Nee Yes/No

Tydsduur Duration

RemediërendeKlasse/Remedial Education Ja/Nee

Tydsduur/Duration

Ekstraklasse/Extra classes:

Grade	Vakke/Subjects

Ander terapie/Other type of therapy: Tydsduur/Duration

Medikasie/Medication: Dr Grade

9. VERSLAE/REPORTS

Spraak/taalterapie/ Ja/Nee
Speech/language therapy Yes/No

Arbeidsterapie/Occupational therapy Ja/Nee
Yes/No

Neuroloog/Neurologist Ja/Nee
Yes/No

Pediater/Paediatrician Ja/Nee
Yes/No

Bring verslaeassebliefsaam met eerstekonsultasie.
Please bring reports with the first consultation

10. TRAUMATIESE GEBEURE/TRAUMATIC EXPERIENCES

Voorval/Incident	Ouderdom/Age

ToestemmingvirSielkundigeEvaluasie

Hiermeeverleenek----------, vader/moeder van----------

toestemmingdat my kind na dr. Rianie de Bruin, OpvoedkundigeSielkundige, vir 'n sielkundigeevaluasie en terapie mag gaan. Die evaluasiesluit in (merk van toepassing):

☐ Ouerbegeleiding

☐ Ontwikkelingsevaluasie

☐ Skoolgereedheidsevaluasie

☐ Skolastiese en IntellektueleEvaluasie
(Skolastieseprobleme)

☐ Evaluasie: ☐Gedragsprobleme
☐ EmosioneleProbleme
☐ Sosialiseringsprobleme
☐ Vakkeuses
☐ Skoolplasing
☐ AansoekvirSpesialeKonsessies
☐ Neurofeedback

☐ Beroepsleiding

☐ Verslag – Kliënt self virbetaling van verslagverantwoordelik

Adres:
……
.

Tel nr: ……

Selnr: ……

ID nr: ……

Epos adres: ……

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-
Handtekening van vader **Datum**

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Handtekening van moeder **Datum**

Rianie de Bruin, Educational Psychologist, 326 Wynandskraal Street, Erasmusrand/999 Haarhoff Street-East, Villieria, Pretoria.Website: elizabethhefer.co.za, E-mail rianiedb@gmail.com
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Consent of Permission for a Psychological Assessment

I, ……., father and mother, hereby give permission for (child's name)…….. to see Rianie de Bruin, Educational Psychologist, for a psychological assessment and therapy, which include the following (check all that apply):

- ✘ Developmental Assessment
- ✘ Parental Guidance
- ✘ School Readiness Assessment
- ✘ Scholastic and Intellectual Assessment (scholastic difficulties)
- ✘ Assessments :
  - × Behavioural Difficulties
  - × Emotional Difficulties
  - × Social Difficulties
  - × Choice of school subjects
  - × School placement
  - × Application for Special Concessions
  - ×Neurofeedback
- ✘ Career Guidance
- ✘ Written Report – client is responsible for the payment

Address: ……

Tel no: ……

Cellphone no: ……

ID no: ……

Email Address: ……

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Signature of father **Date**

---------- ----------

Signature of mother **Date**

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Rianie de Bruin – Psychology Practice
PRACTICE INFORMATION

Procedure for Appointments

* Appointments will be scheduled at a time mutually acceptable to both the patient and the psychologist. We require 24 hour advance notice of cancellations except in an extreme emergency. Appointments missed or cancelled in less than 24 hours will be charged at the usual rate.

*According to the law both parents are required to sign the consent of permission for a psychological assessment.

***Please note that the first consultation/evaluation must be paid in full by the patient. The amount may be claimed back from the medical aid.**

COPY OF CONTRACT

- I, the undersigned, undertake to give 24 hour advance notice of the cancellation of appointments. Appointments missed or cancelled in less that 24-hour notice, will be charged at the normal rate.
- I, the undersigned, am responsible for payment of the full amount on my account on the day of my consultation and/or assessment.
- I, the undersigned, undertake to pay collecting charges for unpaid fees when my account is not paid in full within 30 days. Interest at a rate of 2.2% per month will be charged on unpaid fees older than **30 days**.
- I, the undersigned, declare that my address as given in this file is "domiciliumcitandi et executandi" for receiving documents or and letters of execution.
- I, the undersigned will notify the practice in writing of any changes to my physical address, postal address and or contact details;
- The practice is entered and visited at own risk. The practice is not liable for any accidents and/or injuries sustained by the client or will not be held responsible for any emotional and physical problems that may be activated by sound and light technology and hypnoses at the practice.
- I, the undersigned, declare that I will not use reports or any information received from the practice for any action at law, without the knowledge and permission of Rianie de Bruin.
- The practice charges according to the national reference price list for psychologists which will adjust annually. (Please take note of your medical aid's price list).
- **Written reports are not covered by medical aid. Only on receipt of full payment, will the report be formulated and completed.**
- I, the undersigned, understand that all claims tendered to a medical aid require an ICD 10 (diagnoses code). I hereby give permission to disclose an ICD10 diagnosis code on my account.
- I, the undersigned, understand that my case might be confidentially discussed with a registered senior psychologist for supervision purposes. Confidentiality regarding my name or identity will be upheld. In the case of my child/children, the case may be confidentially discussed with a registered psychologist, speech therapist, occupational therapist, neurologist, paediatrician or general practitioner for referral purposes (attached, Authorization to Release Information).
- I, the undersigned, understand that my child's case may be confidentially discussed with the class teacher or principal at school to support my child effectively (attached, Authorization to Release Information).

PROCEDURES TO ENSURE PROMPT PAYMENT OF ACCOUNTS

Following the given procedure will enable both parties to ensure that accounts are settled promptly.

Payments can be settled by:

- Cash payments 24 hours before assessment
- Internet payments at the practice: 326 Wynandskraal Street, Erasmusrand/999 Haarhoff Street-East, Villieria, Pretoria.

Tel**: 082 377 0411** (office number)
e-mail: rianiedb@gmail.com
Office Hours: 8h00 - 17h00 (Monday-Thursday)
8h00 - 13h00 (Friday)

It remains the patient's responsibility to ensure prompt payment of accounts. An account will be sent to the patient as well as the medical aid. Amounts not paid by the medical aid must promptly be settled by the patient to avoid collection costs.

IMPORTANT INFORMATION TO QUOTE WHEN PAYING ACCOUNTS

Account Holder:	**MAde Bruin**
Bank:	**ABSA**
Account no:	**2140 733 906**
Branch name:	**Waverley Plaza**
Branch Code:	**335 345**

Quote **your name** and **account number** reflected on your statement at all times when paying or corresponding. Email rianiedb@gmail.com copy of deposit and ensure legibility and receipt thereof.

Signature……. Date: …….....