Praxis Wunderkind
Dr. med. Olga Stanković-Dahmen

Date:

Recommendation by:

Details of the child:

First and last name: ____________________

Date of birth - place: ____________________

Street, house number: ____________________

Postcode, City: ____________________

Landline: ____________________

Mobile phone: ____________________

Health insurance: (private/statutory) ____________________

Nationality/Mother tongue ____________________

Which language is spoken at home? ____________________

Knowledge of German: ____________________

Details of mother:

First and last name: ____________________

Business phone: ____________________

Mobile phone: ____________________

Nationality: ____________________

Occupation: ____________________

Custody: No: ☐ Yes: ☐ Signature: ____________________

Details of the father:

First and last name: ____________________

Business phone: ____________________

Mobile phone: ____________________

Nationality: ____________________

Occupation: ____________________

Custody: No: ☐ Yes: ☐ Signature: ____________________

Further information about the mother:

Date of birth: ______

Current age: ______

Place | country of birth: ______

School-leaving qualif.: ______

Education: ______

Studies: ______

Learned profession: ______

Weekly working hours: ______

Physical ilness:

Mental illness:

Further information about the father:

Current age: ______

Place | country of birth: ______

School-leaving qualif.: ______

Education: ______

Studies: ______

Learned profession: ______

Current occupation: ______

Weekly working hours: ______

Physical ilness:

Mental illness:

Parents live together? ______

Information about the siblings:

How many siblings live in the household? ____________________

Are there any half-siblings? ____________________

Sibling 1: Name, age, school type, class
Sibling 2: Name, age, school type, class
Sibling 3: Name, age, school type, class
Difficulties in behaviour at school/kindergarden of siblings or among themselves?
With which sibling does your child get along best and why?
Has a sibling so far received psychiatric help and why?

Current reason for the presentation to the specialist:

What are the current problems that exist with your child?
How do they manifest themselves?
Since when and by whom are these problems noticed and in which situations do they occur?
How much of a burden are these problems for your child?
Do these problems affect your family life or you as parents?
What help do you expect from us?

Self-history of the mother:

Age of the mother at birth: ______

Desired child or unplanned? ______

Did the child come at the on the expected date? ______

Have there been any bleedings, infections,high blood pressure, accidents, operations, premature labour, use of medication, alcohol, nicotine, drugs?
course of birth: Duration, complications, caesarean section, ventilation, newborn jaundice, hospital stay in days
Birth size, birth weight:
As infant: seizures, restlessness, lack of movement, lack of drinking?
When was your child able to crawl?
When was your child able to walk freely?

General medical information of the child:

Does your child suffer from seizures? If yes, with which medication is your child been treated?
Have you had any examinations of your child's vision and hearing? When last time and results?
Has your child had any operations, accidents?
Are there or have there been any physical illnesses?
Does your child take medication (which ones, dosage and since when?)
Have there been any hospital stays (when and where)?

current height: ____________________

current body weight: ____________________

When was your child dry during the day? ____________________

When was your child dry at night? ____________________

Did your child wet the bed again after he/she was already dry? ____________________

At what age did your child wet again after defecated again after he/she was dry? ____________________

When was your child able speak his first words? ____________________

When could your child have the first say 1, 2 and 3 word sentences? ____________________

Did you notice any abnormalities in your child's development?
Is your child growing up bilingual? Which languages does it talk and how well?
Is your child very sensitive to Sounds? Strangers, Children? Darkness?
Do you notice any particular fearfulness of your child?
How skilled is your child in fine and gross motor skills?

From what age can your child read? ____________________

From what age can your child do math? ____________________

Does your child receives extra tuition? ____________________

Attendance at day care from when? ____________________

Attendance at pre-school from when and where? ____________________

Regular school enrolment or before/after? ____________________

Attendance at school from when and where? ____________________

Current school attendance: grade, type of school, where? ____________________

Were there during the school career gruade-drops after moves, separations, divorces, problems in the family, death of relatives, friends, bullying?
What form of treatment has your child received so far? (Occupational therapy, speech therapy, physiotherapy according to Bobath or Vojta, pedagogical early intervention, test psychological examinations) and if yes, please bring the results in copy to the appointment.
Previous outpatient or inpatient child and adolescent psychiatry treatment (when and where)?
Previous contacts with SPZ, SPV practices?

Information about your child's free time:

What hobbies does your child pursue?
Does your child play an instrument (which one)?
Does your child have any friendships at school?
Is your child more likely to meet younger or older?
How much TV, PC, Video games, Social media consumes your child per day in hours?
Does your child already have debts?
Has your child ever been a delinquent or come into conflict with the law?

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Explanation of the cancellation fee

Our practice is run according to the order system. Treatments are therefore only carried out after prior appointment. The agreed treatment time is reserved exclusively for you or your child. This is to avoid long waiting times.

If you or your child cannot keep an appointment in the practice or in the online consultation, please inform us.

Please cancel your appointment at least **24 hours in advance** so that we can use the time for other patients and that you do not have to pay a cancellation fee.

For this purpose, we have set up an **answering machine outside of office hours** on which we ask you to leave your cancellation. For cancellations of test appointments, **please contact the therapist directly**.

If you do not cancel your appointment 24 hours in advance the **cancellation fees** are as following:

30 Euro / control appointment
50 Euro / psychotherapeutic consultation / acute treatment / psychotherapy
50 Euro / cancelled test appointment

Please notice: This has to be paid by yourself regardless of the childs insurance. Reimbursement of costs by the private or statutory health insurance company or the state aid will not take place in this case.

I hereby confirm that I have taken note of the declaration:

Name, first name of the **patient**:

Name, first name of the **child's mother** (custodian) Date, signature

Name, first name of the **child's mother** (custodian) Date, signature

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Declaration of consent

I agree to have my son/daughter

____

born ____________________ treated by Dr. Olga Stankovic-Dahmen and team at the practice Wunderkind in Berlin.

The child's mother has _______% custody and the child's father has _______% custody.

Type of treatment	Mother of child	Father of child
General treatment (Initial presentation and reappearance, testing if necessary)		
Psychotherapy		
Pharmacological treatment		

With a cross (x) behind, you give your consent to the type of treatment.
With your signature you confirm that the information you have given is correct.

____

Name, first name of the **child's mother** (custodian) Date, signature

____

Name, first name of the **child's father** (custodian) Date, signature

PATIENT INFORMATION ON DATA PROTECTION

Dear patient,

the protection of your personal data is important to us. According to the EU General Data Protection Regulation (DSGVO), we are obliged to inform you about the purpose for which our practice collects, stores or passes on data. The information also tells you what rights you have with regard to data protection.

1. RESPONSIBILITY FOR DATA PROCESSING

The person responsible for data processing is: Dr. Olga Stankovic-Dahmen. You can reach the responsible Data Protection Officer at: Dr. Olga Stankovic-Dahmen, Pariser Str. 51, 10719 Berlin, Tel.: 030 88720610.

2. PURPOSE OF DATA PROCESSING

Data processing is carried out on the basis of legal requirements in order to fulfil the treatment contract between you and your therapist and to fulfil the associated obligations. For this purpose we process your personal data, in particular your health data. This includes medical histories, diagnoses, therapy suggestions and findings that we or other therapists collect. For these purposes, other doctors or psychotherapists with whom you are in therapists with whom you are being treated may also provide us with data for these purposes (e.g. in doctor's letters). The collection of The collection of health data is a prerequisite for your treatment. If the necessary information is not provided, treatment cannot be careful treatment cannot take place.

3. RECIPIENTS OF YOUR DATA

We will only pass on your personal data, or that of your underage child, to third parties if this is permitted by law or if you have given your consent. Recipients of your personal data can be other psychotherapists Psychotherapists, doctors, other therapists and health care professionals, clinics, associations of panel doctors, health insurances, the medical service of the health insurance, chambers and private medical clearing houses (e.g. PVS). (e.g. PVS), as well as SMS reminder services (e.g. Telemed). The data is mainly transmitted for the purpose of services rendered to you, to clarify therapeutic issues and issues arising from your insurance relationship. and questions arising from your insurance relationship. In individual cases, data is transmitted to other authorised recipients such as e.g. authorities. We also endeavour to provide patient care by means of video consultation hours. These are patients certified video service providers, which we have been listed by the KV Berlin. Depending on the availability of the individual service providers, we may also change the service provider, and you agree to this. in which case you also agree to this. If you do not agree, please inform us before a video consultation If you do not agree, please inform us before a video consultation. of this before a video consultation. Please bear in mind that from 2021 the TI (telematics infrastructure) will also apply. which requires your consent so that, among other things, the diagnoses, medical data, medicines and therapy recommendations, as well as other data, if applicable, can be stored on the electronic health card (eGK).

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4. STORAGE OF YOUR DATA

We only keep your personal data for as long as is necessary to carry out the treatment. Due to legal requirements, we are obliged to keep this data for at least 10 years after completion of the treatment has been completed. According to other regulations, longer retention periods may apply, for example 30 years..

5. YOUR RIGHTS

You have the right to obtain information about the personal data concerning you. You can also have the right to demand the correction of incorrect data. In addition, you have the right, under certain conditions, to the deletion of data, the right to restrict data processing and the right to data portability. The processing of your data is based on legal regulations. Only in exceptional cases do we require your consent. In these cases, you have the right to revoke your consent for future processing. You also have the right to complain to the competent data protection supervisory authority if you believe that the processing of your believe that the processing of your personal data is not lawful.

The address of the supervisory authority responsible for us is:
Frau Maja Smoltczyk, Friedrichstr. 219, 10969 Berlin
Tel.: +49 (0)30 13889-0 - Fax: +49 (0)30 2155050 - E-Mail: mailbox@datenschutz-berlin.de

6. LEGAL BASIS

The legal basis for the processing of your data is Article 9(2)(h) DSGVO in conjunction with Section 22(1) no. 1 lit. b) Federal Data Protection Act. If you have any questions, please do not hesitate to contact us.

The document submitted has been understood and acknowledged.

Berlin, the

First / Last name: ______________________________

Signature: ______________________________