CHILD ASSESSMENT

FILL OUT ALL FORMS COMPLETELY

YOUR THERAPIST WILL BE WITH YOU IN 45-60 MINUTES LEAVING YOU PLENTY OF TIME FOR THE FORMS

CLIENT INFORMATION

Family Dr. _____ Psychiatrist _____ How did you hear about us?
___ on-line search, ___ friend, ___ family, ___ Dr or clinic referred, ___ Insurance, other _____

Who are you seeing today? ___ Doug Bentley, Ed.D, ___ Renee Bentley, LMSW, ___ David Moskowitz, MD,
___ F. Bert Nelson, LMSW, ___ Rachelle Gorton, LLMSW, other _____

_male _female

Last Name _____ First _____ MI ____ DOB _____ Age _____
Address _____ City _____ Zip _____
Phone (_____) _____ 2nd Phone _____, SSN _____
Email _____ Are you ___ Student, ___ Retired, ___ Employed as _____
Employer _____ Work phone ( ) _____
Employer Address _____ City _____ Zip _____
Accident or work related? Explain? _____
Accident or work contact? _____

Name of ___ Spouse, ___ Parent / Guardian _____ DoB _____ Age _____
Address _____ City _____ Zip _____
Phone (_____) _____ 2nd Phone _____, SSN _____
Email _____ Are you ___ Student, ___ Retired, ___ Employed as _____
Employer _____ Work phone ( ) _____
Employer Address _____ City _____ Zip _____

Name of other Parent / Guardian _____ DoB _____ Age _____
Address _____ City _____ Zip _____
Phone (_____) _____ 2nd Phone _____, SSN _____
Email _____ Are you ___ Student, ___ Retired, ___ Employed as _____
Employer _____ Work phone ( ) _____
Employer Address _____ City _____ Zip _____

Child resides with ___ Mother, ___ Father, ___ Both, Other _____

INSURANCE INFORMATION – WE WILL NEED A COPY OF YOUR INSURANCE CARD(S)

	PRIMARY	SECONDARY	OTHER
Insurance / HMO / Medicare / Medicaid Name			
Policy Holder			
Relationship to client			

Authorization and Assignment of HMO, Insurance, Medicaid and Medicare Benefits

I hereby authorize *Inner Access Therapy Center, LLC* to release information for these services to my insurance carrier, HMO, Medicaid or Medicare for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges not covered by my insurance. I also understand that discounts of co-pays and deductibles are not permitted by insurance carriers, HMO's, Medicaid or Medicare.

If your case is "cash only", please check here _____, and no insurances will be billed.

Signature of financially responsible person _____ **Date** _____

Client Signature (if 18 or older) or guardian signature (if minor child) is mandatory to receive services.

Intake Date _____

INNER ACCESS THERAPY CENTER, LLC

LIMITS OF CONFIDENTIALITY

- **Duty to Warn and Protect**
  Any plans for harm of another will be reported to the police, and the intended victim will be told. Plans for suicide will be reported to the police, and family will be notified.

- **Abuse of Children and Vulnerable Adults**
  If a client states or suggests that he or she is abusing a child (or vulnerable adult), has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

- **Prenatal Exposure to Controlled Substances**
  Health care professionals are required to report admitted prenatal exposure to controlled substances which are potentially harmful.

- **Client's Death**
  In the event of a clients death, the spouse or parents of a deceased client have a right to access to their child's or spouse's records.

- **Client Abuse by Another Professional**
  Professional abuse of a client must be reported to his/her licensing agent. If this professional is disciplined, client records may be necessary for the disciplinary process.

- **Court Orders**
  Records must be released to courts for legal proceedings, except substance abuse treatment records for which the court must show "no other means of obtaining this information".

- **Minor/Guardianship**
  Parents or legal guardians of non-emancipated minor clients have the right to access the clients records, except those receiving substance abuse treatment and are 14 years of age or older.

- **Unpaid Fees**
  When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) are not disclosed. If a debt remains unpaid it may be reported to credit agencies and the clients credit report may state the amount owed, a time frame and the name of the clinic.

- **Insurance**
  Insurance companies and other third party payers are giving information they request regarding services to clients.

- **Consultation**
  Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment.

- **Separate Files**
  When couple's, groups or families are receiving services, separate files are kept for individuals for information disclosed which is of a confidential nature. This information includes (a.) testing results, (b.) information given to the mental health professional which was not in the presence of other person(s) utilizing services, (c.) Information received from other sources about the client, (d.) diagnosis, (e.) treatment plan, (f.) Individual reports or summaries, and (h.) Information which had been requested to be separate. The material disclosed in conjoint family or couples' sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

- **Phone Contact**
  If we phone you for appointment cancellations, reminders, or to give/receive other information, we also try to preserve confidentiality. When we call, we will ask to speak to the client (or guardian) without identifying the name of the clinic, unless you give us permission to use the clinic name. If the person answering the phone asks for more identifying information we will say that it is a personal call and that we will call back later. If we reach an answering machine or voice mail we will follow the same guidelines.

✓ **PLEASE CHECK PLACES IN WHICH YOU MAY BE REACHED BY PHONE.** Include phone numbers and how you would like us to identify ourselves when phoning you.

____ HOME	_____ Phone Number	_____ How should we identify ourselves?	___ Yes ___ No May we say the clinic name?
____ WORK	_____ Phone Number	_____ How should we identify ourselves?	___ Yes ___ No May we say the clinic name?
____ Other	_____ Phone Number	_____ How should we identify ourselves?	___ Yes ___ No May we say the clinic name?

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____ _____

Client's Name (please print) **Client's (or Guardian's) signature** **Date**

INNER ACCESS THERAPY CENTER
BILLING EXPLANATION AND CONSENT FOR TREATMENT
Please read the information here carefully!

Having insurance is not a guarantee that they will pay your bill at Inner Access Therapy Center. Our agreement is with you and not with your insurance. To receive services here, you must know that you will be held responsible for paying the bill if your insurance does not pay, just as you pay for other doctor visits. This is our billing procedure:

CLIENT BILLING RESPONSIBILITY

1. As a new client, it is your responsibility to contact your insurance agency and
   A. Find out if the therapist yo are seeing is an approved provider. We are likely able to tell you if we have worked with your insurance before.
   B. Find out your co-pay amount.
   C. Get approved (Authorized) to see the therapist.

2. As a continuing client, you are responsible to:
   A. Understand the billing procedure, including the policy of charges for late cancellation or "No Show" appointment fees.
   B. Pay your co-pays, deductibles, and fees regularly.
   C. Keep you session receipts for future reference in case there are billing questions. We do not make adjustments without receipts.
   D. Notify the therapist of any changes in your insurance.
   E. Notify your therapist if you are having difficulty paying your bill. Often we can arrange a payment plan to ease the financial burden and still provide the help you need.

INNER ACCESS THERAPY CENTER BILLING RESPONSIBILITY

1. To tell you (if we know) if we are providers for your insurance.

2. To bill your insurance company for you unless you have decided to self-pay. Our billing company is Advantage Billing, Inc. Phone : 616-935-2090

3. To provide you with a receipt at each visit. This is a record of your date of service, therapist name, amount billed, amount you paid, and your next visit date. Please keep your receipts as this will help you with any billing questions or problems you may have later.

COLLECTION PROCEDURES - FAILURE TO PAY
PLEASE CONTACT US BEFORE IT GETS TO THIS POINT!

Your original billing statements will be sent to Advantage Billing, Inc. for processing. You will contact them with questions. Phone : 616-235-2090 f you do not / can not pay on your bill and do not contact them, You will be charged a **RE-BILLING FEE**, and the following happens to your account:

1. You will be sent a "non-payment notice" for these reasons:
   A. If you haven't made a payment in 45 days.
   B. If you haven't set up a payment plan.

2. If you do not respond to the "non-payment notice" within 10 days, you will not get regular billings, and will be put into a special "Collections Account" at Advantage Billing. At this point, an additional **COLLECTION RECOVERY FEE** of 35% of your balance owed will be added to your account to cover extra collection costs. ***REMEMBER - IT ONLY TAKES A PHONE CALL TO TALK IT OVER AND AVOID THESE EXTRA FEES!***

3. If you do not contact Advantage Billing within 30 days of being in Collections, your account is transferred from Inner Access Therapy Center to CBCS. Once you are in Collection Status with CBCS, your account belongs to them, and all communication regarding your bill will be with them and not with Inner Access Therapy Center. <u>YOUR CREDIT RATING MAY BE AFFECTED.</u>

CLIENT FINANCIAL AND TREATMENT AGREEMENT

We know that financial issues add to our client's stress, and we will make every attempt to work with you if you keep open communication with us. This way we can focus on the mental health and substance abuse issues which brought you here.

AS GUARANTOR, I CONSENT AND UNDERSTAND THAT:

- Inner Access Therapy Center may assist in obtaining information about eligibility, co-pays and deductibles from my insurance carrier.
- I am ultimately responsible for obtaining insurance authorizations, and knowing my deductibles and co-pay information.
- I agree to pay, at the time of service (unless otherwise arranged), these deductibles, co-pays and fees not paid by my insurance company.
- Inner Access Therapy Center will bill my insurance for me where that is acceptable by the insurance, but this does not affect my responsibility for payment of services.
- I am responsible for the payment of services for the named client.
- I will make all appointments on time.
- Where I miss an appointment or need to cancel, I will notify Inner Access Therapy Center 24 hours in advance.
- If I am not able to give 24 hours advance notice of cancellation, **REGARDLESS OF THE REASON**, I am responsible for the payment of the clinical hour reserved for me with my therapist.
- Payment of missed appointments is due within 5 days of that missed appointment.
- Insurance companies do not pay for missed appointments.
- I will do my best to keep my receipts and records. If I believe that I have been unfairly charged, I can request a "Chart Audit" for clarification of billing, and will bring my receipts for review. If Inner Access Therapy Center is in error, the fees will be adjusted. If I am in error, there will be a fee for the "Chart Audit" added to my account.
- If I write a check that is returned for Insufficient Funds or Closed Account, there will be a Returned Check Fee added to my account.

I have read this Billing Explanation, Financial Agreement And Treatment Agreement Form, and have had the opportunity to ask questions about it. At this time, I consent for treatment for the named client (either myself or the minor child for whom I am parent or guardian) at Inner Access Therapy Center. I agree to pay for services provided by Inner Access Therapy Center Staff for this client.

_____

CLIENT NAME

_____

SIGNATURE OF GUARANTOR / GUARDIAN / CLIENT

_____

DATE OF SIGNATURE

_____

INNER ACCESS THERAPY CENTER STAFF REVIEWER

COPIES: FILE
ADVANTAGE BILLING, INC.
CLIENT / GUARANTOR (IF REQUESTED)

EMERGENCY CONTACT
AUTHORIZATION FOR RELEASE OF INFORMATION

_____

Print full name of client Date of Birth

I understand the need for Inner Access Therapy Center Professionals to secure my safety and to be concerned for my well being. I understand that should there be need for emergency medical personnel, or emergency contact for other reasons that my consent is required.

EMERGENCY CONTACT PERSON (Initials _____)

Name _____

Address _____

Phone _____

EMERGENCY CONTACT PERSON (Initials _____)

Name _____

Address _____

Phone _____

I understand that this release gives permission for staff at IATC to contact the above person(s) and / or emergency medical personnel on my behalf in the event of a bonafide emergency where my health or well being is in jeopardy.

I understand that this release is only for use while I am a client at IATC, and it expires upon my termination from treatment.

I have read the above information and agree that I am familiar with, and understand the conditions of this authorization for release of information.

I HEREBY CONSENT TO INNER ACCESS THERAPY CENTER STAFF ACTING ON MY BEHALF IN THE EVENT OF AN EMERGENCY.

_____

Client Signature Date

_____

Witness Date

Inner Access Therapy Center Staff would also like your consent to contact others for the following reasons: 1) IATC staff is unavailable for your appointment, and we cannot locate you at your home, or secondary numbers; 2) you have recently moved and we do not have your current address or phone number. Please initial next to the above listed name(s)of the people we can contact to help us keep in touch. Thanks.

INNER ACCESS THERAPY CENTER
CLIENT STATEMENT OF UNDERSTANDING

I have been offered a copy of:

- The IATC Billing Explanation Form
- Copy of Statement pursuant to 42 CFR 2.53(a) and Know Your Rights
- This form which contains client conduct information.

I understand that if I choose to not receive a copy now, I may request them any time during the course of my treatment.

I have reviewed these statements and have had opportunity to discuss them with my therapist. I understand what is in them and I agree to receive treatment with this therapist at Inner Access Therapy Center.

I understand that the following behavior will not be tolerated at Inner Access Therapy Center. Termination of session and / or law enforcement involvement may be expected.

- Any acts of physical or verbal aggression
- Destruction of property
- Stealing
- Coming to a session under the influence of alcohol or drugs
- Selling or Soliciting any form of drug or alcohol
- Selling or soliciting any form of sexual favor or sexual intent

_____ _____

Client Signature Date

_____ _____

Co-client Signature (if needed) Date

_____ _____

Witness Signature Date

HYPNOTHERAPY STATEMENT OF UNDERSTANDING

My therapist has explained that Hypnotherapy is an effective form of therapy, and like all forms of therapy, it is not 100% foolproof. The basic procedures have been explained, and my questions have been answered. I consent to this type of therapeutic intervention.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

COORDINATION OF CARE FORM

Section 1 - Provider Information

It's often helpful to coordinate your care with other health care professionals. Please sign below to indicate whether I may share information about our visits with the following providers:

Primary Care Provider		Phone Number	
		( )	
Street Address	**City**	**State**	**Zip Code**
Additional Behavioral Health Provider (if applicable)		**Phone Number**	
		( )	
Street Address	**City**	**State**	**Zip Code**

☐ Yes. You may share information about my treatment plan with the providers listed above.

Signature: X _____

☐ No. You may not share information about my treatment.

Signature: X _____

Section 2 - Patient Information

Patient Name		Contract Number	Date of Birth
			/ /
Date of Visit	**DSM III - R / DSM IV**	**ICD - 9**	
/ /			

Presenting Problems:

Treatment Plans / Recommendations / Follow-Up:

Current Medications Prescribed:

Medical Follow-Up Recommended:

Other Pertinent Information:

Treating Behavioral Health Provider: X _____ / / ( )

Signature — Date Sent — Phone Number

IATC CHILD BIOGRAPHICAL INFORMATION FORM

To assist us in helping your child, fill out this form as fully and openly as you can. All private information is held in confidence within legal limits. If certain questions do not apply to the child, leave them blank.

Information supplied by: _____ **Relationship:** _____

CLIENT NAME _____ **INTAKE DATE** _____

Has your child received counseling in the past? Y N If yes:

Dates _____ Counselor _____ Reason? _____ Result? + -

Dates _____ Counselor _____ Reason? _____ Result? + -

What is your reason for seeking help today? _____

How long has this been a problem? _____

Under what conditions does the problem get worse? _____

Under what conditions does the problem get better? _____

PERSONAL HISTORY

Age: _____ Gender: _____ Weight: _____ Height: _____

Eye Color: _____ Hair color: _____ Year in School: _____

MEDICAL HISTORY

Family Physician: _____ Phone: _____

Address _____

Major illnesses and operations? _____

Child has not had a physical exam in the past two years T F

Child has present or recurring symptoms
for which he/she is not currently receiving treatment. T F

Child has a physical impairment/disability for which
he/she is not currently receiving treatment. T F

Last Physical: Date: _____ Dr: _____ Results: _____

Referral for Physical:
True to One or more of Above Q's? Y N
If Yes, Mandatory referral by State Health Guidelines

Referred to Dr. _____
Client Agrees to referral Y N

Number of hours child sleeps daily (ave)? _____
Trouble falling asleep? Y N
Waking in the middle of the night? Y N How often? _____
Nightmares? Y N About what? _____

Weight Change of 10 or more pounds in the past year? Y N _____ Gained ? _____ Lost?

Appetite in the past week: _____Poor _____ Average _____High

List child's allergies: _____

MEDICATIONS

MEDICATION & DOSE	PURPOSE

For Therapist Use Only

Notes:_____

_____

Clinical Problem? Y N

Tx. Plan issue? Y N

Referred out? Y N To: _____

FAMILY HISTORY

What is the relationship between the child and his/her custodial parents? Check all that apply:

___ Single Parent Mother ___ Single Parent Father ___ Parents Unmarried

___ Parents Married, Together ___ Parents Divorced ___ Parents Separated

___ With Mother and Step-Father ___ With Father and Step-Mother

___ Child Adopted ___ Other - Describe _____

Child was number ____ in a family of ____ children .

Number of Step / Half brothers _____ Number of Step / Half sisters _____

BROTHERS AND SISTERS

Rate relationship from 1-5 where 5 is the best

NAME	AGE	OCCUPATION OR GRADE IN SCHOOL	QUALITY OF RELATIONSHIP 1-5

Which of the following best describes the family where the child is growing up?

WARM AND ACCEPTING AVERAGE HOSTILE AND FIGHTING

1 2 3 4 5 6 7

Which of the following describes the way in which your family is raising the child?

ALLOWS INDEPENDENCE AVERAGE TRIES TO CONTROL

1 2 3 4 5 6 7

COMMENTS: _____

_____

Describe overall how your child treats the following people. Circle one answer for each.

YOUR CHILD'S TREATMENT OF:	Poor			Average			Excellent
YOU	1	2	3	4	5	6	7
YOUR SPOUSE	1	2	3	4	5	6	7
SIBLINGS	1	2	3	4	5	6	7
THEIR FRIENDS	1	2	3	4	5	6	7
SCHOOL	1	2	3	4	5	6	7

COMMENTS: _____

_____

For Therapist Use Only

Notes: _____

_____

Clinical Problem? Y N

Tx. Plan issue? Y N

Referred out? Y N To: _____

FAMILY SPIRITUAL HISTORY

Do you consider yourself a religious family? Y N

Is your family currently active in a religious group or church? Y N
Which one? _____

Is your child a spiritual person? Y N Comment? _____

What are the family beliefs about God or a Higher Power? _____

_____

Who has your child been unable to forgive? How do they "get even" with them or punish them?

_____

How important is spiritual / religious commitment to your family?

UNIMPORTANT			AVERAGE IMPORTANCE			EXTREMELY IMPORTANT
1	2	3	4	5	6	7

LEISURE, RECREATION, EDUCATION, LEGAL

RECREATION

What does your child like to do during free time? _____

Is your child satisfied with the free time he/she has? Y N

Are you satisfied with the way your child uses free time? Y N

Who can your child count on to support him/her in times of trouble? _____

Please describe your child's friendships: _____

_____

EDUCATION

Highest grade in school _____ Average Grades _____

Does your child experience any of these in school?

_____ Learning Problems _____ Problems with Classmates

_____ Problems with Teachers _____ Emotional Problems

Does your child have any special help in school? Y N Describe? _____

_____

LEGAL

Has your child had any legal problems or encounters with the police? Y N

Please describe _____

_____

Do we need to talk to anyone in Probation, Courts or Attorneys during your child's treatment? Who?

What will they need? _____

For Therapist Use Only

Notes: _____

_____

Clinical Problem? Y N

Tx. Plan issue? Y N

CHILD GROWTH AND DEVELOPMENT

Age first walked _____ Approximate age toilet trained _____

Age started school _____ Approximate age started solid foods _____

Has your child ever experienced:

_____ physical abuse? _____ watched it happen?

_____ emotional / mental abuse? _____ watched it happen?

_____ sexual abuse? _____ watched it happen?

Comment please: Who? Where? When? _____

_____

_____

Please Rate your opinion of the child's development compared to others of the same age:

	Below Average	About Average	Above Average
Social	_____	_____	_____
Physical	_____	_____	_____
Language	_____	_____	_____
Intellectual	_____	_____	_____
Emotional	_____	_____	_____

For each of the areas you rated BELOW AVERAGE, Please describe your concerns.

_____

_____

CHILD'S MOTHER (or female parent figure)

Briefly describe the mother_____

_____

How much time does she spend with the child? ____ Much ____ Ave ____ Little

Comments? _____

Mother's occupation? _____

____ Stays home _____ Works outside part-time _____Works outside full time

Is there anything unusual about the child's relationship with the mother? Y N

Please describe _____

Describe overall how the child's mother treats the following people. Circle one answer for each.

MOTHER'S TREATMENT OF	Poor			Average			Excellent
CHILD	1	2	3	4	5	6	7
CHILD'S FAMILY	1	2	3	4	5	6	7
CHILD'S FATHER	1	2	3	4	5	6	7

CHILD'S FATHER (or male parent figure)

Briefly describe the child's father._____

_____

How much time does he spend with the child? ____ Much ____ Ave ____ Little

Comments? _____

Father's occupation? _____

_____ Stays home _____ Works outside part-time _____Works outside full time

Is there anything unusual about the child's relationship with the father? Y N

Please describe _____

Describe overall how the father treats the following people. Circle one answer for each.

FATHER'S TREATMENT OF	Poor			Average			Excellent
CHILD	1	2	3	4	5	6	7
CHILD'S FAMILY	1	2	3	4	5	6	7
CHILD'S MOTHER	1	2	3	4	5	6	7

DISCIPLINE

What is your child usually disciplined for? _____

How do you discipline your child? _____

When do you reward your child? _____

How do you reward your child? _____

For Therapist Use Only

Notes:_____

_____

Clinical Problem? Y N

Tx. Plan issue? Y N

Referred out? Y N To: _____

FAMILY MENTAL HEALTH AND SUBSTANCE USE HISTORY
Please check the boxes that apply to your family. Check all that apply.

RELATION-SHIP TO CHILD	DEPRESSION	MANIA	ANXIETY / PANIC	SCHIZO-PHRENIA	ALCOHOL / DRUG ABUSE
CHILD					
MOTHER					
MOTHER'S PARENTS					
FATHER					
FATHER'S PARENTS					
SIBLINGS					
OTHER RELATIVES					

*** IF YES TO ANY OF SUBSTANCE ABUSE HISTORY, PLEASE COMPLETE THE FULL S.A. HISTORY FORM ***

Has child been hospitalized for the above illnesses? Y N

Which ones? When? _____

_____

Has anyone else in your family been hospitalized for the above illnesses? Y N

Who? Which Illness? _____

Has child attempted suicide? Y N When? _____

Why? _____

Has anyone else in your family attempted suicide? Y N Who? _____

Why? _____

For Therapist Use Only

Notes: _____

_____

Clinical Problem? Y N

Tx. Plan issue? Y N

Referred out? Y N To: _____

Your child's three greatest strengths

1. _____

2. _____

3. _____

Your child's three most needed areas of improvement

1. _____

2. _____

3. _____

Your child's three main difficulties in school

1. _____

2. _____

3. _____

Your child's three main difficulties at home.

1. _____

2. _____

3. _____

For Therapist Use Only

Notes:_____

_____

Clinical Problem? Y N

Tx. Plan issue? Y N

Referred out? Y N To: _____

CHILD BEHAVIORS OF CONCERN

1.	Loses temper easily	____ Never	____ Rarely	____Sometimes	____ A lot
2.	Argues with adults	____ Never	____ Rarely	____Sometimes	____ A lot
3.	Refuses Adult's requests	____ Never	____ Rarely	____Sometimes	____ A lot
4.	Deliberately annoys people	____ Never	____ Rarely	____Sometimes	____ A lot
5.	Blames others for own mistakes	____ Never	____ Rarely	____Sometimes	____ A lot
6.	Easily annoyed by others	____ Never	____ Rarely	____Sometimes	____ A lot
7.	Change in friends	____ Never	____ Rarely	____Sometimes	____ A lot
8.	Angry / resentful	____ Never	____ Rarely	____Sometimes	____ A lot
9.	Spiteful / vindictive	____ Never	____ Rarely	____Sometimes	____ A lot
10.	Defiant	____ Never	____ Rarely	____Sometimes	____ A lot
11.	Bullies and teases	____ Never	____ Rarely	____Sometimes	____ A lot
12.	Starts fights	____ Never	____ Rarely	____Sometimes	____ A lot
13.	Uses weapons	____ Never	____ Rarely	____Sometimes	____ A lot
14.	Physically cruel to people	____ Never	____ Rarely	____Sometimes	____ A lot
15.	Physically cruel to animals	____ Never	____ Rarely	____Sometimes	____ A lot
16.	Steals	____ Never	____ Rarely	____Sometimes	____ A lot
17.	Forced sex on others	____ Never	____ Rarely	____Sometimes	____ A lot
18.	Intentional arson	____ Never	____ Rarely	____Sometimes	____ A lot
19.	Burglary	____ Never	____ Rarely	____Sometimes	____ A lot
20.	"Cons" others	____ Never	____ Rarely	____Sometimes	____ A lot
21.	Runs away from home	____ Never	____ Rarely	____Sometimes	____ A lot
22.	Truant at school	____ Never	____ Rarely	____Sometimes	____ A lot
23.	Poor with details	____ Never	____ Rarely	____Sometimes	____ A lot
24.	Careless mistakes	____ Never	____ Rarely	____Sometimes	____ A lot
25.	Doesn't listen when spoken to	____ Never	____ Rarely	____Sometimes	____ A lot
26.	Doesn't finish homework or chores	____ Never	____ Rarely	____Sometimes	____ A lot
27.	Difficulty organizing tasks	____ Never	____ Rarely	____Sometimes	____ A lot
28.	Loses things	____ Never	____ Rarely	____Sometimes	____ A lot
29.	Easily distracted	____ Never	____ Rarely	____Sometimes	____ A lot
30.	Forgetful in daily activities	____ Never	____ Rarely	____Sometimes	____ A lot
31.	Fidgets / squirmy	____ Never	____ Rarely	____Sometimes	____ A lot
32.	Difficulty remaining seated	____ Never	____ Rarely	____Sometimes	____ A lot
33.	Runs / climbs excessively	____ Never	____ Rarely	____Sometimes	____ A lot
34.	Difficulty playing quietly	____ Never	____ Rarely	____Sometimes	____ A lot
35.	Hyperactive	____ Never	____ Rarely	____Sometimes	____ A lot
36.	Difficulty waiting turns	____ Never	____ Rarely	____Sometimes	____ A lot
37.	Interrupts others	____ Never	____ Rarely	____Sometimes	____ A lot
38.	Problem pronouncing words	____ Never	____ Rarely	____Sometimes	____ A lot
39.	Change in grades	____ Never	____ Rarely	____Sometimes	____ A lot
40.	Poor school grades	____ Never	____ Rarely	____Sometimes	____ A lot
41.	Expelled from school	____ Never	____ Rarely	____Sometimes	____ A lot
42.	Depression	____ Never	____ Rarely	____Sometimes	____ A lot
43.	Shy / avoidant / withdrawn	____ Never	____ Rarely	____Sometimes	____ A lot
44.	Fatigued / tired/ sleepy	____ Never	____ Rarely	____Sometimes	____ A lot
45.	Anxious / nervous	____ Never	____ Rarely	____Sometimes	____ A lot
46.	Excessive worrying	____ Never	____ Rarely	____Sometimes	____ A lot
47.	Sleep disruption	____ Never	____ Rarely	____Sometimes	____ A lot
48.	Panic attacks	____ Never	____ Rarely	____Sometimes	____ A lot
49.	Mood shifts	____ Never	____ Rarely	____Sometimes	____ A lot
50.	Poor appetite	____ Never	____ Rarely	____Sometimes	____ A lot

How does your child express the following emotions and behaviors?

ANGER: _____

HAPPINESS: _____

SADNESS: _____

ANXIETY: _____

For Therapist Use Only

Notes: _____

_____

Clinical Problem? Y N

Tx. Plan issue? Y N

Referred out? Y N To: _____

List the most important behavior you would like to see change. _____

_____

Other information you believe may be helpful. _____

_____

_____

HOPES, OUTCOME EXPECTATIONS
What would you like to have happen as a result of therapy here?

_____

_____

_____ _____
Parent Signature Date

_____ _____
Therapist Signature Date

c: child bio - parent form