Neurobehavioral Institute of Austin

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Lindsay Heath, Ph.D. Stephen Roeckeman, Psy.D.
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3660 Stoneridge Road | Building F-101 | Austin, Texas 78746
Ph: 512.329.8222 Fax: 512.329.0087

Child Client Information Form (Ages 3 - 17)

Today's date _____

Client Identification *(The following questions refer to the Child)*

Child's name: _____ Age: _____
LAST FIRST MIDDLE

Child's date of birth: _____ Child's Social Sec. # _____ Sex ☐ M ☐ F

Home address: _____
STREET CITY STATE ZIP CODE

Primary phone: _____ Secondary phone: _____ **Email**: _____

How do prefer your appointment reminders? ☐ Call ☐ Text ☐ Email

May we send you our email newsletter? (*you may unsubscribe at any time) ☐ Yes ☐ No

Referred by: _____ Primary Physician: _____

Medications and Prescribing Physicians: _____

Reason for seeking help: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Responsible Party Identification *(The following section refers to the Responsible Party only)*

Relationship to patient: ☐ mother ☐ stepmother ☐ father ☐ stepfather
☐ legal guardian ☐ other (write in) _____

Name: _____ Social Sec#: _____
LAST FIRST MIDDLE

Date of Birth: _____ Sex ☐ M ☐ F Phone: _____

Home address: _____

Email: _____ Employer: _____

Relationship to patient: ☐ mother ☐ stepmother ☐ father ☐ stepfather
☐ legal guardian ☐ other (write in) _____

Name: _____ Social Sec# _____

Date of Birth: _____ Sex ☐ M ☐ F Phone: _____

Home Address: _____

Email: _____ Employer: _____

Financial Information Form

Client: _____
LAST FIRST MIDDLE

Filing Status: We are happy to file your claims with your primary and secondary insurance companies if they are in-network. However, it is not our policy to file claims for out of network insurance policies. Please identify your filing status by selecting one of the following options: *(Please check with office staff if you are in doubt.)*

- ☐ Private pay – Patient's submitting personal claims for insurances out of network with our providers, or patient's choosing not to file for privacy reasons. Itemized statements are available upon request.
- ☐ Provider Filing Insurance - Blue Cross, Medicare Part B, and Seton insurances only. **Not all plans within these companies are contracted with our providers.*

Disclaimer Acknowledgment: I understand that portions of my psychological / neuropsychological assessment may not be covered. I understand that it is my responsibility to verify my own benefits and that Neurobehavioral Institute of Austin (NBA) verifies benefits as a courtesy; benefits quoted are estimates received from the insurance company. NBA files claims only for in-network insurance plans. Clients with out-of-network plans can file their own claims to request reimbursement from their insurance company. If a claim is denied or is processed incorrectly, NBA will re-file the claim once. Any further billing problems will need to be handled by the client. I understand that if there are problems with my insurance paying my claims, I will contact my insurance company to resolve this matter.

- I understand that I am responsible for all copays, co-insurance, and deductibles that are associated with my insurance plan and that the amount is due at the time of service.
- I understand that portions of psychological and neuropsychological assessment may not be covered by my insurance plan and I agree to pay for the amount not paid for by my insurance.
- If the full amount due cannot be paid on the date of assessment, I agree to sign a payment agreement in which I regularly make payments towards the balance until paid in full.
- I understand that the psychological/neuropsychological report may not be released until I have paid my balance.

Assignment of Benefits: I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this form is to be considered as good as the original.

_____ _____ _____
Parent/guardian's) signature Printed Name Date
Indicating agreement to all of the statements above

******Complete this policy information section ONLY if you checked the 'Provider Filing Insurance' box.******

Primary Insurance Co. _____ Policy # _____
Policy Holder: _____Group/Plan #: _____
Policy Holder's DOB: _____Policy Holder's Soc. Sec. # _____
Policy Holder's home address: _____
Policy Holder's employer: _____ Work phone #: _____

Secondary Insurance Co.
Policy # _____
Policy Holder: _____Group/Plan #: _____
Policy Holder's DOB: _____Policy Holder's Soc. Sec. # _____
Policy Holder's home address: _____
Policy Holder's employer: _____ Work phone #: _____

Office Policies, Financial Agreement, and Consent for Treatment

(A copy of this form is available upon request.)

Payment Policy

- If an **in-network insurance company** is being billed, we will file the claim for you. It is not our policy to file claims for out of network insurance policies, although we can provide you with the paperwork to do this on your own. All co-payments, deductibles, percentages, and balances not covered by your insurance carrier are due and payable when services are rendered. **You will be billed for any balances the insurance company does not pay. You are fully responsible for this balance** and payment is due within 15 days of the statement date even if you plan to appeal a denial.

- If you are **paying privately**, we do not bill an insurance company. The full amount for the initial interview is due at the time of service. For testing, full payment of the estimated total is due and payable at the time of testing. If such payment is not possible because of special circumstances, a specific payment plan must be agreed upon with the office manager prior to the beginning of services. The balance is to be paid prior to the report being released. For court appearances, a retainer willbe required before the trial. Court appearances are not covered in the price of the evaluation. If time constraints do not allow, balances will be due within 15 days of the statement date.

- If your account is **not paid as agreed**, any balance over 30 days will accrue a late fee of 1 1/2 % per month (18% APR) or a late fee of $25, whichever is greater. Balances over 60 days old will start in collection procedures and a 20% collection fee, or a collection fee of $75, whichever is greater, will be added to the balance. You agree to allow us to perform all activities that go along with normal collections, including but not limited to obtaining a credit report. You agree to pay all added charges associated with the collection activity including all legal and judgment fees. You also acknowledge that the collection activity will be reported to and adversely affect your credit rating.

Cancellation Fees

A full forty-eight hour (48) notice is required for canceling appointments. Cancellations without full 48 hour notice will be billed at the applicable full session rate. Sessions without any cancellation notice (or "no-shows") will be billed at the applicable full session rate. You agree to pay these cancellation fees.

Assignment of Benefits

I hereby authorize all insurance companies to make payment directly to Scott Hammel, Ph.D. I understand that this order does not relieve me of my obligation to pay the account, and that **any denied amounts, deductibles, co-payments, and percentages not covered by insurance are my responsibility**.

Release of Medical Information

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities). With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities. These uses and disclosures are described more fully in our **Notice of Privacy Practices**.

Receipt of Office Policies and Financial Agreement:

I have read and agree with the payment and office policies above I understand I am responsible for the entire balance and accept the terms as described.

Signature of Responsible Party	Date	Patient Name

Consent for Treatment:

I hereby consent for the completion of Psychological Services and/or Neuropsychological Assessment with Neurobehavioral Institute of Austin providers and associated staff.

Signature of Responsible Party	Date	Patient Name

COVID-19 Informed Consents

The threat of COVID-19 is ongoing throughout the United States. As a way to mitigate the risk of exposure to COVID-19, our practice has transitioned to providing many services via telehealth. However, in some situations, telehealth services may not be adequate, and in-person services may be more appropriate. Please read each section carefully before signing.

Telehealth

There are potential benefits and risks of telehealth (e.g. limits to patient confidentiality) that differ from in-person sessions. Confidentiality still applies for telehealth services, and nobody will record the session without the permission from the others person(s).

A 48-hour cancellation notice applies if you will be unable to make your session as schedule. Late cancellations and no-show fees will apply.

As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Patient checklist per session:

- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- Payment is due at the time of service. (You will be asked to keep a credit card on file for telehealth.)
-

By signing below, I agree to use video-conferencing for our virtual sessions.

Patient / Guardian Signature_____Date signed: _____

In-Person Services:

In some situations, telehealth services may not be adequate, and in-person services may be more appropriate.

We have considered CDC, State, and Local decision- making tools and taken recommended steps to mitigate the risk of exposure to COVID-19. As we slowly re-open and expanded in-person services, the following protocols must be followed by patients/clients and providers:

- Social distancing requirements must be met, meaning that you must maintain a six-foot distance from others while in offices, waiting rooms, and other areas.
- Patients/clients and providers will be required to wear face coverings or masks while in the office. If you do not have a face covering, one will be provided to you.
- Hand sanitizer will be provided at the office entrance and must be used upon entering the office.
- There will be no physical contact with others in the office.
- You will be asked to wait in your vehicle or outside the office until you receive a text, email, or phone call from office staff indicating that you can enter the office.
- You agree to reschedule your appointment and not to present for in-person services if you have a fever, shortness of breath, coughing, or any other symptoms associated with COVID-19 or if you have been exposed to another person who is showing signs of infection or has confirmed COVID-19 within the past two weeks.
- If you are bringing a child or other dependent in for services, you agree to ensure that both you and your child/dependent follow all of these protocols.

NBAustin remains committed to following state and federal guidelines and to adhering to prevailing professional healthcare standards to limit the transmission of COVID-19 in our offices. Despite our careful attention to sanitization, social distancing, and other protocols, there is still a chance that you will be exposed to COVID-19 in our office. If, at any point, you prefer to stop in-person services or to consider transitioning to remote services, please let me know.

As COVID-19 regulations continue to evolve, NBAustin may become legally required at some point to disclose that you and I have been in contact. If I am legally compelled to disclose information, I will only provide the minimum necessary information (e.g., your name and the dates of our contact) required by law.

By signing below, you acknowledge that you understand that there is still a potential risk of exposure and that you agree to follow the safety protocols outlined above in order to engage in in-person services.

_____ _____

Patient / Guardian signature Date

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Fee Schedule as of March 2021

The following fees are in effect as of March 2021:

Sessions

- Initial Diagnostic Interview (45-50 minutes): $200
- Brief Therapy Session (45 minutes): $150
- Standard Individual or Family Therapy (60 minutes): $180
- Feedback Session (45-50 minutes after completion of evaluation): $180
- Family Therapy Session: $180

Assessments and Evaluations

- Neuropsychological Evaluation (full battery)*: $2,400 - $3,400
- Gifted and Talented Assessment*: $1,300- $1,675
- Independent Educational Evaluations*: $5,000- $7,000

* *The total cost of your individual assessment or evaluation will be discussed at the initial diagnostic interview. Academic units are optional and may be offered for an additional fee. A written estimate will be presented to you prior to testing.*

Other Services

- Cogmed Program: $2000
- School Observation: $200/hr
- Telephone Calls (other than therapy or initial interviews), billed in 15 minute increments): $180/hr

Court Appearances, Depositions, Expert Witness

- $350 per hour with a minimum of four hours for depositions and a minimum of eight hours for court appearances. The minimum amount is collected in advance as a retainer and must be paid before the day of testimony. *(Forensic assessments require a $5000 retainer upon approval of case acceptance.)*

I have read and agree with the above fee schedule. I understand that fees listed do not include insurance coverage and that it is my responsibility to check my benefits with my insurance provider.
(A copy of this form is available upon request.)

_____ _____

Signature of Responsible Party Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

This Office is required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be available upon request to the Privacy Officer. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint. Our Privacy Officer is Dr. Hammel. You can contact the Privacy Officer at (512) 329-8222.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

YOUR RIGHTS

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an account of certain disclosures made by us.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE ARE REQUIRED TO MAKE *WITHOUT* YOUR PERMISSION

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT WE ARE *ALLOWED* TO MAKE WITHOUT YOUR PERMISSION

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. We may disclose information from your record to a medical examiner or coroner. We may disclose information to funeral directors to allow them to carry out their duties upon your death. We may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation.

We may assist in health oversight activities, such as investigations of possible health care fraud. We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

We may use or disclose information from your record for research under certain conditions.

Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

Your provider (or office staff) may contact you to provide appointment reminders as a courtesy. However, you are responsible for remembering your appointment.

We may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

Patient _____

_____ _____

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

Child History Form

Child's Name:_____Referral Source:_____Today's Date:_____
Person Completing Information:_____Relationship to Child: _____
Date of Birth:_____ Age: _____ Sex: ☐ F ☐ M Child's Identified Gender: _____
Identified Race/Ethnicity:_____Identified Religion:_____
Name of School: _____ Grade: _____
Special Education? ☐ Yes ☐ No Section 504? ☐ Yes ☐ No
If yes, what Classification/Diagnosis: _____
Mother's Name: _____ Father's Name:_____
Stepmother's Name: _____ Stepfather's Name: _____
If Applicable If Applicable

1. Please identify problem(s):

_____
_____
_____
_____

2. When did the problem(s) begin?

_____

3. List anything you did to improve the problem(s):

_____
_____

4. Is your child taking medication? ☐ Yes ☐ No

If Yes, what type? _____

Family Information

Please list the names of all family members with whom the child currently lives:

Name	Age	Relationship to Patient

Are the biological parents? ☐ Divorced ☐ Separated ☐ Widowed If so, what age was your child when this occurred? _____If the biological parents divorced, who has legal custody? _____
Does your child visit the noncustodial parent? ☐ Yes ☐ No If so, how often? _____
Does your child have a close relationship with an adult not living in the home? (i.e. grandparent, relative, family friend)
If so, with whom? _____
If your child has siblings, do they get along with each other? ☐ Yes ☐ No
Is mother employed outside the home? ☐ Yes ☐ No If so, where? _____
How many hours per week?_____Mother's occupation:_____
Mother's education level:_____Is father employed outside the home? ☐ Yes ☐ No
If so, where?_____How many hours per week? _____
Father's occupation: _____ Father's education level: _____
Does your child play outside in the neighborhood? ☐ Yes ☐ No
What activities does your child enjoy? _____
What kind of jobs or household responsibilities does your child have? _____
Does he/she do them willingly? ☐ Yes ☐ No Without prompting? ☐ Yes ☐ No
What kind of activities do you do together as a family? _____

Family History

Any history of moving? ☐ Yes ☐ No If Yes, at what age(s)? _____

Any problems with adjusting to moves? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Is there a family history of mental health issues (i.e. depression/anxiety/bipolar)? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Is there a family history of substance abuse or addiction? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Is there any family history of learning disorders or ADHD? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Is there any family history of suicide? ☐ Yes ☐ No

Is there any family history of Psychiatric Hospitalization? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Is there any family history of giftedness? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Child's Medical & Psychiatric History

Has your child ever had a private psychological or psychiatric evaluation? ☐ Yes ☐ No

If Yes, when and by whom?

_____

_____

Has your child you ever been tested by any of your previous schools? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Has your child attended any occupational therapy, physical therapy, or speech therapy? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Has your child ever attended psychotherapy? ☐ Yes ☐ No

If Yes, when and with whom?

_____

_____

Does your child have any history of psychiatric hospitalization? ☐ Yes ☐ No
If Yes, when and where?

_____

_____

Does your child have a history of suicide attempts? ☐ Yes ☐ No Self Harm? ☐ Yes ☐ No
If Yes, please describe:

_____

_____

Does your child have a history of any psychiatric diagnoses? ☐ Yes ☐ No
If Yes, please describe:

_____

_____

Does youe child have any history of trauma? ☐ Yes ☐ No
Emotional Abuse? ☐ Yes ☐ No Physical Abuse? ☐ Yes ☐ No
Sexual Abuse? ☐ Yes ☐ No Neglect? ☐ Yes ☐ No
If Yes, please describe:

_____

_____

Does your child have any history of neurological problems? ☐ Yes ☐ No
Seizures? ☐ Yes ☐ No Concussion? ☐ Yes ☐ No
Head Injury? ☐ Yes ☐ No Black Out/Loss of Consciousness? ☐ Yes ☐ No
If Yes, please describe:

_____

_____

Does your child have any history of surgeries or hospitalizations? ☐ Yes ☐ No
If Yes, please describe (include dates of events):

_____

_____

Does your child have any history of allergies? ☐ Yes ☐ No
If Yes, please describe:

_____

_____

Does your child have any history of sensitivities? ☐ Yes ☐ No
Foods? ☐ Yes ☐ No Fabrics? ☐ Yes ☐ No Noises? ☐ Yes ☐ No
Light? ☐ Yes ☐ No Scents? ☐ Yes ☐ No
If Yes, please describe:

_____

_____

Child's Academic History

Daycare? ☐ Yes ☐ No If so, at what ages? _____
Preschool? ☐ Yes ☐ No If so, at what ages? _____

Academic Year	School Name and City/State	Grades Earned
Kindergarten		
1st grade		
2nd grade		
3rd grade		
4th grade		
5th grade		
6th grade		
7th grade		
8th grade		
9th grade		
10th grade		
11th grade		
12th grade		

If receiving Special Education, what type? _____

Has your child skipped or repeated any grades? ☐ Yes ☐ No If Yes, which grades? _____

Best school subjects:_____Worst school subjects: _____

Has your child's school performance ever change dramatically? ☐ Yes ☐ No If Yes, please describe:

_____

_____

Does your child have a history of reading problems? ☐ Yes ☐ No If Yes, please describe:

_____

_____

Does your child have a history of math problems? ☐ Yes ☐ No If Yes, please describe:

_____

_____

Does your child have a history of writing problems? ☐ Yes ☐ No If Yes, please describe:

_____

_____

Child's Developmental History

Prenatal History

Were there any significant problems in the pregnancy? ☐ Yes ☐ No If yes, please specify:

_____

_____

Any use of alcohol? ☐ Yes ☐ No Amount? _____ How Often? _____

Any use of medications or drugs (including tobacco)? ☐ Yes ☐ No

Amount?_____How often?_____Length of pregnancy?_____Labor & delivery?_____

Were there any complications in labor/delivery? ☐ Yes ☐ No

If Yes, please specify:

_____

_____

Neonatal History

Birth weight: _____

Were there any significant problems for your child at birth or in the newborn phase? ☐ Yes ☐ No ☐ Unknown

If yes, please specify:

_____

Infancy (0 to 12 months)

Check if applicable, any significant problems, delays, and/or difficulties your child had in the 1st year:

- ☐ feeding
- ☐ colic
- ☐ breathing
- ☐ sleeping
- ☐ crawling
- ☐ sitting unassisted
- ☐ inability to be consoled
- ☐ allergies/ear infections
- ☐ bowel and or urinary habits
- ☐ intolerance of affection
- ☐ emotional responsiveness

Please describe items checked:

_____

_____

Age 1-3 Years

Check if applicable, any significant problems, delays, and/or difficulties your child had between the ages of 1 to 3 years:

- ☐ walking unassisted
- ☐ first words
- ☐ entertaining self
- ☐ stranger anxiety
- ☐ feeding self
- ☐ using sentences
- ☐ toilet training
- ☐ overactivity
- ☐ allergies
- ☐ ear infections
- ☐ severe temper tantrums
- ☐ self-destructive behavior

Please describe items checked:

_____

_____

Was English your child's first language? ☐ Yes ☐ No

If not, what was the first language and when did you learn to speak English?

_____

Age 3-11 Years

Check if applicable, any significant problems, delays, and/or difficulties your child has displayed since early childhood in these areas:

- ☐ impulsive
- ☐ very shy
- ☐ overactivity
- ☐ uncoordinated
- ☐ aggressive
- ☐ nervous/fearful
- ☐ academic failure
- ☐ sleeping difficulties
- ☐ short attention span
- ☐ separation difficulties
- ☐ obeying adults
- ☐ self-destructive habits
- ☐ bowel/urinary habits
- ☐ severe temper tantrums
- ☐ completing tasks, chores
- ☐ cooperating in group activities
- ☐ prolonged sadness/irritability

Please describe checked items:

_____

_____

Age 12-18 Years

Check if applicable, any significant problems, delays, and/or difficulties your teenager has displayed since early childhood on in these areas:

- ☐ prolonged sadness or irritability
- ☐ "gang" membership
- ☐ aggressive
- ☐ pregnancy
- ☐ temper outbursts
- ☐ questioning sexual orientation
- ☐ skipping school
- ☐ academic failure
- ☐ impulsive
- ☐ drug or alcohol use
- ☐ sleep difficulty
- ☐ gender dysphoria
- ☐ legal trouble
- ☐ social isolation
- ☐ sexually active
- ☐ running away
- ☐ eating/appetite
- ☐ domestic violence

Please describe items checked:

_____

_____

Child's Social & Creative History

Does your child have friends? ☐ Yes ☐ No
If No, please describe: _____
Does your child make friends easily? ☐ Yes ☐ No
If No, please describe: _____
In general, do you approve of your child's friends? ☐ Yes ☐ No
If No, please describe: _____
Does your child have age/developmentally appropriate hobbies or interests? ☐ Yes ☐ No
Please describe:

_____

_____

Does your child participate in social or extracurricular activities? ☐ Yes ☐ No
Please describe:

_____

_____

Does your child have any creative abilities (i.e.- music, dance, drawing, etc.)? ☐ Yes ☐ No
Please describe:

_____

_____

Please describe other strengths your child has:

_____

_____

_____

_____

_____