SIOUX FALLS PSYCHOLOGICAL SERVICES
CHILD & ADOLESCENT THERAPY CLINIC
2109 S. NORTON AVENUE
SIOUX FALLS, SD 57105
P: 605.334.2696 F: 605.339.9944
offermehope.com

Registration Information - Minor

Registration Information

(Please Print)

Date _____

Child's Information _____
First *MI* *Last*

Primary Residence_____ City_____ State_____ Zip_____

Soc Sec # _____-_____-_____ Birth Date _____ Age_____ Gender: M ___ F___

Grade in School _____ School of Attendance _____

Parents: Married_____ Divorced_____ Separated_____ Deceased: Mother_____ Father _____

Primary Custodial Parent: Mother _____ Father _____ Joint _____

Most recent legal paperwork (court order) is required before meeting with child.

Parent or Legal Guardian of the Child

Financially Responsible for the Account: YES or NO

Name _____

Relationship to the Child _____

Address_____ City _____ State_____ Zip_____

Soc Sec # _____-_____-_____ Birth Date _____

Primary Phone: _____ (Home, Work, Cell) Is it OK to leave you messages? YES NO

Secondary Phone: _____ (Home, Work, Cell) Is it OK to leave you messages? YES NO

E-mail Address (only if we can contact you by e-mail): _____

Workplace _____ Work Phone _____

Permission for us to email you Protected Health Information? YES or NO

Is the child covered under the guardian's health insurance policy? Yes or No

If No, please provide the information for the *holder of the insurance policy*:

Name _____

Relationship to the Child _____

Financially Responsible for the Account? YES or NO

Address_____ City _____ State_____ Zip_____

Soc Sec # _____-_____-_____ Birth Date _____

Primary Phone: _____ (Home, Work, Cell)

E-mail Address (only if we can contact you by e-mail): _____

Permission for us to email you Protected Health Information? YES or NO

Referral Information

How did you hear of our services? *(Please check appropriate box)*

___Physician/MD	___Attorney	___Help Line
___Pastor/Church	___Former Client	___Newspaper
___Other Therapist	___Friend	___Radio
___Insurance Company/EAP	___Family	___TV
___Other Agency	___Yellow Pages	___Other *(Please specify*)

Name of person who referred you? *(Optional)* _____

Medical Information

Family Physician Name _____

Clinic Address _____

Phone _____ Most Recent Exam _____

Medical Problems _____

_____

_____

Please explain why you feel you need therapy _____

_____

_____

Previous psychological or psychiatric treatment _____

_____

_____

_____

Please list present medications _____

_____

_____

Per the SD Visitation Guidelines, primary custodial parents have a duty to provide access to records and information pertaining to a minor child, including, but not limited to, medical, dental, orthodontia and similar health care, and school records must be made equally available to both parents. Counseling, psychiatric, psychotherapy, and other records subject to confidentiality or privilege must only be released in accordance with state and federal law; but, if available to one parent, must be available to both. Parents must make reasonable efforts to ensure that the name and address of the other parent is listed on all such records (UJS 302 (1.2)).

Please initial _____

THERAPY AGREEMENT

Confidentiality

The therapy relationship is a professional and confidential relationship. What is revealed in this setting is confidential and is protected by professional and ethical standards. All material is confidential and cannot be released without your written consent. The laws of the state of South Dakota make certain exceptions to this confidentiality privilege. If there is reasonable suspicion that you may harm yourself or others, then your therapist is required by law to inform others in order to protect them or yourself. If there is reasonable suspicion of child abuse, a verbal report will be made to Child Protective Services.

Payments

We are committed to providing you with the best possible care. Co-pay's/co-insurance are due at the time of service unless another agreement has been reached between you and your therapist. We accept cash, checks, MasterCard, Visa and Discover. Any amount not paid by a third party is expected to be paid by you within 30 days unless other arrangements have been made. If after 60 days no payment is received, your therapist will review and advise on additional action. Between 90 and 120 days with no payment, your account will risk being sent to collections including any/all demographic information you provide.

Cancellations

If you are unable to attend a scheduled session, it is your responsibility to let this office know of your intent to cancel your appointment. Appointments must be cancelled at least 24 hours prior to the session in order to avoid being charged. You will be charged $50 if you do not cancel and do not attend the session. Exceptions include weather, family emergencies and unexpected illness.

Emergencies

If you are in need of emergency psychological help at a time when your therapist is not available, it is your responsibility to call 911 or some other emergency service (such as 339-HELP, a 24-hour help line). If you are in a crisis during regular office hours and want to talk to your therapist, the therapist if available will talk with you, or will return your call as soon as possible. There is no charge for brief calls. However, calls requiring more than five minutes of time may be charged according to the closest quarter rate at the discretion of your therapist.

Service Animals

As a privately owned businesses that serves the public, we do not allow animals in the office, with the exception of service animals. Under the Americans with Disabilities Act, a service animal is defined as a dog that has been individually trained to do work or perform tasks for an individual with a disability.

HIPAA Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices dated April 14, 2003.

If you have questions about this agreement, please do not hesitate to ask us. We are here to help you.

My signature below indicates that I have read the above policies, and that I intend to abide by them. I have been given a copy of these policies.

Signature(s): _____ **Date:** _____

(Client, Parent, or Guardian Signature)

Print name: _____

SFPS FINANCIAL AGREEMENT

STANDARD FEES:
Our standard fees are $248 for the initial session and $155 per standard 45 minute session after the initial session. These rates may be adjusted through contract with some insurance providers or other third party contract.

INSURANCE REIMBURSEMENT:
If you have medical insurance providing coverage for mental health counseling, we can help you receive your maximum allowable benefits. We accept assignment of benefits (direct reimbursement from insurance companies) when authorized by you at the bottom of this form.

Processing your insurance claims and tracking reimbursement is a benefit we provide for you. To do so we need your up-to-date insurance information. To avoid a delay in reimbursement, we ask you to inform us if your insurance plan changes or you are issued a new insurance card. As a service to you, we will check co-pays/co-insurance and deductibles with your insurance company at the time we receive your insurance information. Remember this information is no guarantee of benefits. You are ultimately responsible for any cost not covered by your insurance plan.

INSURANCE INFORMATION:
(Fill out or provide a copy of insurance card(s) and required information.)

Primary

Insurance Company _____ Phone Number _____
ID Number _____ Group Number _____
Policy Holder_____ Policy Holder DOB _____
Client's Relationship to Policy Holder _____

Secondary

Insurance Company _____ Phone Number _____
ID Number _____ Group Number _____
Policy Holder_____ Policy Holder DOB _____
Client's Relationship to Policy Holder _____

_____ **I understand that I am responsible for all charges regardless of insurance coverage.**

ASSIGNMENT OF INSURANCE BENEFITS:
The undersigned hereby authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____
Authorized Signature of Subscriber **Date**

Print name: _____

Notice of Privacy Practices

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI (Protected Health Information) for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission about and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your therapist has made about conversations with you during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

Uses and Disclosures with Neither Consent or Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If your therapist has reasonable cause to suspect that a child under the age of eighteen has been abused or neglected, your therapist is required by law to report that information to the state's attorney, the Department of Social Services, or law enforcement personnel.

Health Oversight: If the South Dakota Board of Examiners of Psychologists or other oversight committee is conducting an investigation, then we are required to disclose your mental health records upon receipt of a subpoena from the Board or committee.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we may not release information without your written authorization or court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.

Serious Threat to Health or Safety: When your therapist judges that a disclosure of confidential information is necessary to protect against a clear and substantial risk of imminent harm being inflicted by you on yourself or another person, your therapist may disclose such information to those persons who would address such a problem (for example, the police or the potential victim).

Worker's Compensation: If you file a worker's compensation claim, we are required by law to provide your mental health information relevant to that particular injury, upon demand, to you, your employer, the insurer, and the Department of Labor.

Questions and Complaints

If you have questions about this notice, disagree with a decision we have made about access to your records, or have other concerns about your privacy rights, you may contact the Clinical Director at (605) 334-2696. If you believe that your privacy rights have been violated and wish to file a complaint with the office, you may send your written complaint to Sioux Falls Psychological Services, Attention Clinical Director, 2109 S. Norton Avenue, Sioux Falls, SD 57105. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The Clinical Director can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will post the latest revision of this notice in the office and provide a copy if requested.

SIOUX FALLS PSYCHOLOGICAL SERVICES CLIENT

Your therapist is well-educated and able to help you deal with a variety of personal and relational problems and concerns. Your therapist may have one of the following licenses (Licensed Psychologist, Licensed Marriage & Family Therapist, Licensed Professional Counselor or Licensed Clinical Social Worker), or they may be in the process of acquiring licensure in their particular area of training and expertise. Feel free to ask them about their education and training. You may wish to know something about their areas of expertise. Our therapists practice within the scope of their training and expertise. If at any time your therapist believes you need a different type of therapy they will talk with you about that and either seek appropriate supervision or refer you to someone who is more able to meet your needs.

At times insurance companies require even licensed therapists to be under the supervision of a licensed psychologist. That means your therapist may discuss your case with me from time to time. Confidentiality is maintained in supervision. If you have questions or concerns about your therapy you are welcome to contact me.

Douglas L. Anderson, Psy.D.
Clinical Supervisor, SFPS
Licensed Psychologist, SD #353
Licensed Marriage & Family Therapist #1141

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Signature(s): _____ **Date:** _____

(Client, Parent, or Guardian Signature)

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Child Registration Form for Parents

PARENT QUESTIONNAIRE: Child Health

Child's Name (Last, First):	Date of Birth:	Age:	Sex: M F	Today's Date:
Address: City: State: Zip:				Phone:
Child's Race (circle): White Black Hispanic American Indian Asian Other, specify:				
Child's Doctor:				Doctor's Phone:
Name of person completing this form:	Relationship to child:			Phone:

CHIEF CONCERN:

Who suggested this child be seen for attention, emotional, or behavior problems?

What **concerns** do you have about your child?
a.

b.

c.

How long have you been concerned about this child's behavior?	Please circle ONE: overall, the above concerns are **mild, moderate, or severe**?	Please circle ONE: My concerns are **improving, staying the same, or getting worse**?

Please Describe this child's **strongest areas at home**:
a.

b.

c.

Please describe this child's **weakest areas at home**:
a.

b.

c.

HISTORY: Birth

How much did this child weigh at birth? ___pounds ___ounces
Biological **Father's age** at birth of this child: _____ Number of **pregnancies prior** to this child:_____
Biological **Mother's age** at birth of this child:_____ Number of **miscarriages prior** to this child:_____

Y	**N**	Were there any **problems during the pregnancy**? Specify:
Y	**N**	Were there any **problems during labor / delivery** or **following the birth**? Specify:
Y	**N**	Was the child born by **Cesarean (C-section)**? If yes, circle appropriate response: Planned Emergency
Y	**N**	Was this child born **2 or more weeks before** the 'due date'? If yes, how many weeks early was the child: _____ weeks
Y	**N**	Were any substances or medications used by the mother during the pregnancy? ___Methamphetamine (crystal/ice) ___Beer/wine ___Alcohol ___ Prescription Medication ___Cocaine ___Tobacco ___Marijuana Other:_____
Y	**N**	Were any substances or medications used by the father around the time this child was conceived? ___Methamphetamine ___Beer/wine ___Alcohol ___ Prescription Medication ___Cocaine ___Tobacco ___Marijuana Other:_____

***HISTORY: Developmental Concerns**

Y	**N**	Did this child sit up by 8 months?
Y	**N**	Did this child crawl by 10 months?
Y	**N**	Did this child walk by 15 months?
Y	**N**	Did this child speak two word sentences by 2 years?
Y	**N**	Could strangers understand this child by 3 years?
Y	**N**	Did this child stay dry during the day by 3 ½ years?
Y	**N**	Did this child read simple words by 6 years?

(OFFICE USE ONLY) **Y**= [concern ≥ 6 months: Y N Birth: Y N] * **N**= [Development: Y N]

HISTORY: Behavioral

Y	**N**	Did this child **cry frequently** as an infant?
Y	**N**	Was this child **difficult to calm down** as an infant?
Y	**N**	Did this child **have trouble sleeping** as an infant (e.g., was this child fidgety or overly sleepy)?
Y	**N**	Was this child a **picky or irregular eater** as an infant?
Y	**N**	Did this child have **many temper tantrums** as a toddler?
Y	**N**	Did you have **trouble keeping a babysitter** because of this child's behavior?
Y	**N**	Does this child have **urine accidents**?
Y	**N**	Does this child have **stool / bowel accidents**?
Y	**N**	Does this child often have **nightmares**?
Y	**N**	Has this child ever had **tics or nervous twitches**, such as repeated eye blinking, head jerking, or throat clearing?
Y	**N**	Does this child have any **problems falling asleep**? Specify:
Y	**N**	Does this child have any **problems staying asleep** through the night? Specify:
Y	**N**	Does this child have any **problems getting up** in the morning? Specify:
Y	**N**	Does this child have **frequent stomachaches and headaches**? Specify:
Y	**N**	Does this child have **problems with his/her weight**? Specify:

HISTORY: Health

Y	**N**	Has this child had any **major health problems**? Specify:
Y	**N**	Has this child had frequent **ear infections**?
Y	**N**	Has this child had any **vision / eye or hearing** problems? Specify:
Y	**N**	Has this child ever been **hospitalized** or had **surgery**? Specify:
Y	**N**	Has this child lost **consciousness** or has a **serious head injury**? Specify:
Y	**N**	Has this child had **meningitis** or **encephalitis**? Specify:
Y	**N**	Has this child had **seizures**?
Y	**N**	Has this child had any **difficulties with growth**? Specify:
Y	**N**	Does this child have any **birth defects** or **birthmarks**? Specify:

HISTORY: Family Medical Problems

Is there anyone in this child's family with the following:				If yes, how is this person related to this child?
Y	**N**	**Don't Know**	Neurological Problems	
Y	**N**	**Don't Know**	Learning or reading difficulty	
Y	**N**	**Don't Know**	Depression	
Y	**N**	**Don't Know**	Bipolar Disorder / Manic Depression	
Y	**N**	**Don't Know**	Schizophrenia	
Y	**N**	**Don't Know**	History of physical or sexual abuse	
Y	**N**	**Don't Know**	Alcohol or drug problems	
Y	**N**	**Don't Know**	ADHD / ADD (attention problems)	
Y	**N**	**Don't Know**	Tics or Tourette's disorder	
Y	**N**	**Don't Know**	Trouble with the law	
Y	**N**	**Don't Know**	Medications for nerves or emotional problems	
Y	**N**	**Don't Know**	Thyroid problems	
Y	**N**	**Don't Know**	Exposure to toxic chemicals	
Y	**N**	**Don't Know**	Cardiac problems or sudden death	

(OFFICE USE ONLY) **Behavior:** Y N **Health:** Y N **Family Medical History:** Y N **Baseline: Tics:** Y N **Sleep Problems:** Y N **Stomachache/Headache:** Y N **Weight:** Y N

HISTORY: Child's Past/Current Treatment

Y	**N**	Has this child **ever been diagnosed with ADHD or ADD in the past**? If yes: Year_____ Month _____
Y	**N**	Has this child **ever taken medication for ADHD or ADD in the past**? If yes, do you know the **name**, **dose**, and **time(s) of day** the medication was given?

Name	Dose	Time(s) of Day
Name	Dose	Time(s) of Day

Were you **satisfied** with the medication's effect on the child's symptoms? (circle) Yes No

Y	**N**	Has this child **ever received psychological counseling** for any problems? Specify:
Y	**N**	Has this child ever been on any **long-term medications**? Specify:
Y	**N**	Does this child have any **allergies**? Specify:
Y	**N**	Is this child currently taking **medications**?
Y	**N**	Is this child currently taking any **vitamins or herbal supplements**?

What medication(s), including vitamins or herbal supplements, is this child currently taking?

Name	Dose	Time(s) of day
1.		
2.		
3.		

Are there **any professionals** (such as doctors, psychiatrists, social workers, occupational therapists, speech therapists, physical therapists, or alternative treatments) **currently involved in this child's care?** Please **list them and their role** in your child's care:

HISTORY: Social

Y	**N**	Have there been any **major changes or stresses** in this child's life (e.g., marital problems, a move, change of school, birth of a brother or sister, a death of a pet)? If yes, please specify and include how old the child was at the time: Is this stress still occurring? (circle) Yes No
Y	**N**	Has there been a **serious illness or death** in a parent or close family member of this child? If yes, please specify and include how old the child was at the time:
Y	**N**	Has this child **experienced or seen any traumatic events** (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your therapist? If yes, please specify and include how old the child was at the time: Is this trauma still occurring? (circle) Yes No
Y	**N**	Are there any **major changes or stresses** expected in the future? If yes, please specify:

(OFFICE USE ONLY) **Adhd Dx:** Y N **Adhd Tx:** Y N **Medications:** Y N **Professionals:** Y N **Social:** Y N

HISTORY: Child's Living Arrangement

1. **This child is currently living with** (please check one)
- ☐ Biological mother **and** biological father
- ☐ Biological mother
- ☐ Biological father
- ☐ Relative (specify relationship):
- ☐ Adoptive patent(s), relative
  Does the child know that he/she is adopted? (circle) Y N
- ☐ Adoptive patent(s), non-relative
  Does the child know that he/she is adopted? (circle) Y N
- ☐ Foster Parent(s)
  How long has this child been in foster care? Year_____ Month_____
  How long has this child been living in your household? Year_____ Month_____
- ☐ Other (specify):

2. The **biological** parents of this child are currently
- ☐ Married to each other Year_____ Month_____
- ☐ Divorced from each other Year_____ Month_____
- ☐ Separated from each other Year_____ Month_____
- ☐ Never married to each other
- ☐ Other (please specify):
- ☐ Non applicable (please specify):
- ☐ Don't know

3. How would you describe the **current relationship** between this child's **biological parents**:
- ☐ Friendly/Amicable
- ☐ Unfriendly/Conflict ridden
- ☐ No relationship
- ☐ Not Applicable (please specify):
- ☐ Don't Know

Y	**N**	4. Are there any **immediate family members** who do not live with this child (biological mother, biological father, or siblings? If yes, please specify relationship to child:
Y	**N**	5. Is there anything unusual about this child's **living arrangement** that you would like to discuss with the child's therapist? If yes, please specify:
Y	**N**	6. Are the parent(s)/guardian(s) of this child **working outside of the home**?
Y	**N**	7. Do you have family or social **support locally**?

8. Please list all people who are currently living in this child's household.

Name	Relationship to Child	Age	Name	Relationship to Child	Age

HISTORY: Military Family

Y	**N**	1. Are you or another parent/guardian of your child currently in the Military?
Y	**N**	2. What Branch: Navy Marine Air Force Army Other(specify):
Y	**N**	3. Are any of this child's parent(s)/guardian(s) Active Duty Military? If yes, who (circle): Mother Father Both Other:
Y	**N**	4. Are they deployed or deployable?
		5. When did you PCS/Move to this Location? Date:
		6. When are you due to PCS/Move? Date:
Y	**N**	7. Do you live in military housing?
Y	**N**	8. Is this child or other members of this family in the Exceptional Family Member Program?

(OFFICE USE ONLY) Living Arrangement: Y N

PARENT QUESTIONNAIRE: Child Behavior

Child's Name:				
Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior NOT on medication.*	Never Rarely 0	Occa-sionally 1	Often 2	Very Often 3
1. **Fails to give close attention** to detail or **makes careless mistakes** (e.g., homework).				
2. Has **difficulty attending** to what needs to be done.				
3. **Does not seem to listen** when spoken to directly.				
4. **Does not follow through** when given directions.				
5. Has **difficulties organizing** tasks and activities.				
6. **Avoids, dislikes,** or does not want to start new tasks.				
7. **Loses things** necessary for tasks or activities (school assignments, pencils, books).				
8. Is **easily distracted** by noises or other things.				
9. Is **forgetful** in daily activities.				
10. **Fidgets** with hands or feet or squirms in seat.				
11. **Leaves seat** when he/she is supposed to stay in seat.				
12. **Runs about or climbs** too much when he/she is supposed to stay seated.				
13. Has **difficulty playing** or starting quiet games.				
14. Is "**on the go**" or acts as if "driven by a motor".				
15. **Talks too much**.				
16. **Blurts out answers** before questions have been completed.				
17. Has **difficulty waiting his/her turn**.				
18. **Interrupts** or bothers others when they are talking or playing games.				
19. **Argues** with adults.				
20. **Loses temper**.				
21. Actively **disobeys or refuses** to follow adult's request or rules.				
22. **Bothers people** on purpose.				
23. **Blames others** for his or her mistakes or misbehaviors.				
24. Is **touchy or easily annoyed** by others.				
25. Is **angry or bitter**.				
26. Is **hateful** and wants to get even.				
27. **Bullies**, threatens, or scares others.				
28. **Starts physical fights**.				
29. **Lies** to get out of trouble or to avoid jobs (i.e. "cons" others).				
30. **Skips school** without permission.				
31. Is **physically unkind** to people.				
32. Has **stolen things** that have value.				
33. **Destroys others' property** on purpose.				

(OFFICE USE ONLY) **1—9 :** ____ / 9 Inattentive: ☐ ≥ 6 / 9 DuPaul: **10—18:** ____ / 9 Hyperactive ☐ ≥ 6 / 9 DuPaul: **19—26:** ____ / 8 Oppositional Defiant Disorder ☐ ≥ 4 / 8

Child's Name:				
Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior NOT on medication.*	Never Rarely 0	Occa-sionally 1	Often 2	Very Often 3
34. Is physically **mean to animals**.				
35. Has **set fires** on purpose to cause damage.				
36. Has **broken into** someone else's home, business, or car.				
37. Has **stayed out all night** without permission or **run away** from home overnight.				
38. Has **used a weapon** that can cause serious physical harm (e.g. bat, broken bottle, brick).				
39. Is **fearful, anxious, or worried**.				
40. Is **afraid to try new things** for fear of making mistakes.				
41. Feels **useless or inferior**.				
42. **Blames self** for problems, feels at fault.				
43. Feels **lonely, unwanted, or unloved**; complains that "no one loves me".				
44. Is **sad or unhappy**.				
45. Feels **different and easily embarrassed**.				
46. Is **overly concerned about health/body**.				
47. Has problems getting along with **you**.				
48. Has problems getting along with **others his/her own age**.				
49. Has problems getting along with **his/her own siblings**.				
50. Has problems in **group activities** such as games or team play.				
51. **Decreased interest or pleasure in all**, or almost all, activities of the day.				
52. Has **said things like "I wish I were dead"** or has tried to hurt self.				
53. **Recurrent excessive distress** when separation from home or caretakers.				
54. Has **distinct periods of unusually irritable or unusually cheerful mood** (different from normal).				
55. Has **prolonged temper tantrums** (greater than 20-30 minutes).				
56. **Hears voices** others do not hear.				
57. Has **compulsions** (e.g. child seems driven to wash hands, count, erase until holes appear.)				
58. Has **obsessions** (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).				
59. Has **recurrent recollections or dreams** of a traumatic event.				
60. Seems to **avoid or have phobias** of specific people, animals, things, or situations.				
61. Seems **unaware of others' existence**, is **uninterested in interacting with others**.				
62. Has **odd, eccentric or unusual preoccupations** (e.g. clothing items, toys, neatness).				
63. Appears **uninterested in activities** children his or her age usually like or participate in.				
64. Has experimented with or abused **drugs or alcohol**.				

(OFFICE USE ONLY) **27—38 :** ____ / 12 Conduct Disorder: ☐ ≥ 3 / 12 **39—46:** ____ / 8 Anxiety/Depression ☐ ≥ 3 / 8 **47—50:** ____ / 4 Social Functioning ☐ ≥ 1 / 4 **51—64:** ____ / 14 MH Concerns

PARENT QUESTIONNAIRE: School History

Child's Name:	Length of time at present school:	Current Grade:
Name of School:	School District:	
Teacher (main):	Principal:	School Phone:

1. Please describe this child's **strongest** areas in his/her **schoolwork**:	2. Please describe this child's **weakest** areas in his/her **schoolwork**:
a. b. c.	a. b. c.

HISTORY: School Intervention

Y	**N**	1. Has this child been in an **Early Intervention program or Special Day Care/Preschool**?
Y	**N**	2. Has this child had **speech, occupational or physical therapy**?
Y	**N**	3. Has this child ever **attended summer school**? If Yes, specify subject(s)/grade(s):
Y	**N**	4. Has the school ever **discussed this child attending summer school** with you? Specify:
Y	**N**	5. Has this child ever **repeated a grade**? If Yes, specify subject(s)/ grade(s):
Y	**N**	6. Has the school ever **discussed this child repeating a grade** with you? Specify:
Y	**N**	7. Is there a possibility that **current grade or subjects will need repeating**? Specify:
Y	**N**	8. Has this child ever received any **special education services** (like a 504 Plan or IEP)? Specify:
Y	**N**	9. Is this child **currently receiving any special education services** (like a 504 Plan or IEP)? Specify:
Y	**N**	10. Have any **disciplinary actions** been taken (detentions, suspension, or expulsion)? Specify:
Y	**N**	11. Does this child need any **special medical assistance**? Specify:

HISTORY: School Problems For each of the following grades this child has completed, were any **problems reported**? If Yes, please **describe** the teacher or parent concerns in the space provided.

			Academics	**Behavior**
Y	**N**	1. Preschool		
Y	**N**	2. Kindergarten and First Grade		
Y	**N**	3. Second and Third Grade		
Y	**N**	4. Fourth and Fifth Grade		
Y	**N**	5. Sixth through Eighth Grade		
Y	**N**	6. High School		

CURRENT: School Performance Please circle the appropriate number.

	Above Average		**Average**		**Problematic**		**Above Average**		**Average**		**Problematic**
1. Classroom Assignment Completion	1	2	3	4	5	8. Science	1	2	3	4	5
2. Homework Completion	1	2	3	4	5	9. Written Expression	1	2	3	4	5
3. Getting Homework to and from school	1	2	3	4	5	10. Handwriting	1	2	3	4	5
4. Organizational Skills	1	2	3	4	5	11. Social Studies/History	1	2	3	4	5
5. Reading	1	2	3	4	5	12. Art	1	2	3	4	5
6. Spelling	1	2	3	4	5	13. Other:	1	2	3	4	5
7. Mathematics	1	2	3	4	5						

(OFFICE USE ONLY)	School Intervention: Y N	Academic Social Problems: Y N	Behavior School Problems: Y N	School Performance: Y N

PARENT QUESTIONNAIRE: Child Summary

Child's Name:

HISTORY: Summary

1. Please **summarize** your **child's <u>OVERALL</u> functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare your child's functioning in 3 settings—home, school, and with peers, to "average children" his/her age that you are familiar with from your experience. **Please circle only one number**.

1	**Excellent** functioning / No impairment in settings
2	**Good** functioning / Rarely shows impairment in settings
3	**Mild** difficulty in functioning / Sometimes shows impairment in settings
4	**Moderate** difficulty in functioning / Usually shows impairment in settings
5	**Severe** difficulties in functioning / Most of the time shows impairment in settings
6	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
7	**Needs 24-hour <u>professional</u> care and supervision** due to severe behavior or gross impairment(s)

Do you have any other comments that you think would be helpful?

(OFFICE USE ONLY)	Impairment: ☐ ≥ 4 Y N

