New Patient Packet – Child/Adolescent

Brief instructions for completing the forms are included below. You can call our office at 719-226-0659 if you have any questions.

Forms included in this New Patient Packet:

- Registration
  Be sure to complete the Patient Information section with the child's information.
- HIPAA Notice of Privacy Practices
  This is for your information. You do not need to bring this to the office with your completed forms.
- Health History
  Please complete this form whether or not the child is going to be evaluated for medications.
- Child/Adolescent Biographical Information Form

What is a Release of Information?

A Release of Information is a form that asks for your signature permitting the exchange of information between your clinician and another person. This could be another doctor, another therapist, a school nurse or psychologist, etc. A word of caution: A Release of Information should be specific about "the who and what". You do not want to allow total access to all of your information to just anyone.

How do I get the form?

If you need a Release of Information, please return to the New Patient page on our website and look for the link to the form. You may download and print as many as you need. If you need help filling out the form, call our office or see Leslie when you are there for your appointment.

What to bring for your first appointment with us:

- New Patient Packet (be sure all forms are complete and include all necessary signatures)
- A photo ID and insurance card
- Any psychotropic medications the child is currently taking, in the original pharmacy containers with dosage and instructions clearly printed on the label.
- Copies of reports, lab results (within 4 months), discharge papers, or any other printed information you wish to share with your clinician.

Thank you.

www.ColoradoSpringsTherapy.com

Behavioral Health Center of Excellence, LLC

(PLEASE PRINT)

Patient Information

Name_____ Birth Date _____ Sex ❑ M ❑ F
Last Name First Name Initial

Mailing Address _____City _____, CO Zip _____

Patient SSN: _____ Patient under 18? ❑ Yes ❑ No If Yes, Parent/Guardian Name(s): _____

I wish to be contacted in the following manner (check all that apply):

Home Phone: _____ ❑ Leave message with detailed info ❑ Leave message with call-back number only

Alt. Phone: _____ ❑ Leave message with detailed info ❑ Leave message with call-back number only

Work Phone: _____ ❑ Leave message with detailed info ❑ Leave message with call-back number only

Patient Employed by _____ Occupation _____ Marital Status _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Name of Sponsor or Primary Insured _____ Insurance ID_____
Last Name First Name Initial

Relation to Patient _____ Birth Date _____ SSN _____

Address (if different from Patient's) _____ Phone _____

City _____ State _____ Zip _____ Alt. Phone _____ ❑ Cell ❑ Pager

Person Responsible Employed by _____ Business Phone _____ Ext. _____

Insurance Company _____ MH Services or Provider Phone: _____ Subscriber # _____

Group # _____ Claims Address: _____

Additional Insurance

Is Patient covered by additional / supplemental insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birth Date _____

Address (if different from Patient's) _____ Phone _____

City _____ State _____ Zip _____ Alt. Phone _____ ❑ Cell ❑ Pager

Person Responsible Employed by _____ Business Phone _____ Ext._____

Insurance Company _____ MH Services or Provider Phone: _____ Subscriber # _____

Group # _____ Claims Address: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Behavioral Health Center of Excellence, LLC and/or _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the above individual/entity to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Patient or Responsible Party Signature Relationship to Patient Date

Registration Form

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. I am always legally required to follow the privacy practices described in this Notice. Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. Treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. Health Care Operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. Payment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to Colorado Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the Colorado Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the Colorado Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

17. **I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you.**
18. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.
If you ask for copies of your PHI, I will charge you not more than $1.00 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Request a Paper Copy of this Notice.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you**.**

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

2212 West Colorado Avenue, Colorado Springs, CO 80904, (719) 226-0659 Privacy Officer: Leslie Jackson

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

Health History

Patient Name _____ Today's Date _____

Age _____ Birth Date_____ Date of last physical examination _____

Primary Care Physician: _____ Phone/Address: _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN Only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram?_____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) symptoms you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name _____ Phone_____

Allergies/Sensitivities

_____

_____

_____

_____

_____

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year Hospital Reason for Hospitalization and Outcome

_____
_____
_____
_____
_____
_____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries Date Outcome

_____
_____
_____
_____
_____

Pregnancies

Year of Birth | Sex of Birth | Complications, if any

_____
_____
_____
_____
_____
_____

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other_____

Occupation _____

Vitamins/Supplements

I'm currently taking

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my clinician if I, or my minor child, ever have a change in health.

_____ _____
Signature or Patient, Parent, Guardian or Personal Representative | Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

_____ _____
Reviewed By | Date

Child/Adolescent Biographical Information Form

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. If certain questions do not apply to the child, leave them blank.

Information supplied by: _____ Relationship: _____

Personal History

1) Child's Name: _____ 2) Age: _____ 3) Gender: _____ 4) Year in school: _____

5) Ethnic background: _____ 6) Cultural Influences on child's life: _____

Counseling History

7) Has the child been involved in previous counseling? Yes _____ No _____ If yes, please briefly describe:
_____
_____

8) Why is the child coming to counseling? _____
_____
_____

9) How long has this problem persisted (from # 8)? _____
_____

10) Under what conditions do the problems usually get worse? _____
_____

11) Under what conditions are the problems usually improved? _____
_____

Trauma, Sleep and Appetite

12) List any physical concerns such as head trauma, seizures, etc. that the child has experienced: _____
_____

13) On average how many hours of sleep does the child get daily? _____

14) Does the child have trouble falling asleep at night? Yes ____ No ____ If yes, how long has this been a problem? _____

15) Describe the child's appetite during the past month:

Poor appetite _____ Average appetite _____ Large appetite _____

Family History

16) Mother's age: _____ If deceased, how old was the child when she died? _____

17) Father's age: _____ If deceased, how old was the child when he died? _____

18) If parents are separated or divorced, how old was the child then? _____

19) Number of brother(s): _____ Their ages _____ _____ _____ _____ _____ _____

20) Number of sister(s): _____ Their ages _____ _____ _____ _____ _____ _____

21) This child is number _____ in a family of _____ children.

22) Is the child adopted or raised with parents other than biological parents? Yes _____ No _____

23) Briefly describe the child's relationship with brothers and/or sisters: _____
_____
_____

Patient Name: _____

24) What is the family 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 stepfather _____ With father and stepmother
_____ Child adopted _____ Other, describe _____

25) Is there a history or recent occurrence(s) of child abuse to this child? Yes _____ No _____

If yes, which type(s) of abuse: Verbal _____ Physical _____ Sexual _____
Comments: _____
_____

26) Parents' occupations: Mother _____ Father _____

27) Briefly describe the style of parenting in the household: _____
_____
_____

Developmental History

28) Briefly describe any problems in the child's mother's pregnancy and/or childbirth: _____
_____
_____

29) Please fill in when the following developmental milestones took place:

Behavior	Age began	Comments
Walking	_____	_____
Talking	_____	_____
Toilet Trained	_____	_____

30) List any meds/drugs used by mother or father at time of conception, or by mother during pregnancy or birth:
_____
_____

31) Please rate your opinion of the child's development (compared to others the same age) in the following areas:

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

For each type of development that you rated as *below average*, please describe current areas of concern. Be specific.
_____
_____
_____
_____
_____

32) List the child's three greatest strengths:

1) _____ 2) _____ 3) _____

33) List the child's three greatest weaknesses or needed areas of improvement:

1) _____ 2) _____ 3) _____

Patient Name: _____

34) List the child's main difficulties at school:

1) _____ 2) _____ 3) _____

35) List the child's main difficulties at home:

1) _____ 2) _____ 3) _____

36) Briefly describe the child's friendships: _____
_____
_____

37) What report card grades does the child usually receive? _____

Have these changed lately? Yes _____ No _____ If yes, how? _____

38) Briefly describe the child's hobbies and interests: _____
_____

39) Describe how the child is disciplined: _____
_____

40) For what reasons is the child disciplined? _____
_____

Behaviors of Concern

41) Briefly describe the child's ways of expressing the following emotions or behaviors:

ANGER: _____

HAPPINESS: _____

SADNESS: _____

ANXIETY: _____

42) List the child's behaviors that you would like to see change: _____
_____
_____
_____
_____

43) Please check how often the following behaviors occur. Those occurring FREQUENTLY or of special concern may be described on the next page.

1) Loses temper easily	____Never	____Rarely	____Sometimes	____Frequently
2) Argues with adults	____Never	____Rarely	____Sometimes	____Frequently
3) Refuses adults' requests	____Never	____Rarely	____Sometimes	____Frequently
4) Deliberately annoys people	____Never	____Rarely	____Sometimes	____Frequently
5) Blames others for own mistakes	____Never	____Rarely	____Sometimes	____Frequently
6) Easily annoyed by others	____Never	____Rarely	____Sometimes	____Frequently
7) Angry/ resentful	____Never	____Rarely	____Sometimes	____Frequently
8) Spiteful/vindictive	____Never	____Rarely	____Sometimes	____Frequently
9) Defiant	____Never	____Rarely	____Sometimes	____Frequently
10) Bullies/teases others	____Never	____Rarely	____Sometimes	____Frequently
11) Initiates fights	____Never	____Rarely	____Sometimes	____Frequently
12) Uses a weapon	____Never	____Rarely	____Sometimes	____Frequently
13) Physically cruel to people	____Never	____Rarely	____Sometimes	____Frequently
14) Physically cruel to animals	____Never	____Rarely	____Sometimes	____Frequently
15) Stealing	____Never	____Rarely	____Sometimes	____Frequently

Patient Name: _____

16) Forced sexual activity	____Never	____Rarely	____Sometimes	____Frequently
17) Intentional arson	____Never	____Rarely	____Sometimes	____Frequently
18) Burglary	____Never	____Rarely	____Sometimes	____Frequently
19) “Cons” other people	____Never	____Rarely	____Sometimes	____Frequently
20) Runs away from home	____Never	____Rarely	____Sometimes	____Frequently
21) Truant at school	____Never	____Rarely	____Sometimes	____Frequently
22) Doesn’t pay attention to details	____Never	____Rarely	____Sometimes	____Frequently
23) Several careless mistakes	____Never	____Rarely	____Sometimes	____Frequently
24) Does not listen when spoken to	____Never	____Rarely	____Sometimes	____Frequently
25) Doesn’t finish chores/homework	____Never	____Rarely	____Sometimes	____Frequently
26) Difficulty organizing tasks	____Never	____Rarely	____Sometimes	____Frequently
27) Loses things	____Never	____Rarely	____Sometimes	____Frequently
28) Easily distracted	____Never	____Rarely	____Sometimes	____Frequently
29) Forgetful in daily activities	____Never	____Rarely	____Sometimes	____Frequently
30) Fidgety/squirmy	____Never	____Rarely	____Sometimes	____Frequently
31) Difficulty remaining seated	____Never	____Rarely	____Sometimes	____Frequently
32) Runs/climbs around excessively	____Never	____Rarely	____Sometimes	____Frequently
33) Difficulty playing quietly	____Never	____Rarely	____Sometimes	____Frequently
34) Hyperactive	____Never	____Rarely	____Sometimes	____Frequently
35) Difficulty awaiting turn	____Never	____Rarely	____Sometimes	____Frequently
36) Interrupts others	____Never	____Rarely	____Sometimes	____Frequently
37) Problems pronouncing words	____Never	____Rarely	____Sometimes	____Frequently
38) Poor grades in school	____Never	____Rarely	____Sometimes	____Frequently
39) Expelled from school	____Never	____Rarely	____Sometimes	____Frequently
40) Drug abuse	____Never	____Rarely	____Sometimes	____Frequently
41) Alcohol consumption	____Never	____Rarely	____Sometimes	____Frequently
42) Depression	____Never	____Rarely	____Sometimes	____Frequently
43) Shy/avoidant/withdrawn	____Never	____Rarely	____Sometimes	____Frequently
44) Suicidal threats/attempts	____Never	____Rarely	____Sometimes	____Frequently
45) Fatigued	____Never	____Rarely	____Sometimes	____Frequently
46) Anxious/nervous	____Never	____Rarely	____Sometimes	____Frequently
47) Excessive worrying	____Never	____Rarely	____Sometimes	____Frequently
48) Sleep disturbance	____Never	____Rarely	____Sometimes	____Frequently
49) Panic attacks	____Never	____Rarely	____Sometimes	____Frequently
50) Mood shifts	____Never	____Rarely	____Sometimes	____Frequently

44) For each of the behaviors noted on this and the previous page as occurring FREQUENTLY, or if it causes significant impairment, write a brief description of how it impacts the child’s or other people’s lives. Give examples.

Behaviors of Concern	Impact on Child or Others
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

45) Additional information you believe would be helpful: _____
_____
_____
_____

Patient Name: _____