FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

MINOR CONSENT TO TREAT

Client Name _____
LAST FIRST MIDDLE

DOB _____ **Date of Consent** _____

Purpose and Nature of Consent: To gain permission from the custodial parent or other legal guardian to provide needed services to minors or others (i.e., those under the care of a legal guardian).

Types of Service(s) to be Provided: I hereby authorize **Foundations Counseling** to provide the following services to the above named client (circle the appropriate services):

☐ Individual Counseling ☐ Group Counseling ☐ Psychological Assessment

☐ Case Management ☐ Psychiatric Services ☐ Other (specify): _____

Confidentiality: It is my understanding that such services and any information derived there from are confidential and will be treated as such by the staff of Foundations Counseling. Information regarding such services cannot be provided without the custodial parent/legal guardian's written permission.

Consent: I voluntarily consent to the treatment described above. By doing so, I am stating that I am the custodial parent and/or legal guardian of the above named person and no threat or coercive measures have induced me to sign this consent form. I hereby further release Foundations Counseling from all legal responsibility or liability that may arise from the act(s) that I have authorized above.

Withdrawal of Consent: I understand that I may withdraw this consent at any time except to the extent of action already taken based upon my consent. Such withdrawal must be done formally and in writing, signed and dated.

Client: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Revocation: I have the right to stop this consent to treat at any time. Although I understand that I cannot do anything regarding treatment already given, I am withholding consent at this time.

Signature of Legal Guardian Date

Witness Date

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

STATEMENT OF UNDERSTANDING

WELCOME

Welcome to Foundations Counseling. This introductory letter has been prepared to acquaint you with our services. We provide confidential assessment, counseling and treatment services. We look forward to working with you to be sure you receive prompt, effective treatment and regain your health and ability to function safely and productively.

OUR SERVICES

Our goal is to focus on your health and well-being as well as work related issues. Services are provided by licensed therapists with Master's Degrees in counseling, psychology and social work. Our services include assessment, counseling, coordination of treatment, and follow-up. We follow a model of counseling tailored to your specific needs. Each session lasts approximately 50 minutes. If you need other help it may be necessary to make a referral to another professional. When this occurs, it is important that you be aware of the extent of your medical health coverage. All services are provided by Foundations Counseling, and not affiliated with LifeSpan.

CONFIDENTIALITY

Your counseling records are confidential and secured. Information will not be released to anyone without your written consent except in the following situations:

1) Indication of a clear and present danger of harm to you or other persons.
    - Child abuse or neglect situation; or
    - Abuse or neglect of a dependent adult that is in your care; or
    - Admission of a commission of a crime or a serious health condition that poses a risk to a patient and/or public safety.
2) A court order or other legal order (e.g. a subpoena), or as otherwise required or permitted by law.
3) If you file a complaint or lawsuit against your counselor, your counselor may disclose relevant information about you in order to defend her/himself.

AUTHORIZATION FOR RELEASE OF INFORMATION

In some situations, you will be asked to sign a release of information consent form. The Release of Information form allows Foundations Counseling to release only specific information to the individual(s) you specify. This is necessary to coordinate your care and ensure you appropriate assessment and/or treatment.

All clients treated for a mental health or substance use disorder, when services are covered in whole or in part by Medicaid – Medicaid HMO, ADAMH Board, or OhioMHAS: Ohio Mental Health and Addiction Services has implemented a data tracking system for all providers in the state of Ohio known as OBHIS (Ohio Behavioral Health Information System). As a mental and behavioral health provider, we are mandated to disclose demographic, billing and other general information pertaining to current active clients. By signing this document you are agreeing to release information to the State of Ohio.

SERVICES NOT COVERED

It is the policy of Foundations Counseling not to participate in client's legal actions such as custody evaluations/suits, divorce proceedings, personal injury suits, etc. If you are considering or are involved in such actions, your Foundations counselor can refer you to another professional who may be able to assist you in these matters.

QUALITY OF SERVICE

We would like to ensure that you have the highest quality of services possible. If you experience any concerns or have questions about our services, please feel free to contact Foundations Counseling at (513) 785-4895.

I have read and understand this agreement:

Name: _____ Date: _____

Staff: _____ Date: _____

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

ADDENDUM

SERVICES NOT COVERED

It is the policy of Foundations Counseling not to participate in client's legal actions such as:

PLEASE INITITAL AND DATE EACH ONE:

_____ _____ Custody evaluations/suits

_____ _____ Divorce proceedings

_____ _____ Personal injury suits

_____ _____ Letters containing clinical information

_____ _____ Workplace disputes

_____ _____ Other

If you are considering or are involved in such actions, your Foundations counselor can refer you to another professional who may be able to assist you in these matters.

SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

Informed Consent to participate in Telehealth Services

Client Name (Last, First, MI) _____ MRN#_____ DOB:_____

Consent Date: _____

Consent Type: ☐ Initial Consent

☐ Withdrawal of current consent on file & Date of Previous Consent: _____

Telehealth is the provision of behavioral health service through interactive video conferencing and/or phone sessions.

I understand that telehealth is a live, two-way interaction between myself and a clinician/employee of Foundations Counseling using audiovisual telecommunication technology or phone call(s).

I understand that telehealth is voluntary and that I may refuse to participate at any time verbally or in writing. I understand that my participation, refusal to participate, or decision to stop participation will be documented in my electronic health record.

I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth. I understand that during a pandemic these laws may be waived by government officials in order to continue to provide care.

Prior to receiving services, I will be educated and the process of telehealth will be explained.

I understand that I may not record the audio content or the images of the session.

I have read this document and have had the opportunity to ask questions. I hereby consent to participation in treatment via telehealth videoconferencing or phone sessions.

_____ _____

Client or Client Representative's Signature Date of Signature

If signed by Legal Guardian, Name/Relationship to Client: _____

_____ _____

Foundations Counseling Staff Name and Signature as Witness Date of Signature

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

ABOUT FINANCIAL ARRANGEMENTS AND MENTAL HEALTH SERVICES

We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

FEE SCHEDULE

Most insurance policies cover some percentage of outpatient counseling. You should find out the following information **prior** to your first visit to our office:

1. **What is my deductible? Have I met my deductible yet?**
   You are responsible to pay the full fee of services until your deductible is met.
2. **Do I need pre-authorization for outpatient treatment?**
   Many insurance plans operate under a "pre-authorized" concept. If your counselor at Foundations is not "pre-authorized" to provide treatment, you may be denied payment by your insurance company. **PLEASE NOTE: We strongly encourage you to contact your insurance company BEFORE your first session. Foundations will not be responsible for denial of claims if you have not notified your insurance company for pre-authorization; or, if we are not a covered provider under your plan.**
3. **What percentage of the fee will my insurance pay and what percentage am I responsible to pay?**
   Upon arrival at Foundations, clients are expected to pay **at least** their portion of the fee at each and every session. You should anticipate paying the full fee for the diagnostic session.
4. **Who receives the reimbursement check?**
   If the insurance company sends the check directly to us: (1) you will receive a credit if you "pay-as-you-go," or (2) the payment will be added to your weekly co-payment.

   If the insurance company sends the check directly to you: expect to pay the full fee for each session.

You are ultimately responsible to pay any balance that your insurance company may not cover. We realize that you may have special arrangements with a non-custodial parent for payment of medical bills; however, we do not bill third parties. You are responsible for the bill at the time services are rendered.

CANCELLATION POLICY

Because the demand for counseling is so great, we take very seriously our responsibility to be good stewards of our time and resources. **If you are unable to keep your appointment, please contact us 24 hours prior to your scheduled appointment. Failure to contact us within the 24-hour window to cancel your appointment, may result in the client being charged the FULL AMOUNT due for the session. Also, NO SHOW, or same day appointment cancellations may be charged the full amount due. We maintain a 24-hour answering service at 513-785-4895 in case an appointment must be broken.**

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

MINOR BILLING INFORMATION FORM

CLIENT: _____ GENDER: F☐ M☐ BIRTHDATE: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SOC. SEC. #: _____

PHYSICIAN: _____ PHONE: _____

IN EMERGENCY CONTACT: _____ PHONE: _____

CUSTODIAL PARENT: _____ PRIMARY PHONE: _____

May we identify Foundations? Y☐ N☐ EMAIL ADDRESS: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SPOUSE'S NAME: _____ PRIMARY PHONE: _____

NON-CUSTODIAL PARENT: _____ PRIMARY PHONE: _____
May we identify Foundations? Y☐ N☐

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

WHO REFERRED YOU? _____

INSURED PARTY: _____ BIRTHDATE: _____

EMPLOYER: _____ SOC. SEC. #: _____

INSURANCE CO: _____

CLAIMS ADDRESS: _____

INS. CO. PHONE: _____ POLICY: _____

I understand and agree that **regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered,** and that payment is due at the time those services are rendered. I further understand that the initial one to three sessions are for the purpose of evaluation (i.e., to determine whether or not a treatment relationship will be established) and as such do not guarantee acceptance as a Foundations client. **I have read all the information on both sides of this sheet and agree to the conditions set forth. I certify this information is true and correct to the best of my knowledge and will notify you of any changes in my status or the above information.**

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Foundations, the counselors, and other Foundations staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill, and for issues that concern Foundations operations and responsibilities.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

INSURANCE SIGNATURE REQUIREMENT

(in lieu of insurance form)

Client: _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Foundations Counseling to release any information acquired pertaining to the billing process.

_____ _____

Client (or guardian) Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE:

I authorize payment of medical benefits to Foundations Counseling for services rendered.

_____ _____

Client (or guardian) Date

COMMUNITY BEHAVIORAL HEALTH
DBA FOUNDATIONS COUNSELING
NOTICE OF PRIVACY PRACTICES
Effective 3/31/10, Revised 06/26/2020

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

Community Behavioral Health ("CBH") is required by law to maintain the privacy of your health information. CBH is required to provide this notice of its legal duties and privacy practices with respect to your private health information. The health information which CBH protects is information about you that relates to your health, condition, health care provided to you, and payment for health care services. CBH calls that information Protected Health Information, or "PHI." CBH is dedicated to maintaining the privacy of your health information.

WHO WILL FOLLOW THIS NOTICE

This notice applies to CBH. When used in this notice the term "We" or "CBH" refers to CBH. We are required to follow the terms of this notice so long as it remains in effect.

USES AND DISCLOSURES OF HEALTH INFORMATION

CBH may use and disclose your PHI as described in this notice. The following categories provide examples of ways that we may use and disclose your PHI. These examples do not provide every use and disclosure permitted.

Treatment. We may use and disclose your PHI for your treatment. For example, we may disclose information about you to doctors, nurses, counselors, healthcare professionals in training and other personnel involved in your treatment or services. Different departments of CBH may share your PHI to coordinate your care. We may share your PHI with others involved in your care or treatment, such as your family physician, pharmacy, or home health care agency, who may or may not be associated with CBH.

Payment. We may use and disclose your PHI as necessary for payment for your treatment or services. For example, we may provide PHI to your insurance company about a treatment or service you received so that the insurer will pay for services. We may also inform your insurance company about a planned treatment or service so that prior approval may be obtained, or to determine if your insurance plan covers the planned treatment or service.

Health Care Operations. We may use and disclose your PHI for CBH operations. For example, we may use your PHI to evaluate the performance of CBH staff in their care of you. Other uses can include matters such as quality improvement activities, business management or accreditation. We may also disclose information to other health care providers involved in your care or treatment for their health care operations.

Health Services, Treatment Alternatives and Health-Related Benefits. We may use and disclose your PHI to tell you about health-related benefits or services that we offer, possible treatment options or alternatives, or health related benefits or services that may be of interest to you. We may also use your PHI to communicate with you and coordinate your care.

Appointments. We may use and disclose your protected health information to contact you as a reminder that you have an appointment or to reschedule a missed appointment for treatment or services.

Fundraising. We may contact you to donate to a fundraising effort for us or on our behalf. You may elect not to receive further fundraising materials/communications by sending a statement to that effect, including your name and address to: Privacy Officer, 230 Ludlow St, Hamilton, Ohio 45011.

Other Individuals Involved With or Concerned About Your Care. We may disclose your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), or to a friend or family member who is your personal representative (i.e. empowered under state or other law) to make health-related decisions for you. If you do not object, or if we reasonably infer from the circumstances (for example, if your spouse remains present while discussing

treatment options with your doctor) we may also disclose relevant health information to a family member, other relative, or close personal friend, or any other person you identify who is involved with your case or payment for your care.

Required By Law. We will use or disclose your PHI when that use or disclosure is required by law. Any such use or disclosure will comply with, and be limited to, the permissions or requirements of the law.

Serious Threat to Health or Safety. In certain situations, and as allowed by law, we may use and disclose your PHI when necessary to prevent a serious threat to your health and safety of the public or another person.

Business Associates. CBH contracts with outside vendors to provide some services. These vendors are known as business associates. We may disclose your PHI to business associates. For example, we may provide your PHI to an external company that assists us in processing bills. CBH's business associates are required to safeguard your PHI.

Military and Veterans. If you are or were a member of the U.S. or foreign armed forces, we may disclose your PHI as required by military command authorities.

Worker's Compensation. We may disclose your PHI to worker's compensation insurers, state administrators, employers, and other persons or entities involved in the workers' compensation system, as authorized by law, and as applicable to your treatment and care.

Public Health. We may disclose your PHI for public health activities, including activities to: prevent or control disease, injury or disability; report births and deaths; report child or adult abuse, neglect or violence; report reactions to medications or problems with products; notify people of recalls of products they may be using, or notify a person who may have been exposed to a disease or may be at risk for getting or spreading a disease or condition.

Health Oversight Activities. We may disclose your PHI to federal or state agencies for health oversight activities such as audits, investigations, inspections and licensure. This disclosure would be as necessary for the government to monitor the health care system, government programs and compliance with laws.

Lawsuits and Disputes. We may disclose your PHI in response to a court or administrative order, or certain subpoenas.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety of and security of the correctional institution.

OTHER USES OF PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information not covered by this notice or the laws and regulations that apply to CBH will be made only with your written permission. If you authorize CBH to use or disclose protected health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons listed in your written authorization. The revocation will not apply to uses or disclosures that have already occurred. Also, we will continue to comply with laws that require certain disclosures.

YOUR PRIVACY RIGHTS

Review or Copy. You have the right to request to review and/or receive a copy of your PHI. All requests for access to your PHI must be in writing and signed by you. We may charge you a fee, especially if extensive and/or non-recent personal health information is requested. We may also charge for postage if you request a mailed copy. In some limited situations, your request to review or receive a copy may be denied. In some denial situations, you have the right to have the denial evaluated by a reviewing official. Based upon the determination of the reviewing official we will then provide or deny access. To request to review and/or receive a copy of your protected health information, you will need to complete a signed release of information authorization form that may be obtained from Foundations Counseling, 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

Amendment. You have the right to request that your protected health information be amended if you think that your protected health information in our records is incorrect or incomplete. All requests for amendments must be made in writing and signed by you. All amendment requests must also state the reason(s) for the amendment/correction request and the specific amendment/correction requested. We are not obligated to make all requested amendments but will

give each request careful consideration. For example, an amendment request may be denied if the information to be amended was not created by us or is not part of our protected health information kept by our facility. If an amendment you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment form from Foundations Counseling, 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

Accounting of Disclosures. You have the right to request an "accounting" or list of certain disclosures CBH has made of your PHI. This "accounting" or list is not required to include all disclosures. For example, we are not required to account for routine disclosures between CBH staff coordinating your treatment or care. Types of disclosures not required in the "accounting" or list are: disclosures for treatment, payment, or health care operations, disclosures made before April 14, 2003; disclosures made more than six years prior to the date on which the "accounting" or list is requested; disclosures made to you or which you authorized; and certain other disclosures, such as disclosures for national security or intelligence purposes. To request this accounting of disclosures and obtain information about possible fees, contact: Privacy Officer, Community Behavioral Health, 230 Ludlow St, Hamilton, Ohio 45011.

Restrictions on Disclosures. You have the right to request a restriction or limit on your protected health information we use or disclose about you for treatment, payment or health care operations. If your requested restriction relates to our disclosure of your PHI to a health plan and pertains solely to a health care item or service for which you have paid, out-of-pocket, in full, we will comply with your request. Otherwise, we are not required to agree to your request. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or to make a disclosure that is required under law. Restriction requests should usually be in writing and you must state: (1) what information you want to limit; (2) whether you want to limit CBH's use, disclosure or both; and (3) to whom you want the limits to apply. We may terminate an agreement to a restriction if we inform you of this termination. We will notify you of such termination, if applicable. You may also request to terminate a restriction or limitation. To request a restriction or limit on your protected health information, contact: Foundations Counseling, 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may request that we call you at your office, rather than at your home. We will not require you to explain the reason for your request. We will accommodate reasonable requests. Confidential communication requests should usually be in writing and you must specify how or where you wish to be contacted. To request an alternative communication means or location, contact: Foundations Counseling, 1900 Fairgrove Avenue, Hamilton, Ohio 45011.

Paper Copy of This Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive this notice electronically. You may obtain a paper copy from your Primary Counselor. This notice is also available on Foundation Counseling's website www.Foundations-Counseling.org.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected health information we already have about you as well as for any information we receive in the future. We will post a copy of the current notice in the agency and on Foundations Counseling's website: www.Foundations-Counseling.org.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with the Privacy Officer, contact: Privacy Officer Community Behavioral Health, 230 Ludlow St, Hamilton, Ohio 45011. Generally, a compliant must be filed with HHS within 180 days after the act or omission occurred, or within 180 days of when you knew or should have known of the action or omission. You will not be retaliated against or denied treatment or discriminated against for filing a complaint.

FURTHER INFORMATION
If you have questions or need further assistance regarding this notice, you may contact: Privacy Officer, Community Behavioral Health, 230 Ludlow St, Hamilton, Ohio 45011.

COMMUNITY BEHAVIORAL HEALTH
DBA FOUNDATIONS COUNSELING

WRITTEN SUMMARY OF FEDERAL CONFIDENTIALITY LAW & REGULATIONS
FOR CUSTOMERS IN ALCOHOL AND/OR DRUG PROGRAMS

In accordance with 42 C.F.R. Part 2 alcohol and other drug customer records are subject to the following confidentiality conditions: This agency complies with these requirements.

- Program staff shall not convey to a person outside of the program that a customer receives services from the program or disclose any information identifying a customer as an alcohol or drug services customer unless the customer consents in writing for this release of information, the disclosure is allowed by court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purpose.
- Violation of the federal law and regulations governing this Program is a crime. Suspected violations may be reported to the United States Attorney's Office, Southern District of Ohio, 221 E. Fourth Street, Suite 400, Cincinnati, OH 45202, (513) 684-3711.
- Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a customer either at the program or against any person who works for the program.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Federal authorities.

FOUNDATIONS COUNSELING

COMMUNITY FIRST SOLUTIONS

CHILD DEVELOPMENTAL HISTORY RECORD

A. IDENTIFICATIONS

Child's Name:_____ Date:_____

Birthdate:_____ Age:_____

Person(s) completing form:_____

Mother's Name:_____ Age:_____

Father's Name:_____ Age:_____

Child's parents are currently: ☐ Married ☐ Divorced ☐ Separated ☐ Never married ☐ Other:_____

Child's legal guardian is:_____

B. DEVELOPMENT – Please fill in any information you have on the areas listed below.

Pregnancy – During pregnancy, did the mother:

See a doctor regularly? ☐ No ☐ Yes Smoke? ☐ No ☐ Yes Drink alcohol? ☐ No ☐ Yes

Have any of the following (check all that apply): ☐ Anemia ☐ High Blood Pressure ☐ Toxemia ☐ Bleeding

☐ Flu ☐ Viral Infections ☐ Vomiting ☐ Emotional Difficulties

Experiencing any illness or injuries? ☐ No ☐ Yes If so, what? _____

_____

Take medications? ☐ No ☐ Yes If so, medications? _____

_____

Delivery – How many hours passed from the first contractions until birth? _____ hours

Was the mother given medications? ☐ No ☐ Yes If so, what? _____

Was the child's birth by: ☐ Natural Birth ☐ C-Section

Did the mother have: ☐ General Anesthesia ☐ Local Anesthesia ☐ No Anesthesia

Was labor induced? ☐ No ☐ Yes Was this a breech delivery? ☐ No ☐ Yes

Was the child full-term? ☐ No ☐ Yes Weight at birth?_____

Were forceps used? ☐ No ☐ Yes

Were there complications? ☐ No ☐ Yes If so, what?_____

Post-Delivery (while in hospital) – After delivery, did the child experience any of the following:

Delays in breathing? ☐ No ☐ Yes Delays in crying? ☐ No ☐ Yes

Jaundice (yellow)? ☐ No ☐ Yes Cyanosis (blue)? ☐ No ☐ Yes

Vomiting? ☐ No ☐ Yes Diarrhea? ☐ No ☐ Yes

Birth defects? ☐ No ☐ Yes Explain:_____

The First Few Months of Life

Breast-fed? ☐ No ☐ Yes If so, how long? _____

Any allergies? ☐ No ☐ Yes If so, what? _____

Any unusual reactions to vaccinations? ☐ No ☐ Yes If so, what? _____

Sleep problems? ☐ No ☐ Yes If so, what?_____

Early temperament/personality?_____

_____

Milestones: At what age did this child do each of these?

Sat without support:_____ Crawled:_____

Stood without support:_____ Walked without holding on:_____

Didn't soil his/her pants:_____ Dressed self completely:_____

Stayed dry all day:_____ Stayed dry all night:_____

Spoke his/her first words understandably to strangers:_____

Spoke his/her first sentences understandably to strangers:_____

Did the child have any vision or hearing difficulties? ☐ No ☐ Yes If yes, please specify:_____

_____

Any language or speech difficulties? ☐ No ☐ Yes If so, please specify:_____

C. HEALTH – Did the child experience any of the following?

Operations? ☐ No ☐ Yes If so, please specify:_____

Hospitalizations (other than operations)? ☐ No ☐ Yes If yes, please specify:_____

Head injuries? ☐ No ☐ Yes If so, please specify:_____

Seizures? ☐ No ☐ Yes Fever? ☐ No ☐ Yes Poisoning? ☐ No ☐ Yes

Recurrent ear infections? ☐ No ☐ Yes Bedwetting after three years old? ☐ No ☐ Yes

Was the child clumsy? ☐ No ☐ Yes Explain:_____

_____

D. RESIDENTIAL PLACEMENTS, INSTITUTIONAL PLACEMENTS, OR FOSTER CARE – List any residential placements.

Dates From	To	Program Name/Location	Reason for Placement

E. SCHOOLS – list all schools attended, starting with the current/most recent:

School (Name, Address)	Grade	Age	Teacher

Grades? ☐ Above Average ☐ Average ☐ Below Average

Any problems in school? ☐ No ☐ Yes What?_____

_____

May I call and discuss your child with the current teacher? ☐ No ☐ Yes

F. PRESENT STATUS

Please review this checklist, which contains concerns (as well as positive traits) that apply mostly to children and check any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

- ☐ Affectionate
- ☐ Angry, quick tempered
- ☐ Appetite, increased or decreased
- ☐ Argues, "talks back," smart-alecky, defiant
- ☐ Bullies/intimidates, teases, picks on others
- ☐ Cheats
- ☐ Cruel to animals
- ☐ Concerned for others
- ☐ Conflicts with parents over persistent rule breaking, money, chores, homework, grades
- ☐ Complains
- ☐ Coordination is poor ("all thumbs," bumps into or drops things, etc)
- ☐ Cries easily, feelings are easily hurt
- ☐ Dawdles, procrastinates, wastes time
- ☐ Difficulties with parent's partner/new marriage/new family
- ☐ Dependent, immature
- ☐ Developmental delays
- ☐ Disrupts family activities
- ☐ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ☐ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ☐ Drug or alcohol use
- ☐ Eating – refuses, odd combinations, overeats
- ☐ Exercise problems
- ☐ Extracurricular activities interfere with academics
- ☐ Failure in school
- ☐ Fearful
- ☐ Fighting, hitting, violent, aggressive, hostile
- ☐ Fire setting
- ☐ Friendly, outgoing, social
- ☐ Hypochondriac, always complains of feeling sick
- ☐ Immature, "clowns around," has younger playmates
- ☐ Imaginary playmates, fantasy
- ☐ Impulsive, acts and then thinks
- ☐ Independent
- ☐ Interrupts, talks out, yells
- ☐ Lacks organization, unprepared
- ☐ Lacks respect for authority, insults, dares, provokes
- ☐ Learning difficulty
- ☐ Legal difficulties – drinking, vandalism, theft
- ☐ Likes to be alone, withdraws, isolates
- ☐ Lying
- ☐ Low frustration tolerance, irritability
- ☐ Mental retardation
- ☐ Moody
- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Nervous
- ☐ Nightmares
- ☐ Needs much supervision over play/chores/schedule
- ☐ Obedient
- ☐ Obesity
- ☐ Overactive, restless, out-of-seat behaviors, fidgety
- ☐ Oppositional, refuses, does not comply, negative
- ☐ Physical complaints expressed
- ☐ Prejudiced, bigoted, insulting, name calling, intolerant
- ☐ Pouts
- ☐ Recent move, new school, loss of friends
- ☐ Relationships with siblings, peers are poor
- ☐ Responsible
- ☐ Rocking or other repetitive movements
- ☐ Runs away
- ☐ Sad, unhappy
- ☐ Self-harming behaviors – biting or hitting self, head banging, scratching self
- ☐ Speech difficulties
- ☐ Sexual – sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ☐ Shy, timid
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing, foul language
- ☐ Talks excessively, non-stop
- ☐ Temper tantrums, rages
- ☐ Thumb sucking, finger sucking, hair chewing
- ☐ Tics – involuntary rapid movements, noises, or word productions
- ☐ Teased, picked on, victimized, bullied
- ☐ Truant, school avoiding
- ☐ Underactive, slow-moving or slow-responding, lethargic
- ☐ Uncoordinated, accident-prone
- ☐ Wetting or soiling the bed or clothes
- ☐ Work problems – works too much, can't keep a job

List any other characteristics of your child that you think are important: _____

_____

_____

G. SPECIAL SKILLS OR TALENTS OF CHILD

List any special skills or talents your child has: _____

_____

_____

_____

_____

H. OTHER

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

_____

_____

_____