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Psychotherapy Information Disclosure Statement

We'd like to review what you can expect during the therapeutic/assessment process, and outline some of our policies. We apologize for the length of this form, but we want to fully inform you about your rights, and our procedures, from the very beginning. This form is an agreement between you and Dr. Jennifer Johnston-Jones. If you have any questions, feel free to discuss them with Dr. Johnston-Jones at any time.

It's important to note that you are a vital part of the process. Supporting your child, collaborating with Dr. Jennifer Johnston-Jones, and being involved in the process will maximize therapeutic gains and increase the likelihood of lasting benefits. Therapy is not without its risks as sometimes you or your child may feel discomfort in assessment/therapy. Resolving difficult issues and learning to regulate intense emotions through therapy and assessment can bring on strong feelings, such as anger, sadness, fear, etc. But this is all a normal part of the therapeutic process and can help lead to positive change.

I. <u>My Training and Approach to Therapy</u>

I have a Ph.D. in Clinical Psychology, as well as an M.A. and a B.A. in psychology. I received my education in psychology from the University of Oregon, UCLA Neuropsychiatric Institute, Harbor UCLA Medical Center, the Children's Hospital in Los Angeles and the California School of Professional Psychology at Alliant University. I am a licensed psychologist in Colorado (PSY 5683) and California (PSY 19654). I am a full member of the American Psychological Association and the Association of Neuroscience. My areas of special training and expertise include neuropsychology, parents, teens, women's issues as well as the psychology of children. During the course of my education I received training in several types of Psychological Treatment including the neurofeedback, biofeedback, neuropsychology, the psychology of happiness, play therapy, relationship therapy, EMDR, psychodynamic therapy, cognitive behavioral therapy, hypnosis, play therapy, multicultural therapy and child/teen assessment. I completed an American Psychological Association accredited internship as well as graduate training. I have over 4000 hours of supervised clinical training in addition to more than two decades of seeing clients.. I regularly attend continuing education conferences and workshops for psychologists.

I use a variety of techniques in therapy/assessment, trying to find what is best for you while using evidence-based treatments. These techniques are likely to include neuropsychological assessment, dialogue, interpretation, neurofeedback, biofeedback, EMDR, cognitive reframing, awareness exercises, self-monitoring experiments, visualization, journal-keeping, drawing, and reading books. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you

the risks and benefits of what I am suggesting. I may suggest that you consult with a physical health care provider regarding somatic treatments that could help your problems; I refer both to traditional and non-traditional (homeopathic and Oriental medicine) practitioners, and will be glad to discuss with you the pros and cons of various alternatives. I may suggest that you get involved in a therapy or support group as part of your work with me. If another health care person is working with you, I will need a release of information from you so that I can communicate freely with that person about your care. You have the right to refuse anything that I suggest.

II. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. In order to protect your privacy and to protect our therapeutic relationship, I do not socialize with my current or former clients. If I see you in a public area, I will not greet you. I'm not being unfriendly, only protecting your privacy.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect: 1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim. 2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services or Adult Protective Services immediately. 3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team. 4. Certain legal proceedings such as subpoena of records. However, in order to protect your confidentiality even when the law insists to look at your records, I write only what is necessary. Please see "Record-Keeping" section for more information.

Family/Couples therapy:

_____If you and your partner decide to have some individual sessions as part of family or couples

therapy, what you say in those individual sessions will be considered to be a part of the therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

My Absences:

I am away from the office several times in the year for extended vacations. I will tell you well in advance of any lengthy absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. If you are experiencing an emergency when I am out of town, or outside of my regular office hours (after 5 pm weekdays or over the weekend), please call the Crisis Hotline at 1-800-854-7771. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

III. Record-keeping

In order to protect your privacy, I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record. You have the right to a copy of your file at any time, giving me the chance to print it out from my computer. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

IV. Insurance / Managed Mental Health Care

I do not accept health insurance. However, if you have a PPO health insurance plan and your plan allows for "Out of Network Providers" you may be able to be reimbursed between 50-80% of the cost. Please consult with your individual health insurance company. In addition, your therapy sessions may be tax deductible as a medical expense. Please contact your tax adviser to see if you qualify so I can prepare a receipt for services rendered.

I do not accept insurance because it erodes your right to privacy. If I were to accept insurance, I would have to give you a "mental disorder diagnosis" that would need to be reported to the health insurance company. Some of these diagnoses can cause it to be difficult for you to obtain health insurance in the future. When I send in the report with the mental disorder diagnosis, there can be up to 14 people reading, touching, or hearing about the report. Further, your diagnosis can be considered a "preexisting condition" and future employers may have access to this information. By not using your health insurance, you truly have confidentiality and any diagnosing will stay between us.

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V. Attendance of sessions / Session information

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 50 minutes and occasionally 100 minutes for families. If you are late, we will meet for whatever amount of your time remains and you will be required to pay for the full session. If you miss a session without canceling, or cancel with less than twenty-four hours notice, you must pay for that session at our next regularly scheduled meeting. The voicemail has a time and date stamp which will keep track of time to cancellation. I cannot bill these sessions to your insurance. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires).

You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licensed, registers, or certifies the licensee, registrant, or certificate holder. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Board of [list the name of the Colorado board regulating your profession] can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

VI. Payment of Sessions

You are responsible for paying for your session in advance unless we have made other arrangements in advance. You may pay with a check, cash or by credit card on paypal. If you pay by credit card or paypal, I ask that you pay for four sessions in advance, on a monthly billing schedule to reduce processing time. If you pay in advance and end up not using some sessions, I will return any remaining balance to you. Sessions are $250 for a treatment plan program and $350 for a one-off consultation. but are based on your ability to pay. For those who cannot afford the standard fee, Dr. Johnston-Jones gives pro-bono (no cost) and sliding scale (reduced fee) sessions. We accept credit cards, cash, and have an interest-free option through our medical payment plan. If we decide to meet for a longer session, I will bill you prorated on the hourly fee. In order to retain your confidentiality, I ask that you attempt to communicate with me in person only except to schedule or reschedule an appointment. Emergency phone calls of less than ten minutes are not charged. However, if we spend more than 10 minutes in a week on the phone, if you leave more than ten minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week I will bill you on a prorated basis for that time. My fees go up $30.00 every year. Payment must be settled each week. If you find that therapy is too expensive, a sliding scale fee can be arranged according to your income, or referrals can be made to community clinics. Any overdue bills will be charged 1.5% per month interest. If you eventually refuse to pay your debt, I reserve the right to

give your name and the amount due to a collection agency.

VII. Communications

Because email/texting is not completely confidential, please contact me by email or text only to schedule an appointment. It is much more therapeutic to discuss things in person. Telephone calls and voice mail messages should also be made only regarding appointment times. If an issue arises before your weekly appointment time, please feel free to email or call me to schedule an earlier appointment. I reply to voice messages and emails within 24 hours unless I am on vacation in which case I will reply to your message when I return.

VIII. Length of treatment and Emotional Vulnerability

Although some clients elect to pursue long-term, open-ended treatment, many issues can be resolved in about 25 to 30 sessions, while some highly focused issues can be resolved in about 12 sessions. Of course, the success of any treatment depends on the motivation and aptitude of the person being treated. For this reason, I can make no guarantees about treatment length or success. Therapy also has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

IX. Types of Therapists

There are several kinds of therapists. I am a Licensed Psychologist. A Licensed Psychologist has the most education. A Licensed Psychologist must hold a doctorate degree in psychology, have at least one year of post-doctoral supervision, and pass an examination in psychology. Other therapists include:

- A Registered Psychotherapist: is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience.
- A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam.
- A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.
- A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in

social work.
- A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practice as a social worker for at least two years, and pass an examination in social work.
- A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
- A Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one year post-doctoral practice, and pass an exam in marriage and family therapy.
- A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in professional counseling.

X. <u>For Minors</u>

Therapy and assessment are most effective when a trusting relationship exists between the psychologist and the client. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is our policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed without your child's agreement. This could potentially include activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then we will need to use professional judgment to decide whether your child is in serious and immediate danger of harm. If we feel that your child is in such danger, we will communicate this information to you.

Since your child is still a minor, their right to confidentiality is also limited by our legal right to share information with their parents. However, since an effective therapeutic relationship often involves the provision of a safe place to confidentiality discuss difficulties in one's life, it is best if you (the parents) and your psychologist agree in advance regarding what type of information will be shared. In general, we believe it is important to inform a child's parents if the child is involved in any activity that is seriously harmful to themselves, but we may not reveal information if such activity does not seem to present an imminent risk of harm. For example, if a child reveals that they have been regularly operating a motor vehicle while under the influence of a substance, we would discuss with the child how best to inform their parents of this activity (e.g. either the clinician tells them, the child tells them, or we do it together). However, if the child revealed a one-time experimentation with marijuana, we may not inform the parents.

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Disclosure of Minor's Treatment Records to Parents

Although the laws of California may give parents the right to see any written records kept about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings, and you agree not to request access to your child's written treatment records. However, a summary of treatment including session dates may potentially be provided upon request and discussion.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although our responsibility to your child may require helping to address conflicts between the child's parents, our role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena our records or ask us to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing our opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring our testimony, even though we will not do so unless legally compelled. If we are required to testify, we are ethically bound not to give our opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, we will provide information as needed, if appropriate releases are signed or a court order is provided, but we will not make any recommendation about the final decision(s). Furthermore, if required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for our participation agrees to reimburse us at the rate of $350 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Communicating with other adults

School: Your child's therapist will not share any information with your child's school unless they have your written permission as parents. Sometimes they may request to speak to someone at your child's school to find out how things are going. Also, it may be helpful in some situations for the therapist to collaborate with your child's teacher or school counselor. If the therapist wants to contact your child's school, or if someone at the school wants to contact the therapist, they will discuss it with you as parents/guardians first and ask for your written permission.

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Doctors: Sometimes your child's treating physician and the therapist may need to work together; for example, if your child is taking medication in addition to seeing a counselor or therapist. The therapist will get written permission from you as parents/guardians in advance to share information with your doctor. The only time the therapist will share information with your child's doctor without permission is if your child is doing something that puts them at risk for serious and immediate physical or medical harm.

Release of Information: If you ever want your therapist to share information with someone else (for example, your physician, an attorney, or an insurance company), your therapist will ask you to sign a consent form for the release of confidential information.

CONFIDENTIALITY
Within the limitations articulated in this document, the information you and your child reveal to us during our professional relationship will be kept confidential and will not be released to anyone without your written consent. However, certain conditions do require that confidentiality and privileged communication be breached, including:
1) if there is reason to believe that you or your child represent a danger to yourself;
2) if there is reason to believe that you or your child represent an imminent danger to another person;
3) if there is reason to believe that child abuse or neglect is present;
4) if there is reference to online sexual messages containing images of or being sent to minors;
5) if there is reason to believe that elder or dependent adult abuse is present;
6) if a legitimate court order is issued;
7) if the treatment is ordered or is under the supervision of the court.

Acknowledgement and consent
Your signature below indicates that you have read and understood the information provided here, and that you agree to these terms. Additionally, you are consenting to treatment for yourself or your minor child. This is an agreement directly between you and your independently licensed therapist.

Child/Adolescent client:

By signing below, you show that you have read and understood the policies described above. If you have any questions as you progress with therapy, you can ask your therapist at any time.

Minor's Signature* _____
Date_____
* For very young children, the child's signature is not necessary

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Parent/Guardian of Minor client:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

- I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

- Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment. _____ _____

- I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

- I understand that if I am using my insurance for reimbursement, there are no guarantees that therapy cost will get reimbursed, and that I must file the paperwork for reimbursement. I understand that if I choose to use my insurance, my child will need to be diagnosed with a mental health disorder. _____ _____

- I agree to pay the fee of $250 per 50 minute session. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Jennifer Johnston-Jones, Ph.D. _____ _____

- I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Dr. Johnston-Jones. _____ _____

- I am over the age of eighteen. If I am consenting for my child under 18 to be in therapy, I acknowledge that I am the person with the legal right to authorize treatment. _____ _____

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- I/we authorize my provider from Aspen Neurotherapy, PLLC, P-LLC, to bill the above credit / debit card for professional services as outlined in the Policies. _____ _____

- I will notify Aspen Neurotherapy, PLLC, in writing if I no longer want my credit / debit card billed. _____ _____

- Additionally, I authorize a provider from Aspen Neurotherapy, PLLC, to charge the above credit card when the patient does not give advance notice for a late-cancellation or no-show, as per the Practice Policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly. _____ _____

- I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. _____ _____

Parent/Guardian Signature _____ Date_____
Printed Name: _____

Parent/Guardian Signature _____ Date_____
Printed Name: _____

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

Name as it appears on card _____
Credit / Debit Card Number: _____ - _____ - _____ - _____
Billing Zip Code: _____ Security Code:_____ Exp. Date:_____/_____

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BACKGROUND QUESTIONNAIRE

The client's Full legal name (first, middle, last) _____

What does the client prefer to be called? _____

Your name and relationship to the client: _____

The name and contact information for your child's teacher:

Name: _____ Email/ Phone: _____

BIRTH AND DEVELOPMENTAL HISTORY:

1. How many weeks gestation was the pregnancy? _____

2. Fetal Alcohol exposure? YES / NO (circle one)

a. If Yes, how much and how often? _____

_____

3. Fetal Drug Exposure? YES / NO (circle one)

a. If Yes, how much and how often? _____

_____

4. Normal labor and delivery? YES / NO (circle one)

a. If No, describe medical interventions needed at birth. _____

_____

_____

_____

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5. Did the client remain in the hospital for a normal amount of time following their delivery (i.e. 2-3 days for vaginal delivery, 4 days for C-section)? YES / NO

a. If No, described why they were required to stay in the hospital. Did this include a visit to the NICU? _____

6. The age of the client then they first:

a. Walked without holding on to anything? _____

b. Spoke first words, NOT mama or dada? _____

c. Said 2-3 word phrases? (i.e. "want juice", "go car") _____

d. Potty trained _____

e. Are there issues with incontinence (i.e. accidents) now? YES / NO

If yes, how often and when did they begin? _____

7. How did the client interact with other children early in development? _____

_____

8. Did doctors (pediatrician or other health care providers) have concerns about the client's development? YES / NO

a. If yes, please describe the concerns. _____

_____

_____

PERSONAL HISTORY:

1. Place of birth? (City, State) _____

2. Where does your child currently live? (City, State) _____

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3. Did the family live any other places between where the client was born and where they currently live now? YES / NO (circle one)

a. If yes, please list the places and dates. _____

_____

b. If moved, when was the move to the current home? _____

_____

4. With whom does the client live at present? (names, ages, relationship to the client)

_____

_____

5. How many siblings does the client have? Please list (i.e. stepsister, maternal half sister, etc. AND the ages.) _____

_____

_____

6. Who primarily raised the client? Please describe any changes in caregivers and reasons for the changes. _____

_____

_____

7. Does the other parent know your child is currently undergoing psychological testing? YES / NO (circle one)

a. Please list any important custody issues. _____

_____

_____

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8. If your child does not have contact with one parent, has your child ever had a relationship with this individual? YES / NO (circle one)

a. If so, when did contact end and why? _____

_____

_____

_____

_____

9. *Has your child ever been removed from the custody of primary caregivers (i.e. by DHS)? YES / NO (circle one)

a. If so, why and for how long? _____

_____

_____

_____

10. *Has your child ever had to live with other family members or caregivers? YES / NO (circle one)

a. If so, why and for how long? _____

_____

_____

_____

11. *Has your child witnessed domestic violence in the past? YES / NO (circle one)

12. *Does your child have a history of physical, sexual, or verbal abuse? YES / NO (circle one)

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13. What languages are spoken in the home? _____

a. If a language other than English is spoken in the home, which language is your child most fluent in? _____

b. What is your child's preferred language (if multiple languages are spoke in the home) ? _____

c. Which language was your child first exposed to? _____

d. How did your child come to learn English if they have? _____

_____

14. Does the family have any religious affiliations? YES / NO (circle one)

a. If so, how often do you attend services or activities related to your faith and religion? _____

15. What activities do the family complete together? _____

_____

MEDICAL HISTORY:

1. Does your child have any significant MEDICAL (not psychological) issues at the present time? YES / NO (circle one)

a. If so, please provide the diagnosis, date diagnosed, the person who diagnosed them, and treatment provided _____

_____

_____

_____

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2. Has your child undergone genetic testing in the past? YES / NO (circle one)

a. If yes, please explain the findings _____

_____

3. Is there a history of surgeries? YES / NO (circle one)

a. If yes, please list the dates and types of surgeries, and the doctor or practice who performed the surgery. _____

_____

4. Is there a family history of medical and genetic disorders NOT psychological disorders (i.e. Huntington's disease, Down's syndrome, hypothyroidism, etc.) YES / NO (circle one)

a. Please list along with the relationship of the family member.

_____

_____

5. *Is there a history of concussions, seizures, comas, or significant head injuries? YES / NO (circle one)

a. If your child has a history of significant head injuries or concussions, when did they occur and who diagnosed the concussion? _____

_____

b. If your child has a history of seizures, when was the last seizure? _____

_____

c. When was your child's first seizure? _____

d. Has your child ever lost consciousness during a seizure? YES / NO (circle one)

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6. Please list the primary care physician and the name of the practice.

_____

_____

7. Please list the name of the psychiatrist (they ONLY prescribe medication, they do not do therapy). _____

8. Please list prescribed medications your child currently takes:

a. Medication name: _____

i. When prescribed: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Prescribed for (i.e. depression): _____

b. Medication name: _____

i. When prescribed: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Prescribed for: _____

c. Medication name: _____

i. When prescribed: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Prescribed for: _____

d. Medication name: _____

i. When prescribed: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Prescribed for: _____

9. Please list any over-the-counter medications/supplements:

a. Medication name: _____

i. When began: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Used for: _____

v. Has your child's doctor been told about these? YES / NO (circle one)

b. Medication name: _____

i. When began: _____

ii. How much/how often: _____

iii. Side effects: _____

iv. Used for: _____

v. Has your child's doctor been told about these? YES / NO (circle one)

10. Have any other medications been prescribed and discontinued within the past year? YES / NO (circle one)

a. If yes, please list : _____

11. Has your child ever failed a hearing test? YES / NO (circle one)

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a. When was the last hearing test? _____

12. Does your child have a history of chronic ear infections? YES / NO (circle one)

a. If yes, how frequent were the ear infections? _____

_____

b. How were they treated? _____

_____

c. Did you notice any changes once the ear infections were resolved?

YES / NO (circle one)

i. Please list those changes: _____

_____

13. Does your child have a history of vision issues? YES / NO (circle one)

a. If yes, does your child have a prescription for glasses? YES / NO (circle one)

b. When were they prescribed? _____

c. Does your child wear the glasses regularly? _____

14. When was the last eye exam? _____

15. How many hours of sleep does your child receive per night? _____

16. Does your child have any difficulties with sleep? YES / NO (circle one)

a. If yes, please describe: _____

_____

_____

b. If your child has difficulty sleeping, how many nights per week does this occur?

_____

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c. How do the sleep difficulties impact your child? _____

_____

d. Does your child still wake rested in the morning? _____

e. When did these sleep difficulties begin? _____

f. Any history of nightmares/night terrors? YES / NO (circle one)

i. If yes, when did these begin? _____

ii. What time of night do they occur? _____

17. Has your child ever participated in any of the following:

a. Speech therapy - YES / NO (circle one)

i. Is your child currently in treatment? YES / NO (circle one)

ii. When did treatment begin? _____

iii. How long did treatment last? _____

iv. How often is/was treatment? _____

v. Where is/was treatment? _____

vi. What was the focus of treatment? _____

_____

b. Occupational therapy - YES / NO (circle one)

i. Is your child currently in treatment? YES / NO (circle one)

ii. When did treatment begin? _____

iii. How long did treatment last? _____

iv. How often is/was treatment? _____

v. Where is/was treatment? _____

vi. What was the focus of treatment? _____

_____

c. Physical therapy - YES / NO (circle one)

i. Is your child currently in treatment? YES / NO (circle one)

ii. When did treatment begin? _____

iii. How long did treatment last? _____

iv. How often is/was treatment? _____

v. Where is/was treatment? _____

vi. What was the focus of treatment? _____

_____

d. Applied Behavioral Analysis (ABA) therapy - YES / NO (circle one)

i. Is your child currently in treatment? YES / NO (circle one)

ii. When did treatment begin? _____

iii. How long did treatment last? _____

iv. How often is/was treatment? _____

v. Where is/was treatment? _____

vi. What was the focus of treatment? _____

_____

SUBSTANCE ABUSE OR EXPOSURE:

1. Has your child been exposed to illicit substances in the home? YES / NO (circle one)

a. If yes, please explain. _____

_____

_____

2. Does anyone in the home have a history of substance abuse? YES / NO (circle one)

a. If yes, please explain _____

_____

3. Has your child ever been administered CDB in any form? YES / NO (circle one)

a. If yes, please explain _____

_____

4. Does your child have a history of substance use? YES / NO (circle one)

a. If yes:

i. What type of substance? _____

_____

ii. How often? _____

_____

iii. Have you noticed changes in your child's functioning as a result of their use?

_____

_____

5. Does your child have a history of huffing? YES / NO (circle one)

6. Does your child use tobacco products (including vape pens)? YES / NO (circle one)

7. Has your child ever abused prescription of over the counter medications? YES / NO (circle one)

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LEGAL HISTORY:

1. Does your child have a history of arrests? YES / NO (circle one) a. If yes:

i. What were the charges? _____

_____

ii. When did they occur? _____

iii. What was the outcome? _____

_____

2. Does your child currently have a probation officer or GAL? YES / NO (circle one)

ACADEMIC HISTORY:

1. What school does your child currently attend (if school is out of session, what school was recently attend)? _____

2. What grade is your child currently enrolled in (if school is out of session, what grade was recently completed)? _____

3. Please list the contact information for a teacher. _____

_____

4. If your child is NOT currently in school, describe your child's daily activities and routines. Who watches your child during the day?_____

_____

_____

5. Has your child ever been suspended or expelled from school? YES / NO (circle one)

a. If yes, please note the dates and the reasons given for these punishments.

_____

_____

_____

_____

6. Has your child ever been held back a grade? YES / NO (circle one)

a. If yes, please explain what grade and the reason for being held back?

_____

_____

_____

7. Does your child have an IEP or 504 Plan at present? YES / NO (circle one)

a. If so, what accommodations are outlined by these plans? If not, are there discussions to create an IEP or 504 Plan? _____

_____

_____

8. Does your child participate in special education classes? YES / NO (circle one)

a. If so, how often and for what subject? _____

_____

_____

_____

9. Please describe your child's grades and subjects your child struggles with the most:

_____

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_____

_____

10. Which subjects does your child perform well at? _____

_____

_____

11. What are teachers' concerns? _____

_____

_____

_____

12. How would you describe your child socially? Shy/Outgoing/Social/Withdrawn?

_____

13. Does your child have a best friend? YES / NO (circle one)

a. If yes, who is it? _____

14. Who does your child prefer to play with? _____

15. Does your child have consistent interactions with same aged peers? YES / NO (circle one)

a. If no, who does your child play with? _____

b. If yes, where does your child play with others (i.e. neighborhood, school, after-school activities, at friend's homes). _____

_____

16. What kinds of activities does your child enjoy? _____

_____

_____

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17. What activities does your child participate in outside the home? _____

18. What activities do you complete as a family in the home? _____

19. How long does your child spend on screens per day

(i.e. phones, video games, computers, tablets)? _____

MENTAL HEALTH HISTORY:

1. Has your child ever had a history of suicidal thoughts? YES / NO (circle one)

a. If yes, when did these begin? _____

b. When did they last make a suicidal statement? _____

c. Has your child identified a way they would carry this action out?

YES / NO (circle one)

d. Do you have any concerns for the safety of your child? YES / NO (circle one)

e. Does your child have access to medications, weapons, or other means to harm themselves? YES / NO (circle one)

i. If yes, have you made any attempts to secure these items? YES / NO (circle one)

2. Does your child have a history of self-harm or self-injurious behavior? YES/NO (circle one)

a. If yes, when was the last incident? _____

b. Does the behavior leave significant marks or bruises? YES / NO (circle one)

c. When did these behaviors begin? _____

d. Is there anything that triggers the behavior? _____

_____

3. Does your child have a history of homicidal thoughts? YES / NO (circle one)

4. Does your child have a history of aggression towards others? YES / NO (circle one)

5. Has your child ever been hospitalized in an inpatient psychiatric facility? YES / NO (circle one)

a. If yes, what was the name of the facility? _____

_____

b. How long was your child hospitalized? _____

c. What diagnoses were assigned during the stay? _____

_____

_____

d. What kind of treatment was given? _____

_____

_____

_____

6. *Has your child ever mentioned that they saw things or heard things that others did not see or hear? YES / NO (circle one)

a. If yes, when do these occurrences happen most often? _____

_____

7. Is your child currently in mental health treatment? YES / NO (circle one)

a. With whom and for how long? _____

_____

_____

b. What was the focus of treatment? _____

_____

_____

_____

c. Was treatment helpful? Why or Why not? _____

_____

_____

8. List some of your child's strengths. _____

_____

9. List some of your child's areas in need of growth. _____

_____

10. What motivates your child? _____

_____

_____

11. If mental health treatment were recommended, what would you like to see addressed?

_____

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_____

_____

12. Please list any previous MENTAL HEALTH diagnoses assigned to your child. Please list who diagnosed the disorders and when.

_____

_____

_____

13. Please circle any family history of the following DIAGNOSED mental health and neurodevelopmental disorders. Also specify who (as related to the child) was diagnosed:

a. Depression

i. Family member: _____

b. Anxiety – Specify which type _____

i. Family member: _____

c. Bipolar Disorder

i. Family member: _____

d. Schizophrenia

i. Family member: _____

e. Obsessive-Compulsive Disorder

i. Family member: _____

f. Posttraumatic Stress Disorder

i. Family member: _____

g. Personality Disorder- Specify which one _____

i. Family member: _____

h. Learning Disorder

i. Family member: _____

i. Intellectual Disability

i. Family member: _____

j. Autism (or previous PDD or Asperger's Disorder)

i. Family member: _____

k. Developmental Delays

i. Family member: _____

l. Language Disorder

i. Family member: _____

m. Learning Disorder - Specify which one _____

i. Family member: _____

n. Attention Deficit Hyperactivity Disorder (ADHD)

i. Family member: _____

o. Other: _____

i. Family member: _____

CURRENT/PAST CONCERNS:

Please circle if any of the following have been an area of concern in the past and briefly describe it:

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History of trauma _____

_____

_____

_____

Depression _____

_____

_____

_____

Learning issues _____

_____

_____

_____

Anxiety _____

_____

_____

_____

Relationships _____

_____

_____

_____

Development _____

_____

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_____

_____

Self-harm _____

_____

_____

_____

Concerning behaviors _____

_____

_____

_____

Thank you for taking the time to complete this form!