Registration

to be completed by applicant, parent, guardian or assistant

Applicant _____ age___ sex___ birth date _____

address _____ city, state, zip _____

cell _____ work _____ home _____

eMail _____ fax _____ best time to call: home _____ work _____

preferences: ☐**any** contact is OK *-or-* ***HOME*** ☐no calls ☐no messages ☐no faxes ***WORK*** ☐no calls ☐no messages ☐no faxes

employer/school _____ job/grade _____

street address _____ city, state, zip _____

referred by _____ phone _____

personal physician _____ phone _____

Primary contact _____ relationship _____

address ☐ check if same as above: _____ city, state, zip _____

cell _____ work _____ home _____

eMail _____ fax _____ best time to call: home _____ work _____

preferences: ☐**any** contact is OK *-or-* ***HOME*** ☐no calls ☐no messages ☐no faxes ***WORK*** ☐no calls ☐no messages ☐no faxes

employer/school _____ job/grade _____

address _____ city, state, zip _____

Secondary contact _____ relationship _____

address ☐ check if same as above: _____ city, state, zip _____

cell _____ work _____ home _____

eMail _____ fax _____ best time to call: home _____ work _____

preferences: ☐**any** contact is OK *-or-* ***HOME*** ☐no calls ☐no messages ☐no faxes ***WORK*** ☐no calls ☐no messages ☐no faxes

employer/school _____ job/grade _____

address _____ city, state, zip _____

- I request initial consultative services for myself, my family, my client and/or my dependent. I understand that this consultation does not initiate a doctor/patient relationship and may result in a referral, report, discharge or consultation with a third party.
- If applying for a minor, I certify that I have the legal right to obtain consultation, evaluation and/or treatment.
- My permission for this service and/or release of information can be revoked at any time.
- I understand that I am responsible for the charges incurred for these services unless a specific payor (person, third party or agency) arranged for payment in advance. (Designate agency below). We do not accept assignment of benefits from private insurers.
- I read and understood the Privacy Policy and Practice Information documents provided.

Please specify payor: ☐ myself ☐ third party _____

Responsible party _____ date _____

Applicant _____ Age _____ Date of Evaluation _____

Filled out by [_] parent [_] other _____clinician _____

Use the lines below each section or the back of the page to explain your answers. Although some questions may be difficult to answer in the space provided, do your best to be brief and to the point. During the interview you can ask questions, explain your answers, discuss whatever you like.

This interview is used for children of all ages. For questions that are not appropriate for her age, just write in NA.

1. **What is the purpose of her evaluation?** What problems do you think she has?

Problem list: _____ _____

_____ _____

_____ _____

_____ _____

2. When did these problems start? _____ How long do you think it will take to take care of them? _____
3. What do you think caused them? _____

Treatment

4. Did she have counseling for ADD/ADHD, emotional or behavioral problems? [_] yes [_] no

Age	Where	Who treated her	What for	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Did she take medication in the past? [_] yes [_] no *(List current medications on page 4, past meds below)*

If so **What kind**	**What for**	**How much/how often**	**Doctor**	**She took it for** (how long)	**Until when**
Example: Ritalin	concentration/attention	15 mgs/ 2 times a day	Jones	2 years	until 6 month ago
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

6. Was she hospitalized for these or other problems? [_] yes [_] no If so, how many times? _____

Age	Where	His doctor	What for (diagnosis, if any)	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Did she have any BAD REACTIONS to medications? [_] no [_] yes _____

Was treatment helpful? [_] yes [_] no [_] sort of Explain: _____

7. Placements Other than treatment centers, list the places she lived when she did not stay with her mother or father.

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

age ___ to ___ [_] relative _____ [_] foster/group home _____ [_] shelter/detention _____ [_] other _____

Growing up

8. Did she have any MEDICAL problems [_] at birth [_] birth to age 3 [_] 3 to 5 [_] 5 to 12 [_] 12 to 18? [_] no

Please explain: *(put recent and current conditions on page 4)* _____

_____

9. Did she have DELAYS or problems with: [_] don't know

[_] crawling/walking [_] coordination [_] eating _____

[_] ear infections [_] growing [_] weaning _____

[_] learning to talk [_] toileting [_] attention _____

[_] staying alone [_] playing [_] learning _____

10. What words fit her PERSONALITY best: [_] social [_] leader [_] loner [_] joiner [_] fearful [_] temperamental [_] self-absorbed

[_] shy [_] careful [_] serious [_] scattered [_] fighter [_] withdrawn [_] impulsive [_] aggressive [_] thoughtless [_] gothic [_] stoner

[_] rigid [_] fearless [_] angry [_] fun [_] easy going [_] defiant [_] weird [_] studious [_] other _____

11. Did she have trouble GETTING ALONG _____ [_] no

with [_] other kids [_] brothers/sisters [_] parents _____

[_] teachers [_] other authority figures? _____

starting in [_] preschool [_] KG [_] grade ___ _____

Any past trouble with the law? [_] no [_] yes _____

[_] vandalism/theft [_] fires [_] drugs [_] truant _____

[_] hurt animals [_] gang activity [_] violence _____

12. Did she WORRY about [_] leaving home [_] going to school [_] safety/heath [_] being around people? [_] no

When worried, did she have [_] stomach pains [_] trouble sleeping [_] nightmares [_] panic attacks? Other: _____ [_] no

_____

[_] Did she ever try to harm herself? Explain: _____ [_] no

_____

13. Did she undergo TRAUMA such as [_] DEATHS, illness or losses [_] parents DIVORCED [_] witness ABUSE? [_] no

Was she abused, mistreated or abandoned? [_] yes [_] no <u>Explain this section below</u>

How was she PUNISHED? [_] NA _____

[_] timed out [_] grounded [_] points _____

[_] natural consequences [_] belted _____

[_] lectured [_] chores [_] other _____

_____

Was she [_] poorly accepted or _____

[_] rejected by her parents _____

[_] raised by foster parents? _____

_____

[_] Did her parents lose control? _____

[_] Did either use drugs or alcohol? _____

[_] Were they in trouble with the law? _____

Everyday life

14. School ________________________________ [ ] none. What grade is she in? _____ What grade should she be in?________

Learning disability [ ] NA [ ] yes:[ ] reading [ ] math [ ] written language [ ] verbal [ ] receptive [ ] expressive [ ] processing [ ] speech Other ______

Special classes: [ ] none [ ] resource [ ] self-contained [ ] other: ___________ Was she [ ] RPC'd [ ] Suspended [ ] Expelled [ ] Special schooled: _____________

Give some idea of her range of GRADES last year [ ] As [ ] Bs [ ] Cs [ ] Ds [ ] Fs. Is this different than before? [ ] yes [ ] no When did this change?________________________ Why? ____

15. Does she do chores or work [ ] NA? [ ] yes [ ] no What does she do? _____________________________________

16. Does she follow any religion or spiritual practice? ____________________ [ ] none

17. Problems and stress. Check all areas of concern.

[ ] **PERSONAL**	[ ] self-control	[ ] motivation	[ ] concentration	[ ] fatigue	[ ] mood	[ ] organization	[ ] grief
	[ ] family illness	[ ] health	[ ] accident	[ ] adoption	[ ] parenting	[ ] home/household/move(s)	
[ ] **RELATIONSHIP**	[ ] friend(s)	[ ] roommate	[ ] girl/boyfriend	[ ] coach/tutor	[ ] teacher	[ ] plays with younger kids	
[ ] **FAMILY**	[ ] fighting	[ ] conflicts/divorce	[ ] custody	[ ] sibling problems	[ ] parents	[ ] other relatives	
[ ] **SCHOOL**	[ ] performance	[ ] concentration	[ ] behavioral	[ ] disability	[ ] accommodation	[ ] conflicts	
[ ] **HABIT**	[ ] alcohol/drug	[ ] gambling	[ ] sexual	[ ] obsession	[ ] impulsivity	[ ] other behavioral	
[ ] **LEGAL**	[ ] probation	[ ] parental fitness	[ ] competency	[ ] drug/alcohol	[ ] community safety	[ ] criminal allegation	

18. Explain how she copes with stress:
____
____

How well do you think she is doing? [ ] poorly [ ] could be better [ ] varies [ ] very well [ ] in denial

19. What are her strengths and interests? [ ]reading [ ]writing [ ]music (what kind) ____________ [ ]play sports (which one) _____________

[ ]faith/prayer [ ]community/church [ ]building/mechanics/computer [ ]chores [ ]shopping [ ]collections [ ]video/computer games [ ]plays instrument

[ ]movies/TV [ ]art/photo [ ]travel [ ]friends/social [ ]blogs/chat/online [ ]gamble [ ]journal [ ]design /fashion [ ]coach/volunteer [ ] other: ________

Family

20. Did she go through divorce? [ ] yes [ ] no Was it difficult? [ ] yes [ ] no Is it still? [ ] yes [ ] no
Are/were there problems with [ ] legal custody [ ] physical custody [ ] visitation [ ] alimony/child support [ ] parental differences [ ] abuse allegations

Explain: ____
____

21. Have any of her blood relatives had EMOTIONAL, BEHAVIORAL or ADDICTION problems? [ ] yes [ ] no
[ ]addiction [ ]drugs [ ]alcohol [ ] learning disability [ ] ADHD [ ] Manic depression/bipolar [ ] depression [ ] anxiety [ ] panic [ ] autism
[ ] obsessive/compulsions [ ] psychosis/schizophrenia [ ] diagnosis unknown [ ] needed medication [ ] hospitalized [ ] other:___________

22. List her family members living in her home(s). Use an "[s]" in the box to indicate step-relative.

Example SUSAN SAMPLER_______ . age _15_ .[ ]mom [ ]dad [**S**]sister [ ]brother [ ]other _____--->[**X**] Lives with her [**X**] other home **her father**

Name ________________________ . age____. [ ]mom [ ]dad [ ]sister [ ]brother [ ] ____________---> [ ] Lives w/her [ ] other home_________

Name ________________________ . age____. [ ]mom [ ]dad [ ]sister [ ]brother [ ] ____________---> [ ] Lives w/her [ ] other home_________

Name ________________________ . age____. [ ]mom [ ]dad [ ]sister [ ]brother [ ] ____________---> [ ] Lives w/her [ ] other home_________

Name ________________________ . age____. [ ]mom [ ]dad [ ]sister [ ]brother [ ] ____________---> [ ] Lives w/her [ ] other home_________

Name ________________________ . age____. [ ]mom [ ]dad [ ]sister [ ]brother [ ] ____________---> [ ] Lives w/her [ ] other home_________

Name ________________________ . age____. [ ]mom [ ]dad [ ]sister [ ]brother [ ] ____________---> [ ] Lives w/her [ ] other home_________

Her visitation schedule is [ ] NA: ____

Health

23. Past and current MEDICAL PROBLEMS. Write in her age (approximate) when she was first diagnosed with:

Medical condition(s) and/or check below _____ [_] no medical problems

_____asthma/emphysema/lung disease _____genital _____Tourette's/other tics_____self-injury

_____serious injury to arms, legs, back _____thyroid/pituitary/hormone _____chronic fatigue _____wetting/soiling

_____blood pressure/anemia/valve _____urinary/bladder _____skin cancer/disease_____other cancer

_____ulcers/colitis/rectal/colon/esophagus_____prostate cancer/disease _____shaking _____AIDS/HIV/STD

_____jaundice/hepatitis/liver disease _____heart attack/heart disease _____paralysis/sensory _____kidney/renal

_____black-outs/epilepsy/seizures _____head injury/stroke/migraine_____infectious disease_____diabetes

_____eyes/ears/nose/throat _____lymphoma/leukemia/blood _____arthritis _____ear infections

Is your daughter having monthly periods? [_] NA [_] yes [_] no Using contraception? [_] yes [_] no Could she be pregnant? [_] yes [_] no

_____

24. Check any persistent or bothersome symptoms:

[_]back problems [_]headaches [_]allergies [_] bed wetting/soiling [_]stomach aches [_]nausea [_]vomiting [_]diarrhea
[_]bloody/black stools [_]unusual weight gain or loss [_]bladder control [_]leg swelling [_]excessive coughing or coughing blood
[_]chest pain [_]wheezing [_]fatigue [_]joint pain [_]muscular pain [_]visual problems [_]changes in sexual behavior [_]sleeping
[_]rash/abnormal itching [_]persistent fever [_]shortness of breath [_]drug problems Other _____

Last physical exam by doctor _____ Month/year _____

25. List below major accidents:

Date	Type of Injury	Location of accident	case pending?
_____	_____	_____	[_] yes [_] no
_____	_____	_____	[_] yes [_] no
_____	_____	_____	[_] yes [_] no

26. Did she ever have an EKG (heart monitor)? [_] yes [_] no Was it abnormal? [_] yes [_] no

27. Did she have a head injury, an EEG (brain wave test) or seen a neurologist (brain specialist)? [_] yes [_] no

28. List the medications she is allergic to: [_] penicillin [_] sulfa [_] others _____

29. Does she have a poor DIET? [_] yes In what way?_____ [_] no

30. CAFFEINATED beverages (energy drinks, colas, tea, coffee) each day?____ Tobacco [_] NA [_] chew [_] smoke_____

31. On average, how many cigarette packs does she smoke for how many years? [_] NA [_] quit __packs/day __years

32. **CURRENT MEDICATIONS** and TREATMENTS she is taking still. Also list herbal remedies and supplements.

	What kind	**What for**	**How much/how often**	**Prescribing doctor**	**How long**
Example:	DOXYCYCLINE	acne	100 mgs/ twice a day	Dr. Smith	1 year
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Drug and Alcohol Profile

Check here if this section is [_] Not Applicable

Has anyone told her they were concerned about her drug or alcohol use? [_] yes [_] no
Does it annoy her when others tell her how they feel about her drinking or use? [_] yes [_] no
Has she ever felt guilty about drinking? [_] yes [_] no
Did she ever drink to get the day started when she first woke up (had an eye-opener)? [_] yes [_] no

Has she ever: had a seizure while withdrawing from alcohol or drugs? [_] yes [_] no
hallucinated, had shakes, anxiety, agitation or physical craving after stopping? [_] yes [_] no
gone to two or more, or switched doctors to get more prescriptions? [_] yes [_] no

Has she ever lost memory due to alcohol or drugs? [_] temporarily [_] permanently [_] Ever blacked out?
Ever overdose [_] on purpose? [_] by accident? [_] go to the hospital? [_] stomach pumped? [_] admitted overnight?
If she no longer drink or use drugs, why did she stop?._____

Ever go to [_] AA [_] NA [_] CA [_] ACOA [_] Al-anon [_] Ever have a sponsor? [_] Is she familiar with the 12 steps?

Check all the substances she has tried and circle her favorites.

	When did she start? Age	How much and how often do/did she use? Cost per week.	Did she stop?	When
[X] EXAMPLE (weed)	10	One or two blunts every day, $50 to $300 per week	[X] yes [_] no	2 months ago
[_] alcohol	_____	_____	[_] yes [_] no	_____
[_] weed/marijuana	_____	_____	[_] yes [_] no	_____
[_] crystal meth/speed	_____	_____	[_] yes [_] no	_____
[_] cocaine/ crack	_____	_____	[_] yes [_] no	_____
[_] XTC/ecstasy/MDMA/X	_____	_____	[_] yes [_] no	_____
[_] heroin	_____	_____	[_] yes [_] no	_____
[_] mushrooms/peyote	_____	_____	[_] yes [_] no	_____
[_] LSD/ PCP	_____	_____	[_] yes [_] no	_____
[_] GHB/ DXM/ K	_____	_____	[_] yes [_] no	_____
[_] sherm	_____	_____	[_] yes [_] no	_____
[_] Xanax/Valium/Ativan	_____	_____	[_] yes [_] no	_____
[_] barbiturates	_____	_____	[_] yes [_] no	_____
[_] other prescriptions	_____	_____	[_] yes [_] no	_____
[_] huffing paint, glue, etc.	_____	_____	[_] yes [_] no	_____
[_] other _____	_____	_____	[_] yes [_] no	_____

[_] I mixed them as follows _____

_____

[_] Did she get into legal or other trouble in any way due to her substance use? Please explain:

_____

_____

List any other addiction she might have. _____

CHILD Psych Symptoms Checklist –(Girl)

Daughter's Name _____ Date _____ Filled out by _____ Relationship _____

This questionnaire defines your daughter's problem areas. Many of these questions may not apply. Some may sound strange *or be inappropriate but please do your best. You can ask questions and explain your answers during the interview.*

Check NOW, PAST, or N/A (Not Applicable/appropriate) for each line as it applies to your daughter NOW, in the past only, both or neither.

For example:

NOW	PAST	N/A	
[x]	[x]	[ ]	Does your daughter like to watch television?
[ ]	[ ]	[x]	Does your daughter drive carefully?
[x]	[ ]	[ ]	Does your daughter have allergies?
[ ]	[x]	[ ]	Does your daughter wet her bed?

If your daughter has DEPRESSION, please describe what it is like for her: (If not, check [ ] here, and move on to page 2)

NOW	PAST	N/A	
[ ]	[ ]	[ ]	Does her depression or sadness COME AND GO frequently?
[ ]	[ ]	[ ]	Do her moods come OUT of the BLUE?
[ ]	[ ]	[ ]	Is her depression triggered by things that HAPPEN?
[ ]	[ ]	[ ]	Does she stay depressed for 2 WEEKS or more with little if any relief?

When she is depressed, does she:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	… lose her ENERGY?
[ ]	[ ]	[ ]	… have a "WHATEVER" attitude *only* when she is depressed?
[ ]	[ ]	[ ]	… lose INTEREST in everything? … [ ] slow down … [ ] become RESTLESS?
[ ]	[ ]	[ ]	… lose her APPETITE? … [ ] LOSE weight … [ ] GAIN weight?
[ ]	[ ]	[ ]	Does she have trouble FALLING ASLEEP?
[ ]	[ ]	[ ]	… wake up in the [ ] MIDDLE of the night, or [ ] EARLY in the morning? [ ] wake up IN A PANIC?
[ ]	[ ]	[ ]	… need a lot of NAP TIME?
[ ]	[ ]	[ ]	Does your daughter wake GASPING for breath? [ ] SNORE?

During periods of depression, does your daughter:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	… get very ANGRY AT HERSELF? … [ ] all the time? … [ ] only when very depressed?
[ ]	[ ]	[ ]	… feel GUILTY for things that are not her fault?
[ ]	[ ]	[ ]	… STAY ALONE … [ ] MOPE around?
[ ]	[ ]	[ ]	… have trouble THINKING or CONCENTRATING?
[ ]	[ ]	[ ]	… CRY easily … [ ] seem DESPERATE?

If your **daughter** has thoughts about hurting herself:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	Do you have reason to believe she has INJURED HERELF on purpose?
[ ]	[ ]	[ ]	Do you think she has THOUGHTS about taking her life?
[ ]	[ ]	[ ]	Do you think that she has PLANS to do it?
[ ]	[ ]	[ ]	Has she ever TRIED to end her life?

[ ] Do you think she has any such thoughts or plans NOW?

Is your daughter ever ON EDGE (anxiety or panic) to an extreme? (If not, check [ ] here, and move on to the next section.)

NOW	PAST	N/A	
[ ]	[ ]	[ ]	Do her nerves effect EVERY PART of her life?
[ ]	[ ]	[ ]	Does she have sudden ATTACKS …[ ] MINUTES or … [ ] HOURS that go away quickly?
[ ]	[ ]	[ ]	…does she stay nervous for a …[ ] FEW DAYS, or … is it [ ] ALWAYS THERE?
[ ]	[ ]	[ ]	Does your daughter complain about FEELINGS IN HER BODY when she gets upset, such as…
[ ]	[ ]	[ ]	PAINS in her …[ ] CHEST, …[ ] HEAD or …[ ] STOMACH?
[ ]	[ ]	[ ]	When nervous, does your daughter have trouble BREATHING?
[ ]	[ ]	[ ]	complain that her …[ ] HEART POUNDS? …[ ] LOSES FEELING in her hands, head or feet?
[ ]	[ ]	[ ]	Does your daughter look SHAKY, SWEATY, FLUSHED or DIZZY when she gets nervous?
[ ]	[ ]	[ ]	Does your daughter AVOID PEOPLE or …[ ] THINGS? _____ (For instance)
[ ]	[ ]	[ ]	Does she have extreme NIGHTMARES?
[ ]	[ ]	[ ]	Does she talk about memories that are so real, it's like she is actually LIVING them?
[ ]	[ ]	[ ]	Does she ever seem to be OUT OF TOUCH like she is OUTSIDE OF HER BODY as though she is watching a movie of her life instead of living it?

Does your daughter have abnormal MOVEMENTS of her face or other parts of her body?
(If not, check [ ] here, and move on to the next section below.)

NOW	PAST	N/A	
[ ]	[ ]	[ ]	Does she get movements or irritations in her THROAT or MOUTH such as throat clearing or sniffing?
[ ]	[ ]	[ ]	Do her hands SHAKE a lot of the time?
[ ]	[ ]	[ ]	Do other parts of your her body JERK uncontrollably?
[ ]	[ ]	[ ]	Does this happen only when she is nervous?
[ ]	[ ]	[ ]	Does it happen at BEDTIME when she is trying to fall asleep?
[ ]	[ ]	[ ]	Does your daughter call out FOUL LANGUAGE out of the blue as though she has no control?
[ ]	[ ]	[ ]	Does your daughter have severe HEADACHES?
[ ]	[ ]	[ ]	Has she ever …[ ] BLACKED-OUT … [ ] had FITS … [ ] FAINTED … [ ] SEIZURE(S)?
[ ]	[ ]	[ ]	Has your daughter WET or SOILED her clothes? … [ ] DURING BLACKOUTS?

Does your daughter have:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	THOUGHTS that just WON'T GO AWAY?
[ ]	[ ]	[ ]	… the need to DO THINGS OVER AND OVER almost unable to stop?
[ ]	[ ]	[ ]	… uncontrollable urges such as CHECKING her body, locking the door over and over again, washing, counting, or having to have everything … [ ] "JUST SO"?
[ ]	[ ]	[ ]	If your daughter tries to control these, does it seem to be extremely UNCOMFORTABLE for her?

Does your daughter take things very SERIOUSLY to the point that she performs:

[ ]	[ ]	[ ]	RITUALS, ROUTINES or HABITS that don't make sense?
[ ]	[ ]	[ ]	Would you or others describe your daughter as RIGID?
[ ]	[ ]	[ ]	Do you ever think that your daughter's "trying to be PERFECT" gets out of hand?

Does your daughter

NOW	PAST	N/A	
[ ]	[ ]	[ ]	BINGE eat or PURGE food?
[ ]	[ ]	[ ]	Use LAXATIVES or make herself VOMIT?
[ ]	[ ]	[ ]	Does your daughter think he or she is over-weight whiles others see her as just fine?

Has she done things OUT OF CHARACTER such as:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	Gone SEVERAL NIGHTS WITH LITTLE IF ANY SLEEP?
[ ]	[ ]	[ ]	SPENT a lot? … [ ] GAVE away THINGS she treasured?
[ ]	[ ]	[ ]	Shown a lot of … [ ] ENERGY? Acted exceptionally … [ ] STRONG or… [ ] SMART?
[ ]	[ ]	[ ]	Treated OTHERS POORLY, acted RUDE, HOSTILE or ARGUMENTATIVE out of character?
[ ]	[ ]	[ ]	Did your daughter feel SHAME or regret LATER about unusual things she did?
[ ]	[ ]	[ ]	Has her SEXUAL DRIVE or behavior ever been a concern to you?
[ ]	[ ]	[ ]	Does she get very, very focused on HORROR films, PAIN or REVENGE?
[ ]	[ ]	[ ]	Did your daughter show signs of EXTREME JEALOUSY?
[ ]	[ ]	[ ]	Do these characteristics come and go together in episodes?
[ ]	[ ]	[ ]	Are they part of her EVERYDAY behavior?
[ ]	[ ]	[ ]	Do you think these out of character reactions are due only to drug use?
[ ] Is your daughter showing these characteristics now?			

Did your daughter ever say that BIZARRE things were happening, such as:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	VOICES whispering, talking, calling her name or swearing at her?
[ ]	[ ]	[ ]	SMELLING things no one else does?
[ ]	[ ]	[ ]	… heard or saw THINGS or PEOPLE that no one else does?
[ ]	[ ]	[ ]	… lost her sense of DIRECTION … [ ] MEMORY?
[ ]	[ ]	[ ]	Has your daughter ever said that things looked like they were breathing, shrinking or growing?

Has she:

NOW	PAST	N/A	
[ ]	[ ]	[ ]	stopped TAKING CARE of herself?
[ ]	[ ]	[ ]	become ill at ease WITH PEOPLE?
[ ]	[ ]	[ ]	… lost her SENSE OF HUMOR?
[ ]	[ ]	[ ]	… said that the RADIO or T.V. was TALKING to her?
[ ]	[ ]	[ ]	… said her THOUGHTS WERE BEING READ or CONTROLLED?
[ ]	[ ]	[ ]	Does she have thoughts or beliefs that are IRRATIONAL and hard to follow, understand or believe (aside from those other kids her age might have)?
[ ]	[ ]	[ ]	Do you think ALCOHOL or DRUGS were responsible for these reactions?

Would you use any of the following terms to describe your daughter's USUAL behavior?

[ ] Selfish	[ ] Steals	[ ] Inattentive	[ ] Stubborn	[ ] Hurts animals
[ ] Fidgety	[ ] Sets fires	[ ] Destructive	[ ] Anti-authority	[ ] Lacks conscience
[ ] Lies	[ ] Fights	[ ] Restless	[ ] Distractible	[ ] Insensitive to pain
[ ] Willful	[ ] Argues	[ ] Irresponsible	[ ] Calls out in class	[ ] Can't wait turn
[ ] Bullies	[ ] Cheats	[ ] Disrespectful	[ ] Short attention	[ ] Acts without thinking
[ ] Hateful	[ ] Whines	[ ] Demanding	[ ] Takes risks	[ ] Uncaring about others
[ ] Abusive	[ ] Defiant	[ ] Out of control	[ ] Manipulative	[ ] Other:

Describe any illegal or other activities not covered elsewhere that you are concerned about below or on the back.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			

Release of information

Filled out by applicant, parent or guardian, completed by assistant..

Today's date _____

Applicant _____ Age ____ Sex _____ Date of Birth: _____

I hereby authorize Dr. Roitman and his staff to (check all that are applicable):

- ❒ exchange information with:
- ❒ only request information from:
- ❒ only release information to:

Name _____ Title _____

Street _____

City, State and Zip Code _____

Phone _____ fax _____ cell _____ **Initial** _____

Name _____ Title _____

Street _____

City, State and Zip Code _____

Phone _____ fax _____ cell _____ **Initial** _____

Name _____ Title _____

Street _____

City, State and Zip Code _____

Phone _____ fax _____ cell _____ **Initial** _____

NORTON A. ROITMAN, MD
2340 PASEO DEL PRADO #D 307
LAS VEGAS, NEVADA 89102
Phone 702-222-1812 Fax 702-297-6561 eMail: NRoitmanMD@gmail.com

The purpose of this release of information is to

- ❒ Coordinate treatment with other providers
- ❒ Verify attendance
- ❒ Evaluate status
- ❒ Obtain assistance
- ❒ Other _____

I release Norton A. Roitman, MD and his staff from any legal liability resulting from the release of this information with the understanding that reasonable professional safeguards will be taken. Unless otherwise specified, release authorization will expire in one year. Release of information is subject to revocation at any time.

Responsible party _____ Staff _____

Privacy Practices

This document describes the information processes and protections of this practice. You should know how we conduct our practice and assure your privacy.

Prescribing

Certain prescriptions require an original for each fill, such as most ADD medications. Others require a new prescription after the 6 refills, such as antianxiety medications. Some can be filled, after shown to be safe and effective, for up to a year. We prepare your original prescription on a word processor and hand it to you, usually with prescribing and risk information attached. For refills, you pharmacy will fax us a form to complete. We receive and return these forms to them through by fax by way of gmail and HelloFax, a paperless method that replaces a fax machine. Prescriptions and protected pharmacy information on paper does not float around this office. Prescribing and all medical information are digitalized and are stored in password protected computers on a dedicated password protected network.

Invoices and payments

The practice uses QuickBooks in a dedicated local cloud server to track services and prepare invoices. We send invoices by email (gmail) to the payor. We produce diagnostic and service codes for you on the invoice for you to submit for insurance reimbursement, but we don't accept assignments of payments the insurance companies. The invoice should help you to get the benefit allowed by your insurance. Payment at time of service is expected unless other arrangements are made and approved by Dr. Roitman. We accept cash, checks, Amex, MasterCard or Visa.

Communications

We ask your permission to phone, text, email, fax, FaceTime or (when prearranged) Skype you or your family member with the understanding that Skype, and metadata on emails, may not be 100% secure. The degree of security is just like that you have for your private home operations.

Medical records

We produce your record on an Apple Word processor (Pages) that most computers can't open, so if they are sent accidentally, almost never able to be opened. They are produced and stored in a cloud server (Dropbox) which has encrypted storage. Although the metadata (file names) could theoretically detected during transmission to storage, no contents is at risk. This is similar to gmail. We have looked at alternative sites and dedicated servers, but the degree of risk is so small, and the advantage of using universal digital tools and software like these, the decision was to stick with these services. We send record requests by converting the word processing document to PDFs and then send by HelloFax.

Storage and Archives

There are no paper records in the office. The server keeps an archive of every document produced including changes and additions over time. In addition, we use Time Machine backs up for files on a hard drive at a distant location that refreshes on an hourly basis. This drive is encrypted and password protected so it can't be stolen and broken into. Time Machine archives the original and versions of each file. All paper records received or produced elsewhere are scanned. Hard copies are retained for a month under lock and key, and then shredded. We don't destroy digitalized files so your medical record is accessible in case you need it in the future. Old records have been scanned and stored in PDF format.

Medical record content

Proper medical records only track the diagnostic information necessary to guide treatment, such as observations about the effect of medications and their side effects, assessment of other interventions, referrals, labs and future planning. They should document a doctor's reasoning underlying the choice of treatments. The greatest protection against invasion of privacy is selective recording of information, eliminating that which is not relevant to the medical treatment. The practice avoids documenting the names of other people in a patient's file or complicated interpersonal issues. We don't record particulars about conflicts such as who said what to whom. Wishes and fears are recorded only about their pertinence to treatment. Other desires or other personal, private thoughts do not get recorded unless it is necessary to document risks or benefits of treatment.

Routinely information in the records contain whether the patient showed up, what their feeling tone has been in general, examples of improvement or set backs, target behaviors and observations related to medical and psychiatric treatments. Results to date, plans, side effects, prescriptions and informed consents are what they contain. Personal, libelous or embarrassing content not relevant to treatment, especially that which could harm a party, are not recorded. Just as a surgeon records the size, depth and complications of a laceration, and does not describe the person who stabbed them or what the fight was about, psychiatry, as any medical speciality, is concerned with signs and symptoms of disorders. It is not be necessary to record beyond the psychiatric injury except concerning how it was produced and how it can be mitigated.

information releases

The government has a right to records under conditions such as terrorism threat, emergencies, etc and the Board of Medical Examiners may request records to determine whether a doctor is conducting their practice appropriately. Records are be released in case of medical emergencies. Courts can order the release for a variety of reasons, and your insurer will ask to review them if you use your insurance. You may request a release to another provider or ask for a copy yourself at any time. Unless the record is judged to possibly psychologically injure you, it will be released. We think that your record should be accountable and transparent and every entry is chosen with forethought and your privacy in mind.

Online services

Gmail is our email program and is SSL secure and HIPAA compliant. Skype is not complaint and we would need your permission to use it for distant services. We have access to Apple's FaceTime which is HIPAA complaint. Phone sessions are an option. Phones have their limits too, but have always been accepted, as have faxes. Texting is convenient for recording instructions for medication use and provides both parties with a written record about risk and benefit and in this way is superior to voice communications for certain communications. The practices uses an iPhone that is password protected as are all 5 computers on the network. If there is frequent or extensive use of online services, the practice may issue a charge commensurate with the time spent, inconvenience, the urgency of a service or the delivery of therapeutic services off hours. Normally a simple communication or required task is not a chargeable item. When the online service is substituting for outpatient, in office service a charge may be issued.

In summary

HIPAA privacy regulations and standard electronic health records are mostly designed for major health care organizations with many personnel and employee turnover, who could be targets from a variety of sources. They are major financial targets as well. They have complicated computers systems and billing software. Healthcare companies are require to have compliance offices, audits and signed forms, and quality assurance systems. As a small solo practitioner, it is not possible to keep up with changing rules and multilayered requirements. We don't think it is feasible a very small private practice like ours to be compliant the way major health care organizations have to be. If any party is intent on invading your privacy they will find a way around the basic HIPAA regulation anyway. In our estimation, this disclosure meets meet the intent of HIPAA privacy regulations and we are confident in our safety and privacy protection. The practice has always been respectful and based its processes on traditional medical values of total privacy. If you need additional safeguards please let us know and we will accommodate you.

I have read this Privacy Practices document regarding communications, privacy standards, medical records, information storage, prescribing and invoicing. By signing below I signify that I've had the opportunity to discuss them and I accept the Privacy Practices above. I am informed about how this office manages practice information systems and give my consent.

Responsible party date

Witness date