

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

Client Registration Information

(PLEASE PRINT CLEARLY)

CLIENT
NAME _____ **DATE** _____

DATE OF
BIRTH _____ **AGE** _____

Name of Legal Guardian (if applicable) _____

CLIENT
ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

CLIENT PHONE NUMBER _____

MARITAL STATUS: *(circle)* SINGLE ENGAGED MARRIED SEPARATED
DIVORCED WIDOWED IN A RELATIONSHIP LIVING WITH A PARTNER

EMPLOYMENT STATUS: *(circle)* FULL-TIME PART-TIME RETIRED
DISABLED UNEMPLOYED FULL-TIME STUDENT PART-TIME STUDENT

In Case of an Emergency notify *(specify relationship to patient):*

NAME _____ **RELATIONSHIP** _____

EMERGENCY CONTACT'S PHONE: _____

PLEASE TELL ME HOW YOU HEARD ABOUT ME: _____

CLIENT SIGNATURE (OR LEGAL REPRESENTATIVE) _____ **DATE** _____

MARIYA KHOLODOVA, Ph.D. _____ **DATE** _____

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**INFORMED CONSENT TO TREATMENT
AND
NOTICE OF BUSINESS POLICIES AND PRIVACY PRACTICES**

This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

ABOUT YOUR PROVIDER:

I have a doctorate degree in clinical psychology from Alliant International University, San Diego, and I am a licensed psychologist in the state of California. I have experience in both individual and group psychotherapy with adults and adolescents; I also have experience in couples counseling. I have worked in various clinical settings throughout my career, and have provided treatment for mood disorders, anxiety disorders, trauma, substance abuse, divorce, domestic violence, grief, and relationship concerns, among other clinical issues. If you have any questions regarding my training and qualifications, I would be happy to discuss them with you. I look forward to working with you.

COMMUNICATION:

I am available between the hours of 9:00 a.m. and 7:00 p.m., Monday through Friday. I am generally able to return voicemail messages within 24 hours. I am not, however, always able to return emergency messages right away. If you are in need of immediate help and I can't reach you soon enough, please call 911 or the San Diego Crisis Line at 1-888-724-7240. Please keep in mind that email and texting are not the secure ways to transmit confidential information. To discuss confidential matters, emergency situations, and safety concerns, please call me instead.

If I leave on vacation and if you would like to continue your sessions while I am away, I will designate another therapist to see you for the duration of my absence. Both you and I will discuss this prior to my departure. If you decide not to see another therapist in my absence, please call the Access and Crisis line (888-724-7240) or call 911 if you are in need of immediate assistance or if you are experiencing a psychiatric crisis (i.e. having thoughts of harming yourself or harming another person).

PSYCHOTHERAPY:

In general, psychotherapy is a type of treatment of psychological concerns that uses the strategies of talking, in addition to other techniques. The goal of therapy is to relieve or change emotional, behavioral, or cognitive factors that may stand in the way of living a healthier, happier, and a more meaningful life. Another goal of psychotherapy could be self-exploration – to learn more about yourself.

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Each psychotherapy session will last approximately 45 minutes. Please remember that your session starts and ends at the scheduled time. If you are late, your session will still end at the scheduled time and you will be responsible for the entire fee, regardless of how late you were. Generally, clients attend sessions once a week for 45 minutes.

Occasionally, I see clients more or less often than once a week. Both you and I will agree on the frequency of sessions, according to your needs.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own impressions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures or become dissatisfied for any reason with your clinical care, please let me know your concerns as soon as possible. This may provide you with a helpful means to work through the issues that concern you about your treatment. If your doubts persist or if you are still unhappy with your care, I will be happy to provide referrals to you to see a different therapist. I also suggest you discuss terminating treatment with me before doing so, as the majority of clients find this to be a beneficial part of their treatment.

MY APPROACH:

My approach to therapy is psychodynamic and cognitive behavioral in orientation. I use a variety of techniques in therapy, trying to find what will work best for you. These techniques are likely to include dialogue, interpretation, and cognitive reframing, among others. 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 corollary medical treatment that could help you. You have the right to refuse anything that I suggest.

RISKS INVOLVED:

Therapy has potential emotional risks. Approaching feelings or thoughts that you have tried to distance yourself from may be painful, and may sometimes, temporarily, disrupt relationships or other aspects of your life. Learning new strategies and releasing the old ones can be frightening and energy consuming. It is important that you consider carefully whether these risks are worth the benefits to you. Most people who take these risks find that therapy is helpful. It is important to remember that there are no guarantees of what you will experience or if the treatment will work for you.

CONSULTATION:

To ensure that I am providing you with appropriate care, I may, on occasion, consult (talk) about your treatment with another mental health professional. I will not reveal your full identity, and the other professional is also legally bound to maintain the confidentiality of your information.

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 chose, and you can change your mind and revoke that permission at any time. You may also request anyone you wish to attend a therapy session with you.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record. In addition, please note that text messages can, in theory, be retrieved by your cell phone company, and hence, are not confidential either.

The following are the exceptions to your right to confidentiality:

- 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 and Adult Protective Services.
- 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 obligated to protect your

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safety, and would explore all other options with you before I involve other parties. If at that point you were unwilling to take steps to guarantee your safety, I would call the police or the crisis team.

4. In general, if you get involved in court proceedings you can prevent me from testifying about what you have told me. This is called privilege, and it always your choice to invoke it or waive it allowing me to testify. However, I cannot assert privilege on your behalf if I receive a court order instructing me to testify in legal proceedings that you might be involved in, or instructing me to release any/all records.

5. Section 215 of the Patriot Act of 2001 requires mental health providers to disclose parts or all of the client's record (if requested by the FBI) and prohibits the therapist from disclosing to the client that an FBI agent sought or obtained the client's personal information under the Act.

6. If you are using your insurance plan to pay for my fees, I am required to disclose certain information about your treatment to the insurance company. This information may include your diagnosis, my fee, dates of service, treatment plan, or/and a summary of treatment.

REKORDKEEPING:

The laws and standards of my profession require that I keep treatment records. What may be included in your record is the initial assessment, intake paperwork, your diagnosis, notes regarding each session, any communication that occurs outside of session, any information released to third parties, court documents, and other paperwork I receive or send out regarding your treatment. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them, or a treatment summary to a mental health professional of your choice. You will be charged a fee for any time spent in preparing information requests. I do not keep electronic records at this time.

DIAGNOSIS:

Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If you are using your insurance plan to pay for my services, I am normally required to give a diagnosis in order to be paid. If you do not meet the criteria for a mental health diagnosis, I will not be able to bill your insurance. In that case, you will be responsible for payment for my services.

TERMINATION:

You have the right to end your treatment any time for any reason. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures or become dissatisfied

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for any reason with your clinical care, *please let me know your concerns as soon as possible*. This may provide you with a helpful means to work through the issues that concern you about your treatment. If your doubts persist or if you are still unhappy with your care, I will be happy to provide referrals to you to see a different therapist. I also suggest you discuss terminating treatment with me before doing so, as the majority of clients find this to be a beneficial part of their treatment.

You alone or both of us together will decide when therapy will end *except under the following circumstances*:

1. If we have contracted for a specific short-term work, we will finish therapy at the end of that contract.
2. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs.
3. If you or a person close to you does violence to, threatens verbally or physically, or harasses myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but I cannot guarantee that they will accept you for therapy.

Psychotherapy is not the only option for dealing with emotional concerns. Depending on the reasons that led you to seek therapy, alternative options that may be helpful for you may include meditation, yoga, diet and exercise, psychiatric medications, pastoral counseling, and others.

OTHER RIGHTS:

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I am doing, and to look at alternatives that might work better. Please feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing your concerns with me, you can always contact California Board of Psychology, and they will review your complaint.

Board of Psychology
1625 North Market Blvd., Ste. N-125
Sacramento, CA 95834
866-503-3221

PAYMENT INFORMATION:

Please Read This Information Carefully Regarding Your Financial Responsibility.

1. My fee is \$200 per session with each session lasting approximately 45 minutes. Payment is made in the beginning of the session on the day of service, unless prior arrangements have been made. I accept cash or check.
2. Payment of any unpaid balance on an account must be received in full before close of the month. You will be charged a \$30 fee for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings for which you agree to pay all associated costs.
3. If you have health insurance, it will usually provide some coverage for mental health treatment. I am an in-network provider with Anthem Blue Cross, Blue Shield, Magellan, and Aetna. Please note that *you* are financially responsible for my fees if your insurance plan does not cover my services for any reason (unless I made a billing error and in that case I will resubmit the claim).
4. I also accept other PPO plans as an out-of network provider. If I am an out-of-network provider with your insurance plan and if you plan to seek reimbursement for a part of my fee, I will provide a signed receipt with the necessary information for you to submit to your insurance company.

Please note that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes, I have to provide additional clinical information such as treatment plans or treatment summaries. This information will become a part of the insurance company files and will probably be stored in the computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide your insurance company with only the information required in order to meet their administrative needs. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above. *By signing this consent, you authorize me to provide information to your insurance company as needed for payment for my services.*

5. You are financially responsible for sessions missed without a 24-hour advance cancellation. Please keep in mind that you will be charged a full fee for the missed appointment.

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6. Insurance plans do not reimburse for late notice cancellations or missed appointments. Phone calls are charged at the usual session rate and charges are made if they last longer than five minutes. Your insurance company may not provide reimbursement for phone calls.

Please provide the following information for your insurance plan:

INSURANCE COMPANY: _____

NAME OF INSURED SPONSOR: _____

SPONSOR DATE OF BIRTH: _____

SPONSOR ADDRESS: _____

SPONSOR PHON NUMBER: _____

GROUP NUMBER: _____

POLICY NUMBER: _____

Client Consent to Psychotherapy

I have read this statement (Informed Consent to Treatment and the Notice of Business Policies and Privacy Practices), had sufficient time to be sure that I considered it carefully, and asked any questions that I needed to understand it fully. I agree to pay the agreed upon fee per session. I understand my rights and responsibilities as a client, and I understand my therapist's responsibilities to me. I agree to undertake therapy with Mariya Kholodova, Ph.D., and I know I can end therapy at any time. I know I can refuse any requests or suggestions made by Mariya Kholodova, Ph.D.

I have read, understand, and agree to comply fully with the above policies (pages one through eight). I accept full financial responsibility for all professional services rendered.

CLIENT SIGNATURE (OR LEGAL REPRESENTATIVE)

DATE

MARIYA KHOLODOVA, Ph.D.

DATE

NOTICE OF PRIVACY PRACTICES (HIPAA)

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. As required by “HIPAA” I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I may use and disclose your medical records only for the following purposes:

- Treatment - providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment - such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running my practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. I may also create and distribute de-identified health information by removing all references to individually identifiable information. I may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing - I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other persons identified by you. I, however, am not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from me by alternative means or at alternative locations.

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- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from me upon request.

I am required by law to maintain the privacy of your protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of my Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with my office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of my office. I will not retaliate against you for filing a complaint. Please contact me for more information at the address listed at the top of this page.

For more information about HIPPA or to file a complaint:
The U.S. Dept. of Health & Human Services Office of Civil Right
200 Independence Avenue, S.W.
Washington, D.C. 20201

CLIENT SIGNATURE (OR LEGAL REPRESENTATIVE)

DATE

MARIYA KHOLODOVA, Ph.D.

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ADDITIONAL CONFIDENTIALITY CONSIDERATIONS WHEN TREATING MINORS OR DEPENDENT ADULTS

This written policy is intended to inform you, the client’s legal representative or responsible party, about confidentiality issues specific to treating minors or dependent adults, and supplements the documents already given to you that deal with related issues of privacy in therapy.

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is important in securing and maintaining that trust. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy, or for older adults who have already lived such a life. By signing this agreement, and although it is not legally binding, you are waiving your right of access to the patient’s clinical record.

It is my policy to provide you with general information about treatment status. I will meet with you or communicate regularly with you if that is important for us. I will tell you if your child or an older adult does not attend sessions.

There are important exceptions to the confidentiality limitations. It is possible that the client will reveal sensitive information about sexual contact, alcohol and drug use, or other potentially high risk behaviors. Sometimes these behaviors are experimental, occasionally they are regularly occurring practices, and sometimes they escalate to behaviors that involve imminent threat to the health or safety of the patient. I am only allowed by law to violate confidentiality when there is an imminent threat of harm.

Your signature below indicates that you have read the information in this document and agree to abide by these terms during our professional relationship. If you have any questions or concerns regarding this information, I would be happy to discuss them with you.

SIGNATURE OF THE PARENT OR LEGAL REPRESENTATIVE **DATE**

CLIENT SIGNATURE **DATE**

MARIYA KHOLODOVA, Ph.D. **DATE**

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Background Questionnaire for Parents

Instructions: Please take a few minutes to answer these questions. If you are uncertain about any question, leave it blank and we will discuss it later. Thank you.

Child's Name:

Date:

Your Name:

Relationship to child:

Please answer the following questions regarding the child:

Address:

Telephone: _____

Age: _____

Sex:

Date of Birth: _____

Place of birth: _____

School: _____ Teacher: _____ Grade: _____

Pediatrician: _____ Date of last physical: _____

Please list everyone who lives with the child:

What brings you/your child to see me today and why *now*?

Has your child seen a *therapist* before? If yes, please provide the following: the name of the therapist, when your child saw him/her, and the reason for seeking treatment. Was it helpful? Why/why not?

Has your child ever seen a *psychiatrist* before? If yes, please provide the doctor's name, when your child saw this doctor, and what medications were prescribed.

Is your child seeing a psychiatrist currently? Please provide the name of the treating psychiatrist and list the medications that your child is currently prescribed.

I. FAMILY COMPOSITION

1. Please answer the following questions regarding the child's natural father:

Name:

Address:

Telephone: Day

Evening

Education:

Occupation:

Race/Nationality:

Religion:

Briefly describe the child's relationship with the father:

2. Please answer the following questions regarding the child's natural mother:

Name:

Address:

Telephone: Day

Evening

Education:

Occupation:

Race/Nationality:

Religion:

Briefly describe the child's relationship with the mother:

3. List any other adults who act as parental figures or caretakers for this child:

Name

Relationship to child

4. Please provide the following information regarding siblings, including children from other marriages:

Name	Age	Any problems or concerns
------	-----	--------------------------

5. Age of parents when married: Mother _____ Father _____

6. Number of times mother has been married: _____

7. Number of times father has been married: _____

II. Family History

1. Have any of the child's relatives (parents, grandparents, siblings, aunts, or uncles) ever . . .

- _____ Been treated in a psychiatric hospital?
- _____ Threatened to commit suicide?
- _____ Committed suicide?
- _____ Had problems with alcohol?
- _____ Abused drugs?
- _____ Had an eating disorder?
- _____ Been obese?
- _____ Been in trouble with the law/arrested?
- _____ Been severely depressed?
- _____ Been diagnosed with bipolar disorder or depression?
- _____ Been diagnosed with schizophrenia?
- _____ Seemed excessively anxious or prone to worry?
- _____ Had problems with reading or spelling?
- _____ Had problems with paying attention or restlessness?

2. To your knowledge, has anyone ever . . .

- _____ Made the child feel unwanted?
- _____ Told the child that they were proud of them?
- _____ Told the child they wished they were the opposite sex?
- _____ Embarrassed the child?
- _____ Threatened to leave or send the child away?
- _____ Told the child they love them?
- _____ Yelled or cursed at the child?
- _____ Called the child names?
- _____ Threatened to hit the child?
- _____ Physically hurt the child?
- _____ Used excessive force in disciplining the child?
- _____ Sexually molested the child?
- _____ Made the child feel that nothing they did was good enough?
- _____ Made the child feel that sex is bad or wrong?
- _____ Made the child feel overprotected?

- Made the child responsible for things that the adults should be responsible for?
- Placed the child in a parental role?
- Hit another person in the child's presence?

3. Place a check by any area you feel is a problem in the child's household:

- | | |
|---|---|
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Inconsistency in discipline |
| <input type="checkbox"/> Not enough time with child | <input type="checkbox"/> Problems with in-laws |
| <input type="checkbox"/> One parent absent much of the time | <input type="checkbox"/> Excessively harsh discipline |
| <input type="checkbox"/> Drug or alcohol problems | |
| <input type="checkbox"/> Too much fighting | <input type="checkbox"/> Other: _____ |

III. Pregnancy

1. Age of mother at the time of child's birth: _____
2. Was this a planned pregnancy? Yes No
3. How did each parent react when they found out about the pregnancy?
Mother: _____
Father: _____
4. Were there any complications in the pregnancy or delivery? If yes, please explain.

IV. DEVELOPMENTAL HISTORY

1. As an infant, did the child . . .
 - Have problems with feeding or sucking?
 - Have problems breathing (infant apnea)?
 - Have any infections?
 - Vomit excessively?
 - Have excessive diarrhea?
 - Enjoy cuddling and being held?
 - Resist being calmed by being held or stroked?
 - Have colic?
 - Exhibit excessive restlessness?
 - Have trouble establishing a regular sleeping schedule?
 - Seem to wake up a lot at night?
 - Bang his or her head?
 - Get into everything as soon as they could crawl?
2. As best you can recall, record the age at which the child first . . .
 - smiled
 - sat without support
 - crawled
 - stood without support
 - walked

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- spoke first words
- said sentences
- bowel trained, day
- bowel trained, night
- bladder trained, day
- bladder trained, night
- rode tricycle
- rode bicycle
- buttoned clothing
- tied shoelaces
- named colors
- named coins
- said alphabet in order
- began to read

3. Rate your child on the following skills:

- Walking
- Running
- Throwing
- Catching
- Shoelace tying
- Buttoning
- Writing
- Reading
- Math Skills
- Overall coordination
- Musical ability

4. As a toddler and preschooler, did the child . . .

- Rock him/herself to sleep
- Seem to have more accidents than other children
- Have temper tantrums
- Burst into tears easily
- Hit, bite or kick other children
- Act like he/she was driven by a motor
- Seem disinterested in other people outside the family
- Have difficulty tolerating change
- Fail to imitate adult behaviors
- Seem heedless to danger
- Seem especially afraid of strangers
- Act the same to strangers as to people they know
- Have trouble remembering things
- Seem more active than most children
- Have trouble following instructions or directions

5. Would you say the child had a happy childhood? Yes No

6. Who would you say your child feels closest to? (Circle one)

Father Mother Brother Sister Grandparent Friend Other No one

7. How was the child disciplined as a toddler? _____

8. How was the child disciplined as a school-age child? _____

9. How was the child disciplined as a teenager? _____

V.SCHOOL HISTORY

1. What kinds of schools has the child attended? (check all that apply)
- | | |
|--|--|
| <input type="checkbox"/> Pre-school | <input type="checkbox"/> Public school |
| <input type="checkbox"/> Private school | <input type="checkbox"/> Continuation school |
| <input type="checkbox"/> Parochial or religious school | <input type="checkbox"/> Independent learning school |
| <input type="checkbox"/> Special education classes | <input type="checkbox"/> Remediation classes |
| <input type="checkbox"/> Summer school | <input type="checkbox"/> Home study |
2. What subjects is your child good in? _____
3. What subjects are difficult for your child? _____
4. What are the usual grades your child makes? _____
5. Did your child's grades ever suddenly change (get better or worse than usual)?
 Yes No When? _____
6. Did the child ever . . .
- | | |
|--|--|
| <input type="checkbox"/> Become afraid of going to school | <input type="checkbox"/> Need help in reading |
| <input type="checkbox"/> Have trouble doing math | <input type="checkbox"/> Have trouble with writing |
| <input type="checkbox"/> Fail a class | <input type="checkbox"/> Have to repeat a grade |
| <input type="checkbox"/> Get suspended from school | <input type="checkbox"/> Skip classes |
| <input type="checkbox"/> Have behavioral problems in class | <input type="checkbox"/> Have trouble getting along with teacher |

VI. PEER RELATIONSHIPS

1. Does your child seek out friends? Yes No
2. Do other children seek to befriend your child? Yes No
3. Does the child play primarily with children his/her own age younger, or older
4. Does your child . . .
- | | |
|---|---|
| <input type="checkbox"/> Tease or bully others | <input type="checkbox"/> Get teased or bullied often |
| <input type="checkbox"/> Seem to fight a lot | <input type="checkbox"/> Seem sensitive to rejection |
| <input type="checkbox"/> Get feelings hurt easily | <input type="checkbox"/> Seem shy |
| <input type="checkbox"/> Need to get his/her own way | <input type="checkbox"/> Get along better with girls |
| <input type="checkbox"/> Get along better with boys | <input type="checkbox"/> Seem popular at school |
| <input type="checkbox"/> Seem sensitive to others' feelings | <input type="checkbox"/> Like to help others |
| <input type="checkbox"/> Prefer being alone | <input type="checkbox"/> Seem excessively self-centered |
| <input type="checkbox"/> Get angry easily | <input type="checkbox"/> Seem guarded around others |

VII.INTERESTS AND HOBBIES

- 1.What are the child's main interests and hobbies?

- 2.In what areas does the child show talent?

- 3.What does the child enjoy doing most?

- 4.What does the child dislike doing the most?

5. What does the child feel most proud of?

VIII.PROBLEMS, CURRENT AND PAST

Please check any problems the child has had in the past or present. Only check problems you consider unusual or atypical for the child's age.

- | | |
|---|---|
| <input type="checkbox"/> Thumb-sucking | <input type="checkbox"/> Baby Talk |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Preoccupied with food |
| <input type="checkbox"/> Soiling in pants | <input type="checkbox"/> Jealous of brother or sister |
| <input type="checkbox"/> Afraid of being apart from parents | <input type="checkbox"/> Can't sit still |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Frequent bad dreams / nightmares |
| <input type="checkbox"/> Overly dependent | <input type="checkbox"/> Preoccupied with bowel movements |
| <input type="checkbox"/> Acts like opposite sex | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Excessive silliness or clowning | <input type="checkbox"/> Needs too much attention |
| <input type="checkbox"/> Cries frequently | <input type="checkbox"/> Seems immature |
| <input type="checkbox"/> Eats non-edible substances | <input type="checkbox"/> Night terrors |
| <input type="checkbox"/> Overeats | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Poor motivation | |
| <input type="checkbox"/> Looks for easy way out | <input type="checkbox"/> Blames others for problems |

IX.PROBLEMS (continued):

- | | |
|--|---|
| <input type="checkbox"/> Frequent sex play with other kids | <input type="checkbox"/> Lack of appetite |
| <input type="checkbox"/> Diets or skips meals | |
| <input type="checkbox"/> Avoids responsibility | <input type="checkbox"/> Fights with other kids |
| <input type="checkbox"/> Steals | <input type="checkbox"/> Lies |
| <input type="checkbox"/> Suspicious of others | <input type="checkbox"/> Little curiosity |

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- | | |
|--|---|
| <input type="checkbox"/> Defiant of authority figures | <input type="checkbox"/> Poor common sense |
| <input type="checkbox"/> Few friends | <input type="checkbox"/> Acts like a loner |
| <input type="checkbox"/> Oppositional | <input type="checkbox"/> Blatantly uncooperative |
| <input type="checkbox"/> Swears | <input type="checkbox"/> Not accepted by peer group |
| <input type="checkbox"/> Excessively competitive | <input type="checkbox"/> Does not follow through |
| <input type="checkbox"/> Cheats when playing games | <input type="checkbox"/> Bites nails |
| <input type="checkbox"/> Trouble with police | <input type="checkbox"/> Too critical of self |
| <input type="checkbox"/> Torture animals | <input type="checkbox"/> Set fires for fun |
| <input type="checkbox"/> Run away from home | <input type="checkbox"/> Use drugs or alcohol |
| <input type="checkbox"/> Attempt suicide | <input type="checkbox"/> Carve marks or words on body |
| <input type="checkbox"/> Truant from school | <input type="checkbox"/> Does not respect rights of others |
| <input type="checkbox"/> Violent outbursts of rage | <input type="checkbox"/> Has to have things his/her own way |
| <input type="checkbox"/> Cruel to younger children | <input type="checkbox"/> Feels life is not fair |
| <input type="checkbox"/> Hits other children | <input type="checkbox"/> Destroys property |
| <input type="checkbox"/> Argumentative | <input type="checkbox"/> Critical of others |
| <input type="checkbox"/> Often unhappy | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Likes to tease others | <input type="checkbox"/> Worries too much |
| <input type="checkbox"/> Little guilt over wrong-doing | <input type="checkbox"/> Pessimistic |
| <input type="checkbox"/> Disorganized | <input type="checkbox"/> Feelings easily hurt |
| <input type="checkbox"/> Hair pulling | <input type="checkbox"/> Picks on skin |
| <input type="checkbox"/> Nervous tics | <input type="checkbox"/> Stutters |
| <input type="checkbox"/> Seems tense much of the time | <input type="checkbox"/> Perfectionist |
| <input type="checkbox"/> Speaks rapidly under pressure | <input type="checkbox"/> Little concern for appearance |
| <input type="checkbox"/> Doesn't take care of own things | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Excessive desire to please others | <input type="checkbox"/> Unable to concentrate |
| <input type="checkbox"/> Preoccupied with certain ideas | <input type="checkbox"/> Seems insincere or superficial |
| <input type="checkbox"/> Acts older than actual age | <input type="checkbox"/> Excessive guilt |
| <input type="checkbox"/> Afraid to try new things | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Mute (refuses to speak) | <input type="checkbox"/> Shows little emotion |
| <input type="checkbox"/> Is never angry | <input type="checkbox"/> Passive and easily led |
| <input type="checkbox"/> Gullible and naïve | <input type="checkbox"/> Lives in his/her own world |
| <input type="checkbox"/> Procrastination | <input type="checkbox"/> Fidgets or squirms in seat |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Has difficulty playing quietly |
| <input type="checkbox"/> Talks excessively | <input type="checkbox"/> Difficulty expressing feelings |
| <input type="checkbox"/> Argues with adults | <input type="checkbox"/> Deliberately annoys others |
| <input type="checkbox"/> Reluctance/refusal to go to school | <input type="checkbox"/> Reluctant to sleep alone |
| <input type="checkbox"/> Lack of friends | <input type="checkbox"/> Startles easily |
| <input type="checkbox"/> Worries about the future | <input type="checkbox"/> Self-conscious |
| <input type="checkbox"/> Excessive need for reassurance | <input type="checkbox"/> Unable to relax |
| <input type="checkbox"/> Wishes to be opposite sex | <input type="checkbox"/> Motor or vocal tics |
| <input type="checkbox"/> Little contact with people outside family | |

Does the child show fears of . . .

- | | |
|--|---|
| <input type="checkbox"/> The dark | <input type="checkbox"/> New situations |
| <input type="checkbox"/> Strangers | <input type="checkbox"/> Being alone |
| <input type="checkbox"/> Death | <input type="checkbox"/> Separation from parents |
| <input type="checkbox"/> Visiting other children's homes | <input type="checkbox"/> Going away to camp |
| <input type="checkbox"/> Certain animals | <input type="checkbox"/> Talking with adults |
| <input type="checkbox"/> Being assertive | <input type="checkbox"/> Dating situations |
| <input type="checkbox"/> Crowded places | <input type="checkbox"/> Heights |
| <input type="checkbox"/> Small, enclosed places | <input type="checkbox"/> Blood or injury |
| <input type="checkbox"/> Being in a car | <input type="checkbox"/> Air travel |
| <input type="checkbox"/> Open, airy spaces | <input type="checkbox"/> Medical or dental visits |

_____ Other:

X. MEDICAL HISTORY

1. Do you worry about your child's health? _____ Yes _____ No
2. Does the child worry about his/her health? _____ Yes _____ No
3. List any allergies the child has:
4. Does the child wear glasses or contact lenses? _____ Yes _____ No
5. Does the child eat three well-balanced meals each day? _____ Yes _____ No
6. Does the child exercise regularly? Yes No
7. Describe any surgeries the child has had:

8. Does the child smoke cigarettes? Yes No
9. Does the child drink caffeine? Yes No
10. Do any family members have a history of serious medical illness?
Yes No If so, please describe:

11. List any medications the child is currently taking:

12. Please place a check by any physical problems the child has had. Indicate any current problems with an (C), and any past problems with a (P).

_____ Headaches	_____ Stomachaches
_____ Head injury	_____ Convulsions
_____ High fever	_____ Infections
_____ Meningitis	_____ Encephalitis
_____ Poisoning	_____ Coma
_____ Difficulty swallowing	_____ Loss of voice
_____ Choking	_____ Excessive sweating
_____ Loss of hearing	_____ Problems with vision
_____ Memory loss	_____ Seizures
_____ Paralysis	_____ Trembling or shaking
_____ Numbness or tingling	_____ Muscle tension
_____ Muscle weakness	_____ Difficulty urinating
_____ Trouble walking	_____ Nausea
_____ Frequent vomiting	_____ Tires easily
_____ Joint pain	_____ Eating binges
_____ Diarrhea	_____ Dizziness or fainting
_____ Shortness of breath	_____ Wheezing
_____ Frequent urination	_____ Changes in appetite
_____ Grinding teeth	_____ Overeating
_____ Problems with menstruation	_____ Skin problems
_____ Does not like to be touched	_____ Diabetes
_____ High blood pressure	_____ Liver or kidney problems
_____ Heart problems	_____ Asthma