



Is there an Order of Protection on anyone? YES/NO

If yes, name of person _____

Is Assessment/Treatment Court-Ordered? YES/ NO

PATIENT INFORMATION:

Last name: _____ First: _____ M.I. ____ Nickname: _____

SSN: _____ - _____ - _____ Birth date: __/__/____ Allergies: _____ Sex: _____

Race: _____ Patient's marital status: _____ Patient's Spouse: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: H: _____ W: _____ C: _____ Email: _____

Permission to leave voicemails? YES/ NO Permission to email? YES/ NO

Choose One Option for Appointment Reminder(s): _____ Email _____ Text Message _____ Voicemail

Referral Source: _____ Primary Doctor: _____ Reason for Referral: _____

RESPONSIBLE PARTY (if other than patient)

(Shared Custody? Please provide name and phone number of other party)

Last name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: home _____ work _____ cell _____

Employer's Name: _____ City: _____ State: _____

Other Party: Last name: _____ First Name: _____ Phone Number: _____

EMERGENCY CONTACT **Same as Responsible Party**

Last name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: home _____ work _____ cell _____

Employer's Name: _____ City: _____ State: _____

INSURANCE INFORMATION: (Present Insurance Card to Office Staff Please)

Primary Insurance Company: _____ *Secondary Insurance Company:* _____

Card Holder _____ Card Holder _____

Birth Date _____ Birth Date _____

SSN _____ SSN _____

Address _____ Address _____

Phone # _____ Phone # _____

Employer _____ Employer _____

Policy ID # _____ Policy ID # _____

Group # _____ - _____ Group # _____ - _____

Please complete all information correctly and legibly.

266 Henrietta Ave. N., Park Rapids, MN, 56470
Phone: (218) 252-2785 Fax: (218) 732-4695

BILLING INFORMATION – Read and sign:

1. I authorize A Better Connection, Inc. to release medical and other information concerning this or related claims to government agencies including Social Security Administration and its intermediaries, agency accountant(s), agency legal representatives, RPT-S Supervisor, and insurance companies and carriers who may be responsible for payment of benefits.
2. I authorize A Better Connection, Inc. to release my medical records and billing information to my Primary Care and/or Referring Physician.
3. I authorize my insurance benefits to be paid to A Better Connection, Inc..
4. If a requested insurance claim is filed, I will receive a bill each month if my account has a balance due. I am responsible for any charges not paid by insurance.
5. I understand that if I do not provide the above insurance information, I will be responsible for my bill, regardless of whether or not I have insurance.
6. I understand that I am responsible for providing a referral to my insurance company if they require it.

Name of person completing this form (please print) _____

Signature of person completing this form _____ Date: _____

Relationship to Patient: _____

PERMISSION TO TREAT A MINOR

I, _____, hereby authorize A Better Connection, Inc. to provide psychotherapy to _____, a minor. I attest to the fact that I have the legal authority to grant this permission.

Signature: _____ Date: _____

RESTRAINING ORDER OR ORDER OF PROTECTION

Is there currently a Restraining Order or Order of Protection on anyone? YES / NO

If so, what is the name of the individual(s)? _____

NOTICE OF PRIVACY PRACTICES

Please read this notice and **sign and date** the attached acknowledgement.

The Health Insurance Portability and 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 has given you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

- Treatment means 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 means 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 our practice, such as conducting quality assessment activities and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified by removing all references to individually identifiable information.

We may contact you to provide appointment reminders and information about treatment alternative 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 and we are required to honor and abide by that written request, except to the extent that we 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 person identified by you. We are, however, 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 review confidential communications of protected health information from us at alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have an obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We 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 has been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights, 200 Independence Avenue, S. W., Washington, D.C. 20201 Phone: (202) 619-0257 Toll Free: 1-877-696-6775

A Better Connection, Inc.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received a written copy of the **A Better Connection, Inc. Privacy Practices**. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such a time as I may choose to revoke this acknowledgment. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Date

Signature of Client or Legal Guardian

Cancellation Policy/Agreement

Due to high demand for mental health services at A Better Connection Inc., clients and families are being asked to sign, and agree to, the cancellation policy terms and conditions. Text Message reminders 24 hours prior containing the appointment date and time are a courtesy provided by A Better Connection Inc. to ensure attendance. Please request this service if you do not currently receive text message reminders.

Late Cancel/No Shows: If patients arrive 15 or more minutes late to an appointment without calling to inform A Better Connection Inc. of the late arrival, they may be asked to reschedule as their appointment will be considered a Late Cancel/ No Show. Patients unable to attend a scheduled appointment or group session must cancel the appointment more than 24 hours prior to the appointment time. Reminder text messages are sent at this time. To cancel an appointment, please text or call 218-252-2785. In cases of extraordinary circumstances that arise less than 24 hours prior to the appointment time (e.g. physical illness), the clinic still appreciates to be informed about the missed appointment. There is a daily cancellation list of patients hoping to attend an open appointment time. It is appreciated by other clients and their families if you call with enough time to allow their attendance at that time. This also ensures the possibility of an appointment opening to reschedule your appointment at a later date. Failure to cancel an appointment less than 24 hours prior to an appointment will require:

- One late cancel/no show in a six month period= Client must call to confirm an appointment the following week. If no call is made, no appointment will be made for the following week.
- Two late cancels/no shows in a six month period= Client will lose their weekly/ biweekly session time and must schedule an appointment each week.
- Three late cancels/no shows in a six month period= Client will be required to call the morning of the day the client prefers to attend an appointment. A session will be scheduled if an appointment time is available. If no time is available, the client will need to call back at a later date.

I understand and agree to the above cancellation policy.

Signature: _____ Date: _____

Printed Name: _____



Child/Adolescent Diagnostic Assessment

(TO BE COMPLETED BY PARENT/CAREGIVER)

CHILD NAME (FIRST, MI, LAST)

DATE

Living situation

Parent's Home

RENT

OWN

Residential Care/Treatment Facility**

HOSPITAL TEMPORARY HOUSING

RESIDENTIAL CARE NURSING HOME

Other**

FRIEND'S HOME RELATIVE/GUARDIAN'S HOME

HOMELESS

**IDENTIFY PERSON'S NAME OR FACILITY

Primary Household

STREET ADDRESS

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship
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Does the client live in more than one household?

NO If no, skip to "Additional Family Members" **YES** If yes, complete the secondary household information below.

Secondary Household

STREET ADDRESS

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship
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Family members who live in both households

ONLY CHILD

CHILD and (list):

Additional family members living outside of the home

Was a twin or triplet					
Had an infection					
Had seizures (fits, convulsions)					
Needed oxygen					
Was very jittery					
Childhood Health Issues	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Seizures (convulsions) or spells					
High fevers (over 103° F. or 39° C.)					
Head injury					
Asthma					
Trouble with hearing					
Trouble with vision					
Lead poisoning					
Other poisoning or overdose					
Other serious illness					
Other hospitalizations					
Functioning	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Poor appetite					
Constipation					
Stomach aches					
Trouble falling asleep					
Trouble staying asleep					
Overactivity					
Head banging					
Rocking in bed					
Temper tantrums					
Self-destructive behavior					
Difficulty in being comforted or consoled					
Stiffness or rigidity					
Looseness or floppiness					
Crying often and easily					

Shyness with strangers					
Irritability					
Extreme reaction to noise or sudden movement					
Attention problems	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Can concentrate for only a short time unless things are very interesting					
Understand the main ideas of things but misses important details					
Does work or performs many tasks carelessly without thinking					
Learns a new skill well one day and then can't seem to do it a few days later					
Receives very unpredictable (inconsistent) grades or test scores in school					
Can work well only on things he/she really enjoys doing or thinking about					
Often doesn't notice when he/she makes mistakes					
Seems not to realize when he/she is disturbing someone					
Doesn't do much better after punishment or correction					
Makes comments about or is distracted by background noises or unimportant things					
Seems to want things right away and/or is hard to satisfy					
Annoys or bothers other children					
Behavior is variable and hard to predict					
Is a troublemaker; bullies others					
Behaviors	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Has bad dreams					
Is often very quiet or withdrawn					
Is often "down" on himself/herself					
Is often tired					
Speaks unclearly, stutters, or stammers					
Wets bed or pants often					
Soils underwear or has accidents with bowel movements					

Is often too neat or orderly					
Is often too concerned about cleanliness					
Often plays with matches					
Destroys objects at home					
Destroys objects away from home					
Is fearless					
Is cruel to animals					
Is not liked by other children					
Feels ill on school mornings					
Has eating problems (either overeats or undereats)					
Is preoccupied with food or diet					
Is part of a clique or gang that causes trouble					
Other behaviors not noted above					
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?					
Have you ever had concerns about your child's sexual development or behaviors?					

IF THERE ARE INDICATIONS OF ISSUES, PLEASE EXPLAIN

Child's school functioning

Education classification	Current School	Current Grade	Current Teacher			
Level of learning:	Gifted	Above Average	Average	Below Average	Borderline	Developmentally Delayed
COMMENTS ON CLASSROOM LEARNING:						
Is homework a problem?	Yes	No				
IF YES, PLEASE EXPLAIN:						
Does your child receive special education services?	L YES	L NO				

If no, has your child ever been tested and determined not to need services? <input type="checkbox"/> YES <input type="checkbox"/> NO											
Regular education classroom, no special services <input type="checkbox"/> YES <input type="checkbox"/> NO											
If no, check all that apply below.											
<input type="checkbox"/> Early Childhood Spec. Ed./Developmental Delay				<input type="checkbox"/> Special learning disability				<input type="checkbox"/> Physically Impaired			
<input type="checkbox"/> Special Learning Disability				<input type="checkbox"/> Autism Spectrum Disorder				<input type="checkbox"/> Emotional/Behavioral Disorder			
<input type="checkbox"/> Hearing Impaired				<input type="checkbox"/> Traumatic brain injury				<input type="checkbox"/> Developmental/Cognitive Disability			
<input type="checkbox"/> Visually Impaired				<input type="checkbox"/> Other health impaired				<input type="checkbox"/> Other:			
<input type="checkbox"/> Speech or Language Impaired				<input type="checkbox"/> Unsure				<input type="checkbox"/> Current 504 plan			
COMMENTS ON EDUCATIONAL CLASSIFICATION											
Has your child: Repeated a Grade Advanced a Grade Received In School Suspension Been Suspended Been Expelled											
Child's legal history											
Does your child have a history of legal charges? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, DESCRIBE CHARGES											
Is the child currently on probation? <input type="checkbox"/> NO <input type="checkbox"/> YES											
Has the child ever been on probation? <input type="checkbox"/> NO <input type="checkbox"/> YES											
Has the child ever been court-ordered into chemical health or mental health treatment? <input type="checkbox"/> NO <input type="checkbox"/> YES											
Child's trauma history											
Children's Protective Services (CPS) involvement with family <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, DESCRIBE											
NAME OF CPS CASEWORKER(S) ASSIGNED TO FAMILY (IF APPLICABLE)											
NAME OF GUARDIAN AD LITEM (GAL) OR COURT APPOINTED SPECIAL ADVOCATE (CASA) ASSIGNED TO FAMILY											
Has your child ever experienced any of the following? <input type="checkbox"/> REPORTED TO AUTHORITIES? WHEN? TO WHOM? <input type="checkbox"/> NONE REPORTED											
<input type="checkbox"/> NO TRAUMA HISTORY <input type="checkbox"/> CAR ACCIDENT <input type="checkbox"/> OTHER ACCIDENT <input type="checkbox"/> COMMUNITY VIOLENCE <input type="checkbox"/> SEXUAL ABUSE/MOLESTATION <input type="checkbox"/> COMMUNITY VIOLENCE											
<input type="checkbox"/> PHYSICAL ILLNESS <input type="checkbox"/> PHYSICAL ABUSE <input type="checkbox"/> DOMESTIC VIOLENCE/ABUSE <input type="checkbox"/> EMOTIONAL ABUSE/NEGLECT <input type="checkbox"/> PHYSICAL NEGLECT <input type="checkbox"/> FIRE <input type="checkbox"/> OTHER:											

Child's mental health treatment history

Previous mental health treatment NO YES If yes, please list reason for treatment, and dates:

Reason

Dates

What did you find helpful in your treatment?

What was not helpful in your treatment?

Currently on any medication(s)? NO YES

Please List All Medications and Dosages:

PRIMARY CARE PHYSICIAN

CLINIC

OTHER PRESCRIBING PHYSICIAN(S)

CLINIC

Child's alcohol and drug history

Do you have any concerns about your child's use of alcohol or drugs? NO YES

Do you have any other issues or concerns about your child you would like to have addressed? NO YES COMMENTS

Child/Adolescent CageAid

Have you felt you ought to cut down on drinking or drug use? NO YES

Have you felt bad or guilty about your drinking or drug use? NO YES

Have people annoyed you by criticizing your drinking or drug use? NO YES

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? NO YES

Family Environment/Relationships

Please indicate below the best descriptions of parent-child relationships.

Parent-Child (Client) Relationship(s) **P** = Primary household **S** = Secondary household **B** = Both

Parent-child conflict

_____ NONE - MILD

_____ MODERATE

_____ SEVERE

Issues with supervision and monitoring of child	_____ ALWAYS	_____ USUALLY	_____ INCONSISTENTLY	_____ RARELY	
Cooperation between parents regarding child-rearing	_____ ALWAYS	_____ USUALLY	_____ INCONSISTENTLY	_____ RARELY	_____ NOT PERTINENT
Parent positive activities with child	_____ FREQUENT	_____ OCCASIONALLY	_____ INFREQUENT		
Parent satisfaction with relationship	_____ SATISFIED	_____ NEUTRAL	_____ DISSATISFIED		
Child satisfaction with relationship	_____ SATISFIED	_____ NEUTRAL	_____ DISSATISFIED		

COMMENT ON PARENT-CHILD RELATIONSHIPS (describe further if needed)

MATERNAL (MOM'S) SIDE OF THE FAMILY'S MEDICAL AND MENTAL HEALTH HISTORY

PATERNAL (DAD'S) SIDE OF THE FAMILY'S MEDICAL AND MENTAL HEALTH HISTORY

SIBLING MEDICAL AND MENTAL HEALTH HISTORY

Please indicate below the best descriptions of sibling-child relationships.

Sibling-Child (Client) Relationship(s) L NO SIBLINGS P = Primary household S = Secondary household B = Both

Child-sibling conflict	_____ NONE – MILD	_____ MODERATE	_____ SEVERE
Sibling(s) positive activities with child	_____ FREQUENT	_____ OCCASIONAL	_____ INFREQUENT
Sibling(s) satisfaction with relationship	_____ SATISFIED	_____ NEUTRAL	_____ DISSATISFIED
Child satisfaction with relationship	_____ SATISFIED	_____ NEUTRAL	_____ DISSATISFIED

COMMENT ON SIBLING-CHILD RELATIONSHIPS (describe further if needed)

Please indicate below the best descriptions of parent marital or couple relationships.

Parent Marital or Couple Relationship(s) L NOT APPLICABLE P = Primary household S = Secondary household B = Both

Marital or couples conflict	_____ NONE – MILD	_____ MODERATE	_____ SEVERE
Marital or couples satisfaction	_____ SATISFIED	_____ NEUTRAL	_____ DISSATISFIED

COMMENT ON PARENT MARITAL OR COUPLES RELATIONSHIPS (describe further if needed)

Other Family Concerns	If yes, indicate:				
	No	Yes	Parent	Sibling	Other
Family member health problems					
Family member disability					
Family member legal issues					
Family financial concerns					
Family member alcohol abuse					
Family member substance abuse					
Family member anxiety					
Family member depression					
Family member ADHD					
Family member mania					
Family member schizophrenia/other psychosis					
Significant family stressors (moves, deaths, divorce, loss of employment)					

OTHER FAMILY CONCERNS AND CHANGES IN CLIENT'S LIFE MAKING ADJUSTMENT DIFFICULT (Specify problems that impact child's needs.)

PLEASE INDICATE STRENGTHS (Including characteristics, activities, achievements, talents, etc.)

PARENT OR LEGAL GUARDIAN SIGNATURE: _____ **DATE:** _____

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example CD's, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often offers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees chores or homework through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Mother/Father/Other (please specify:)

Thank you very much for your help

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

Your name.....

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others, for example CD's, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would rather be alone than with people of my age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often offer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get along better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in any of the following areas:
emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties upset or distress you?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	A medium amount	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Signature

Today's Date

Thank you very much for your help