A Better Connection, Inc.
Park Rapids, Minnesota

Is Assessment/Treatment Court-Ordered? YES/ NO

Intake Paperwork (Children Ages 11 to 12)

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.

1009 Hollinger Street, 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-identification by removing all references to individually identifiable information.

We may contact you to provide appointment reminders and 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 and we are required to honor and abide by that written request, except to the extent that we have already taken actions relaying 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 disclosers 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 much 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 disclosers of protected health information.
- The right to obtain and we have to 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: (2202) 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 218-252-6608. 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: _____

A BETTER CONNECTION, INC.
YOUR RIGHTS AND RESPONSIBILITIES

CIVIL RIGHTS: You have the right to complain if you feel you have been discriminated against because of race, religion, nationality, origin, sex, age, or sexual orientation. complaints may be registered with: Minnesota Department of Human Services

444 Lafayette Road North
St. Paul, MN 55155
Phone: (651) 431-6500

RIGHT TO APPEAL: If you feel you have been unfairly treated, you may appeal for a fair hearing. An appeal form may be obtained from your county social service agency or from:

Appeals Office
Minnesota Department of Human Services
444 Lafayette Road North
St. Paul, MN 55155
(651) 431-6500

PATIENT BEHAVIORAL HEALTH(including CHEMICAL DEPENDENCY RIGHTS):

Pursuant to Minnesota Statute **148F.165 Subd. 2.**
Consumers of alcohol and drug counseling services have the right to:
(1) expect that the provider meets the minimum qualifications of training and experience required by state law;
(2) examine public records maintained by the Board of Behavioral Health and Therapy that contain the credentials of the provider;
(3) report complaints to the Board of Behavioral Health and Therapy;
(4) be informed of the cost of professional services before receiving the services;
(5) privacy as defined and limited by law and rule;
(6) be free from being the object of unlawful discrimination while receiving counseling services;
(7) have access to their records as provided in sections 144.92 and 148F.135, subdivision 1, except as otherwise provided by law;
(8) be free from exploitation for the benefit or advantage of the provider;
(9) terminate services at any time, except as otherwise provided by law or court order;
(10) know the intended recipients of assessment results;
(11) withdraw consent to release assessment results, unless the right is prohibited by law or court order or was waived by prior written agreement;
(12) a nontechnical description of assessment procedures; and
(13) a nontechnical explanation and interpretation of assessment results, unless this right is prohibited by law or court order or was waived by prior written agreement.

The provider shall treat the client as an individual and not impose on the client any stereotypes of behavior, values and roles related to human diversity.

The provider shall not misuse the relationship due to a relationship with another individual or entity.

Provider shall not exploit the professional relationship with a client for the provider's emotional, financial, sexual, or personal advantage or benefit. This extends to former clients who are vulnerable or dependent on the provider.

SEXUAL BEHAVIOR WITH A CLIENT: A provider shall not engage in any sexual behavior as defined in section 604.20, subd 7; any physical verbal written interaction or electronic communication, conduct or any act that may be reasonable interpreted to be sexually seductive, demeaning, or harassing to the client. Client refers to current or former client and applies whether provider has formally terminated the professional relationship, indefinitely for a former client who is vulnerable or dependent on the provider.

RIGHTS TO PRIVACY: Information received by this facility is considered privileged and will be kept private. It may be released only with your signed authorization on a proper release form.

PREFERENCES AND OPTIONS FOR TREATMENT: Provider shall disclose to the client the provider's preferences for choice of treatment or outcome and shall present other options for the

consideration or choice of the client.

REFERRALS: A provider shall make a prompt and appropriate referral of the client to another professional when requested.

RIGHTS TO ACCESS OF RECORDS: Your individual rights include the following:

- Right to records under 144.92 and 148F.135 except as otherwise provided by law;
- Right to know what kind of information is being maintained and whether you are the subject of any data;
- The right to be informed of the purpose for, or intended use of, any information requested for you by an agency;
- The right to be informed of any change in the purpose of, or the intended use of, any information you have supplied;
- The right to have disputed data withheld from disclosure except under conditions of demonstrated need, and then only if your statement or disagreement is included with the disclosed data.

GRIEVANCE PROCEDURE: If a problem or complaint arises where you feel your rights are being violated, proceed with the following steps:

- Within three business days of when the grievance occurred, report problems or complaints to ABC's President, who will assist you in processing of the grievance.
- If the grievance is unresolved, contact one of the following:

Minnesota Department of Human Services 444
Lafayette Road North
St. Paul, MN 55155
(651) 431-6500

Minnesota Department of Health PO
Box 64975
St. Paul, MN 55164
(651) 201-5000 or (888) 345-0823

Office of Health Facilities Complaints PO Box
64970
St. Paul, MN 55164-0970
(651) 201-4201

Office of the Ombudsman for Mental Health 121 7th
Place East, Suite 420
St. Paul, MN 55101-2117 (651)
757-1800 or (800) 657-3506

Minnesota Board of Behavioral Health and Therapy 2829
University Avenue Southeast, Suite 210
Minneapolis, MN 55414
(612) 548-2177

IT IS YOUR RESPONSIBILITY: To provide proof on income to establish eligibility; to report any subsequent changes in circumstances which impact eligibility; to cooperate with subsequent facility efforts to assess the appropriateness of the eligibility process.

RISK RESPONSIBILITY: You have the right to be informed that there are risks associated with any therapeutic procedure undertaken, such as, but not limited to:

- You could be subject to embarrassing moments or questions in group or individual counseling
- There could be someone in therapy that you would feel uncomfortable with;
- Your name could leave the building inadvertently

BY ACCEPTING TREATMENT YOU STATE THAT YOU ARE FULLY AWARE OF THESE AND OTHER RISKS INVOLVED.

Signature:_____ **Printed Name:**_____ **Date:**_____

A Better Connection, Inc. Intake Forms (all information on this form is strictly confidential)

Patient First Name:	**Patient Last Name:**
Name of Person completing form (if other than patient):	
Date Completed:	**Patient Date of Birth:**
Primary Care Physician:	**Physician Phone:**

Current Symptoms Checklist (please check all appropriate columns)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Aggression				Irritability			
Agitation				Judgment errors			
Anger				Loneliness			
Anxiety				Loss of interest in activities			
Appetite change				Memory impairment			
Change in libido				Mood swings			
Compulsions				Obsessions			
Crying/tearful				Oppositional behavior			
Cyber addiction				Panic attacks			
Delusions				Paranoia			
Depression				Phobias/fears			
Disorientation				Physical trauma perpetrator			
Difficulty getting out of bed				Physical trauma victim			
Difficulty making decisions				Poor concentration			
Distractibility				Poor grooming			
Eating disorder				Racing thoughts			
Elevated mood				Recurring thoughts			
Emotional trauma perpetrator				Self-mutilation			
Emotional trauma victim				Sexual addiction			
Excessive energy				Sexual difficulties			
Fatigue				Sexual trauma perpetrator			
Flashbacks/Nightmares				Sexual trauma victim			
Gambling				Sleep problems			
Grief				Speech problems			
Guilt				Social isolation			
Hallucinations				Substance abuse			
Hearing voices				Suicidal thoughts			
Heart palpitations				Worried			
Hopelessness				Worthlessness			
Hyperactivity				Other:			
Impulsivity				Other:			

MEDICAL HISTORY

Medication Name	Total Daily Dosage	Estimated Start Date

Describe current physical health: o Good o Fair o Poor

List any known allergies:

Past nonpsychiatric hospitalizations or surgeries:

Do you exercise regularly? o Yes o No

Personal and Family Medical History (Have you or a family member ever had any of the following? If family, specify which family member)

	You	Family	Who?		You	Family	Who?
Alzheimer's/Dementia				Head Injury			
Anemia				Heart Disease			
Arthritis				High Blood Pressure			
Asthma				High Cholesterol			

	You	Family	Who?		You	Family	Who?
Behavioral problems				HIV Positive or AIDS			
Birth defects				Kidney Problems			
Cancer				Liver Problems/Hepatitis			
Chronic Fatigue				Lung Disease			
Chronic Pain				Mental Retardation			
Diabetes				Migraine/Cluster Headaches			
Ear/Nose/Throat Problems				Neurological Problems			
Eating Disorder				Skin Disease			
Emotional Problems				Sleep Apnea			
Endocrine/Hormone Problems				Stroke			
Epilepsy or Seizures				Thyroid Disease			
Eye Problems				Tuberculosis			
Fibromyalgia				Urological Problems			
Gastrointestinal Problems				Viral Illness/Herpes			
Genital/Gynecological Problems				Other:			

EMOTIONAL/PSYCHIATRIC HISTORY

Prior Outpatient Treatment? o Yes o No If yes, please describe:

Reason	Dates Treated	By Whom

Prior Inpatient Treatment (for psychiatric, emotional, or substance abuse disorder)? o Yes o No If yes, please describe:

Reason	Dates Hospitalized	By Whom

Family History (has anyone in your family ever been treated for any of the following?)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
Anxiety			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
Panic Attacks			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
Post Traumatic Stress			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
Bipolar Disorder/Manic Depression			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
Schizophrenia			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
Alcohol Problems			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
Drug Problems			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
ADHD			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
Suicide Attempts			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal
Psychiatric Hospitalization			o Maternal o Paternal	o Maternal o Paternal				o Maternal o Paternal

Past Psychiatric Medications (if you have ever taken any of the following medications, indicate the date, dosage, and how helpful)

Medication Name	Check if taken	When?	Dosage?	Did it help?	Side effects?
				o Yes o No	o Yes o No
				o Yes o No	o Yes o No
				o Yes o No	o Yes o No

SUBSTANCE USE HISTORY

Substance Use Status:

o No history of abuse o Active abuse o Early full remission o Early partial remission o Sustained full remission o Sustained partial remission

Treatment History:

o Outpatient o Inpatient o 12-step program o Stopped on own o Other:

Substances Used (check all that apply)

Ever Used?	First use age	Last use age	Currently Used?	Frequency	Amount
o Alcohol			o Yes o No		
o Amphetamines/Speed			o Yes o No		
o Barbiturates			o Yes o No		
o Caffeine			o Yes o No		
o Cocaine			o Yes o No		
o Crack Cocaine			o Yes o No		
o Ecstasy			o Yes o No		
o Hallucinogens (LSD)			o Yes o No		
o Heroin			o Yes o No		
o Inhalants			o Yes o No		
o Marijuana			o Yes o No		
o Methadone			o Yes o No		
o Methamphetamine			o Yes o No		
o Painkillers			o Yes o No		
o Nicotine/Tobacco			o Yes o No		
o PCP			o Yes o No		
o Tranquilizers			o Yes o No		
o Other:			o Yes o No		

FAMILY HISTORY

Family of Origin	Present entire childhood	Present part of childhood	Not present at all	Parents' Current Marital Status:	Childhood Family Experience:
Biological Mother				o Married to each other o Separated for years o Divorced for years o Mother remarried times o Father remarried times o Mother involved with someone o Father involved with someone o Mother deceased for years Age of patient at mother's death: o Father deceased for years Age of patient at father's death:	o Outstanding home environment o Normal home environment o Chaotic home environment o Neglected o Witnessed physical/verbal/ sexual abuse towards others o Experienced physical/ verbal/sexual abuse from others Age of emancipation from home:
Biological Father					
Adoptive Mother					
Adoptive Father					
Stepmother					
Stepfather					
Brother(s)					
Sister(s)					
Other:					

TRAUMA HISTORY (Circle **Hx** for History and/or **P** for Present)

Abusive relationship	Hx	P	Miscarriage	Hx	P	Unhappy childhood	Hx	P
Experienced physical abuse	Hx	P	Abortion	Hx	P	Poor academic progress	Hx	P
Experienced emotional abuse	Hx	P	Crime Victim	Hx	P	Few Friends	Hx	P
Experienced sexual abuse	Hx	P	War	Hx	P	Family Problems	Hx	P
Witnessed physical abuse	Hx	P	Poverty	Hx	P	Rape	Hx	P
Witnessed emotional abuse	Hx	P	Natural Disaster	Hx	P	Death of someone close	Hx	P
Witnessed sexual abuse	Hx	P	Death of a parent	Hx	P	Traumatic Brain Injury	Hx	P

DEVELOPMENTAL HISTORY

Pregnancy Complications	o None o German measles o Alcohol use o Other: o High blood pressure o Emotional stress o Drug use o Kidney infection o Bleeding o Cigarette use
Birth	o Normal delivery o Difficult delivery o Cesarean delivery o Complications:
Birth Weight	_____ lbs. _____ oz.
Infancy	o Feeding problems o Sleep problems o Toilet training problems

Delayed Development Milestones (check only those milestones that did not occur at an expected age)

o Sitting	o Rolling over	o Standing	o Walking	o Feeding self
o Speaking words	o Speaking sentences	o Controlling bladder	o Controlling bowels	o Sleeping alone
o Dressing self	o Engaging peers	o Tolerating separation	o Playing cooperatively	o Riding tricycle
o Riding bicycle	o Other:			

Childhood Health

o Chickenpox (age:) o German measles (age:) o Red measles (age:) o Rheumatic fever (age:) o Whooping cough (age:)

o Scarlet fever (age:) o Lead poisoning (age:) o Mumps (age:) o Diphtheria (age:) o Poliomyelitis (age:)

o Pneumonia (age:) o Tuberculosis (age:) o Mental retardation o Autism o Ear infections

o Asthma o Allergies to:

Emotional/Behavioral Problems

o Drug use	o Alcohol abuse	o Chronic lying	o Stealing	o Violent temper
o Fire setting	o Hyperactive	o Animal cruelty	o Assaults others	o Disobedient
o Repeats words of others	o Not trustworthy	o Hostile/angry mood	o Indecisive	o Immature
o Bizarre behavior	o Self-injurious threats	o Frequently tearful	o Frequently daydreams	o Lack of attachment
o Distrustful	o Extreme worrier	o Self-injurious acts	o Impulsive	o Easily distracted
o Poor concentration	o Often sad	o Breaks things	o Other:	

Social Interaction

o Normal social interaction	o Isolates self	o Alienates self	o Inappropriate sex play
o Dominates others	o Very shy	o Associates with acting out peers	o Other:

Intellectual/Academic Functioning Highest education level completed:

o Normal intelligence	o High intelligence	o Learning problems	o Authority conflicts	o Attention problems
o Underachieving	o Mild retardation	o Moderate retardation	o Severe retardation	

SOCIO-ECONOMIC HISTORY

Living Situation: o housing adequate o homeless o housing overcrowded o dependent on others for housing o housing dangerous/deteriorating o living companions dysfunctional	Social Support System: o supportive network o few friends o substance-use-based friends o no friends o distance from family of origin	Financial Situation: o no current financial problems o large indebtedness o poverty or below-poverty income o impulsive spending o relationship conflicts over finances
Employment: o employed and satisfied o employed but dissatisfied o unemployed o coworker conflicts o supervisor conflicts o unstable work history o disabled:	Legal History: o no legal problems o now on parole/probation o arrest(s) not substance-related o arrest(s) substance related o court ordered this treatment o jail/prison __ time(s) total time served: _____	Military History: o never in military o served in military – no incident o served in military – with incident o currently serving in military o honorable discharge o other type of discharge:
Sexual History: o straight/heterosexual orientation o lesbian/gay/homosexual orientation o bisexual orientation o transsexual o unsure/questioning orientation o currently sexually active o currently sexually satisfied o currently sexually dissatisfied o age first sex experience: o age first pregnancy/fatherhood: o history of promiscuity age to o history of unsafe sex age to	Cultural/Spiritual/Recreational History Cultural Identity (ethnicity, religion): Describe any cultural issues that contribute to current problem(s): Currently active in community/recreational activities? o Yes o No Formerly active in community/recreational activities? o Yes o No Currently engage in hobbies? o Yes o No Currently participate in spiritual activities? o Yes o No Relationship History and Current Family: o married o children living at home o divorced o children living elsewhere o single o widowed o in a relationship	

TO BE FILLED OUT BY PARENT/GUARDIAN

Strengths and Difficulties Questionnaire

P 11-17

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

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
☐	☐	☐	☐

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
☐	☐	☐	☐

• Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

• 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	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

• 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
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

© Robert Goodman, 2005

TO BE FILLED OUT BY CHILD

Strengths and Difficulties Questionnaire

S 11-17

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

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
☐	☐	☐	☐

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
☐	☐	☐	☐

• Do the difficulties upset or distress you?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

• 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	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

• 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
☐	☐	☐	☐

Your Signature ..... Today's Date .....

Thank you very much for your help

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