# Client Information and Agreement

Welcome to my practice. This document contains important information about how I like to work with my clients. Please read it carefully and jot down any questions you might have so that we can discuss them when we meet.

## *Psychological Services*

Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. To help you, I may use many different methods, including Cognitive-Behavioral Therapy (CBT), solution-focused therapy, family therapy, and others. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

While psychotherapy has been shown to have significant benefits for most people who apply themselves to it, no outcome is guaranteed, and it can be unpleasant, difficult work. Because it often involves discussing troublesome aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.

Our first few sessions will be an evaluation of how best to meet your needs. By the end of the evaluation, I will be able to offer you an assessment of your situation and a plan for moving forward. You should evaluate this information along with your own sense of how comfortable you feel working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. Most clients have questions about the process of therapy, and I encourage you to raise those so we can discuss them when they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

## *Contacting Me / What to do in an Emergency*

I am often not immediately available by telephone. I check voicemail daily, except weekends and holidays, and will make every effort to return your call as soon as I get it. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, the nearest emergency room, or Crisis Support Services at 1 (800) 309-2131. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Ted G. Obbard
Licensed Clinical Psychologist
License #PSY 21799

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## *Arriving Late*

If you are going to be more than 10 minutes late, please call me to let me know, or I may not be available when you arrive.

## *Fees*

I charge $130 for a 50-minute session. I prefer that you pay at the time of the session. If you would like to set up a different arrangement, please let me know.

Once we schedule an appointment, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.

I charge my regular fee for other professional services, including phone calls lasting longer than 10 minutes, report writing, attendance at meetings with other professionals you have authorized, etc. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding.

## *Confidentiality*

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

- If I believe that a child, elderly person, or disabled person is being abused, I am required to file a report with the appropriate state agency.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- If a patient presents a threat of bodily harm to another, I am required to notify the potential victim and contact the police. I also may need to seek hospitalization for the patient.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally

bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you.

## *Minors*

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have.

## *Insurance*

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will give you a bill for my services that you can submit to your insurance carrier for reimbursement. In addition, I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. It is important to me that you receive the services you need, so if your insurance limits your coverage, please inform me of this when we begin, so that we can determine how best to meet your needs.

You should also be aware 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 summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a 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. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

## *Access to Records*

As outlined in the accompanying HIPAA Notice of Privacy Practices, you have certain rights to your Health Insurance Portability and Accountability Act (HIPAA) – defined Protected Health Information. In addition, you are entitled to review or receive any other records that I keep, unless I believe that seeing them would be emotionally damaging. I generally recommend that we review records together. Alternately, I may be able to prepare a summary for you or to send them to a mental health professional of your choice who can review them with you.

Your signature below indicates that you have read and agree to the information in this document.

_____________________________ ____________
Signature Date

_____________________________ ____________
Signature of Parent/Guardian Date

_____________________________ ____________
Signature of Parent/Guardian Date

# Notice of Privacy Practices

**I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCUSSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).**
I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. In addition, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website.

**III. HOW I MAY USE AND DISCLOSE YOUR PHI**
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

**A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

**1. For Treatment.** I can disclose your PHI to physicians, psychiatrists, psychologists, any other licensed health care providers who provide you with health care services or are involved in your care. For example, if you are being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
**2. To obtain payment for treatment.** I can use and disclose your PHI to bill and collect payment for services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
**3. For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountants, attorneys, consultants, and others to make sure that I am complying with applicable laws.
**4. Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. For example, your consent is not required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but your are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

**B. Certain Uses and Disclosures Do Not Require Your Consent.** I can use and disclose your PHI without your consent or authorization for the following reasons:

**1. When disclosure is required by law; judicial or administrative proceedings; or law enforcement.** For example, I may make a disclosure to applicable officials with a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
**2. To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
**3. For workers' compensation purposes.** I may provide PHI in order to comply with workers' compensation laws.
**4. For public health activities.** For example, I may have to report information about you to the county coroner.
**5. For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a healthcare provider or organization.
**6. For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
**7. For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
**8. Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

**C. You Have the Right to Object to Disclosures to Family, Friends, or Others Involved in Your Care.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

**D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

## IV: RIGHTS YOU HAVE REGARDING YOUR PHI

**A. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

**B. The Right to Choose How I send PHI to You.** You have the right to ask that I send information to you at an alternate address or by alternate means. I must agree to your request so long as I can easily provide the PHI to you in the format you request.

**C. The Right to see and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 per page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and the cost in advance.

**D. The Right to Get a List of the Disclosures I Have Made.** You have the right to get a list of instances over the previous six years in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made directly to you, or to your family, or for treatment, payment, or health care operations. The list also will not include uses and disclosures made for national security purposes, or to corrections or law enforcement personnel.

**E. The Right to Request Corrections or Updates to Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI.

**F. The Right to Get this Notice by Email.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

**V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES.** If you think that I may have violated your privacy rights, or you disagree with a decision I make about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

**VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES.** If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Dr. Ted Obbard, 2801 Piedmont Avenue, Berkeley, CA 94705, (510) 495-5080; DrTedObbard@Gmail.com

This notice went into effect on January 1, 2008.

**I have received, reviewed, and agree to the above Notice of Privacy Practices:**

Name: ___________________________________________________

Signature: ________________________________________________ Date: ___________________

## Insurance Information

Policy holder's Name: ________________________________________

Policy holder's Employer ____________________________________

Policy holder's Date of Birth: _____/_____/____ Marital Status: _______

Policy holder's Social Security Nr: ______________________________

Policy holder's Address: ______________________________________

City: ___________________ State: _______ Zip: _______________

Is this policy in client's name? Yes ( ) No ( )

If no: Client's name: ______________________________

Client relationship to policy holder (e.g. spouse, child)? ______________________

Client's Date of Birth: _____/_____/____ Soc. Security Nr. ______________________

**Insurance company**: ______________________________

Insurance ID# ______________________________ Policy or Group# __________________________

Authorization #: ____________________________ Co-payment (if any) ____________________

Billing Address: ______________________________________________________

City: ___________________ State: _______ Zip: _______________

**Second Insurance company (if any)**: ______________________________

Insurance ID# ______________________________ Policy or Group# __________________________

Authorization #: ____________________________ Co-payment (if any) ____________________

Billing Address: ______________________________________________________

City: ___________________ State: _______ Zip: _______________

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# Confidential Information Sheet – Child, Adolescent, and Family

(to be filled out by parent or guardian)

Child's Name: ________________________________________ Today's Date: ____________________

Address: _____________________________________________ Phone (Home): ____________________

Child's Birthday: ______________Age: _____

School: _______________________ School District: _____________________ Grade: ____________

Religion / Spirituality (if any): _____________________ Ethnicity: _____________________________

Pediatrician: ______________________________

Date of Last Medical Check-Up: ____________ Referred by: __________________________________

Name of Person Completing Form: _____________________ Relationship to Child: ____________

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Unmarried

If divorced, who has legal custody : ____________________

Mother's name: _______________________ Hm Ph#: _____________ Cell/Wk Ph#: ______________

Father's name: _______________________ Hm Ph#: _____________ Cell/Wk Ph#: ______________

Emergency Contact: ________________________________ Day time Ph#: _______________

Guardian's name, if different: _______________________ Day time Ph#: ______________

## Consent for Treatment

I am the legal guardian of ___________________________, I have full legal authority to consent to treatment, and I consent to mental health evaluation and treatment of him/her by Dr. Ted Obbard.

_______________________________________________ ____________________________

Signature of Parent / Guardian Date

_______________________________________________ ____________________________

Signature of Patient (12 and older), if applicable Date

Child's Main Problem / Main reason(s) for seeking help: ________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Other Behavior or Emotional Problems: ________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Impact on the Family of these Problems: ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Your Child's Unique Qualities and Strengths ________________________________________________

________________________________________________________________________________

________________________________________________________________________________

What have you tried to do to deal with your child's main problem? ______________________________

________________________________________________________________________________

________________________________________________________________________________

Have you tied counseling previously for your child? If so, for what? ______________________________

________________________________________________________________________________

________________________________________________________________________________

How are you hoping therapy will help you? ________________________________________________

________________________________________________________________________________

How long are you hoping it will take? ____________________________________________________

Has there been any abuse of the child?

| | | |
|---|---|---|
| Physical | ☐ Yes | ☐ No |
| Sexual | ☐ Yes | ☐ No |
| Emotional | ☐ Yes | ☐ No |
| Neglect | ☐ Yes | ☐ No |

If yes, please describe briefly __________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Is there any legal action pending? If yes, please describe: ______________________________________

________________________________________________________________________________

Is there any history of legal action? If yes, please describe: ____________________________________

________________________________________________________________________________

| | | |
|---|---|---|
| Custody | ☐ Yes | ☐ No |
| Visitation | ☐ Yes | ☐ No |
| Probation | ☐ Yes | ☐ No |
| Child Protection | ☐ Yes | ☐ No |
| Adoption | ☐ Yes | ☐ No |

**Behavior Checklist**: Please check any of the following behaviors that concern you:

| | Now | Past | | Now | Past | | Now | Past |
|---|---|---|---|---|---|---|---|---|
| Sadness, crying, depression | | | Temper outbursts | | | Worries more than others | | |
| Loss of enjoyment of usual activities | | | Irritable, angry | | | Unusual fears or phobias | | |
| Expressing a wish to die | | | Argues a lot | | | Panics | | |
| Bedtime fears, won't sleep | | | Disobeys | | | Anxious, nervous | | |
| Has threatened or attempted suicide | | | Does things that annoy other people | | | Repeats an act over and over that is unnecessary (e.g. washing, checking doors, counting, lining things up) | | |
| Sleepwalking | | | Blames others for own mistakes | | | Is overly concerned about things (e.g. germs, safety, or their health) | | |
| Withdrawn | | | Easily annoyed by others | | | Has rituals, habits, superstitions | | |
| Nightmares, night terrors | | | Swears and uses obscene language | | | Twitches or unusual movements | | |
| Low self-esteem | | | | | | Eats little or fasts to lose weight | | |
| Low motivation level | | | Wanting to run away | | | Gorges on food | | |
| Tiredness, fatigue | | | Sneaks out at night | | | Injures self | | |
| Daydreams, fantasizes | | | Stealing | | | Hallucinations (hears or sees things that aren't there) | | |
| Poor appetite | | | Lying | | | Vomits intentionally | | |
| Under or overweight | | | Hurts animals | | | Strange or unusual behavior | | |
| Trouble going to sleep | | | Hurts people | | | Disorientation (confused about the time, who he/she is and where he/she is) | | |
| Sleeps too much | | | Destroys property | | | Bedwetting/daytime wetting | | |
| Easily Distracted | | | Drug use | | | Soiling (pooping) in pants | | |
| Over activity | | | Alcohol use | | | Waking up very early and unable to go back to sleep | | |
| Frequently acts without thinking | | | Cigarette use | | | Restless sleep, wakes up frequently | | |
| Doesn't finish things | | | Sexual problems | | | Has been arrested and/or on probation | | |
| Disruptive | | | Problems with authority | | | | | |
| Short attention span | | | Problems with the law | | | | | |

**Check items that describe your child's relationship development (present or past):**

- ☐ Prefers to be alone
- ☐ Is alone a lot, but is lonely
- ☐ Is shy
- ☐ Has few friends
- ☐ Has many friends
- ☐ Plays with "problem kids"
- ☐ Is picked on a lot
- ☐ Poor relationship with teacher(s)
- ☐ Is oversensitive
- ☐ Is demanding and bossy
- ☐ Fights with others
- ☐ Bullies others
- ☐ Teases a lot
- ☐ Plays with younger kids
- ☐ Plays with older kids
- ☐ Poor relationship with peers
- ☐ Has difficulty getting along with sibling(s)
- ☐ Conflict with parents or step-parents

**Forms of discipline used:**

- ☐ Time out
- ☐ Loss of privileges
- ☐ Grounding
- ☐ Physical punishment
- ☐ Extra chores
- ☐ Rewards/incentives
- ☐ Other: ________________________________________________________________________

________________________________________________________________________________

**School:**

***Check any area of concern:***

- ☐ Dislikes school
- ☐ Works hard, but does not do well
- ☐ Unmotivated, refuses to complete work
- ☐ Learning problems
- ☐ Missed many school days
- ☐ Repeated a grade
- ☐ Discipline referrals / detention
- ☐ Expulsions. How many? ___________

***School Environment***

- ☐ Resource classes / special education
- ☐ Gifted program
- ☐ Speech therapy
- ☐ Continuation School
- ☐ Home Study
- ☐ Independent Study

**Family Stresses**

***Now or in the past, have there been:***

- ☐ Marital problems
- ☐ Marital separation
- ☐ Divorce
- ☐ Custody disputes
- ☐ Financial problems
- ☐ Housing problems
- ☐ Death of a friend
- ☐ Death of a relative
- ☐ Death of a pet
- ☐ Parents using drugs or alcohol
- ☐ Job loss
- ☐ Family Illness. Days missed of work ______
- ☐ Legal stress. What kind? __________________

☐ Other: ______________________________________________

## Developmental History

During pregnancy, did you: ☐ Drink ☐ Smoke ☐ Drugs ☐ Accident ☐ Illness

Did you have any problems with pregnancy, labor, or delivery? ☐ Yes ☐ No

If yes, please describe: ______________________________________________

______________________________________________

Do you remember if your child doing any of the following earlier or later than other children?

Hold Head up / Turn over / Crawl / Sit up / Sleep through the night / Stop breastfeeding / Feed self / Walk on own / Use single words / Use sentences / Toilet train

If yes, please describe how your child was different: ______________________________________________

______________________________________________

**My child as a baby (check all that apply):**

☐ Ate poorly

☐ Was colicky

☐ Was clumsy

☐ Had head banging

☐ Had rocking behavior

☐ Was hard to soothe

☐ Had wild, risky behavior

☐ Wanted to be left alone

☐ Was more interested in things than people

☐ Was hard to get to sleep or eat normally

☐ Had trouble changing situations (getting in car, sitting down to eat, leaving the park)

## Medical History

Indicate if your child had or has any of the following

| | Yes | No | Age | Explain |
|---|---|---|---|---|
| Serious infection | | | | |
| Convulsions | | | | |
| Head injuries | | | | |
| Other injuries | | | | |
| Hospitalizations | | | | |
| Operations | | | | |
| Poisonings | | | | |
| Alcoholism | | | | |
| Drug use | | | | |
| Sexual problems | | | | |

Does your child have other medical conditions? ☐ Yes ☐ No

If yes, please describe: ______________________________________________

______________________________________________

Does your child frequently complain of bodily aches and pains? ☐ Yes ☐ No

If yes, please describe: ______________________________________________

______________________________________________

Does your child miss school because of his/her physical complaints? ☐ Yes ☐ No

If yes, please describe: ______________________________________________

______________________________________________

Does your child have any allergies to medications / drugs? ☐ Yes ☐ No

If yes, please describe: ______________________________________________

______________________________________________

List any medications your child is taking, when it was started, and the dosage.

______________________________________________

______________________________________________

______________________________________________

## Family Information

List all the people who live with the child now

| Name | Age | Relationship | Occupation / School Grade |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Other important people in your child's life

| Name | Age | Relationship | Occupation / School Grade |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Family Information (continued)

| | Father | | Mother | | Sibling | | Other ______ | | Other ______ | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Now | Past (When) | Now | Past (When) | Now | Past (When) | Now | Past (When) | Now | Past (When) |
| Problems with attention, activity, impulse control | | | | | | | | | | |
| Learning disabilities | | | | | | | | | | |
| Did not graduate High School | | | | | | | | | | |
| Alcohol Abuse | | | | | | | | | | |
| Drug Use | | | | | | | | | | |
| Problems with aggressive behavior | | | | | | | | | | |
| Jail arrests / legal problems / probation | | | | | | | | | | |
| Abuse victim | | | | | | | | | | |
| Abusive to others | | | | | | | | | | |
| Depression | | | | | | | | | | |
| Nervous disorder | | | | | | | | | | |
| Mental retardation | | | | | | | | | | |
| Serious illness/operation | | | | | | | | | | |
| Physical handicaps | | | | | | | | | | |
| Tics or unusual movements | | | | | | | | | | |
| Other mental problems | | | | | | | | | | |

What are your family supports? (for example, church, friends, clubs)? ______________________________

_______________________________________________________________________________

_______________________________________________________________________________

What are your family strengths? _______________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Anything else I should know about your child or your family? ____________________________

_______________________________________________________________________________

_______________________________________________________________________________