Mark Barnes, PhD.
5080 North Fruit Avenue Suite 103 Fresno, CA 93711 (559) 978-3339

Child & Adolescent Intake Packet

Please complete each item thoroughly and currently. Take your time and give your thoughtful consideration to each question. When done, give this packet to Dr. Barnes.

Today's Date _____/_____/_____

Name of Person Filling Out This Form: Relationship to Child:		Name of Legal Custodians: Relationship to Child:			
Patient's Last Name	First	Middle	Birth Date / /	Age	Gender □ M □ F □ Other
Street Address	City		State	Zip Code	
Home Phone No. ( )	School:			Grade:	
Best phone number to reach responsible party if session has to be cancelled or rescheduled: **Party:** **Number: ( )** **Confidential Voice Mail** □ **Yes** □ **No**					

Biological Parents Status:

□ Married □ Living Together Not Married □ Divorced □□ Separated □ Parental Rights Terminated □□ Widow

□ Joint Legal Custody □ Sole Legal Custody □ Specify Custodian:

Attach a copy, if applicable of the court order which determines custody arrangements and legal custodianship. This is necessary for our records.

Biological Mother's Last Name	First	Middle	Birth Date / /	Gender □ M □□ F	*Email address:*	
Street Address	City				State	Zip Code
Home Phone No. ( )					Cell Phone No. ( )	
Occupation	Employer				Employer Phone No. ( )	

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Biological Father's Last Name	First	Middle	Birth Date / /	Gender ☐ M ☐ F	*Email address:*	
Street Address	City				State	Zip Code
Home Phone No. ( )					Cell Phone No. ( )	
Occupation	Employer				Employer Phone No. ( )	

Nearest Relative Not Living with You _____ Address _____

Phone#:_____ Cell#_____

Emergency Contact _____ Address _____

Phone# _____ Cell# _____

Other Family Relations

Check Relationship:

☐ Stepfather ☐ Foster Father ☐ Adoptive Father ☐ Legal Custodian

☐ Stepmother ☐ Foster Mother ☐ Adoptive Mother ☐ Other

Last Name	First		Middle	Birth Date / /	Sex ☐ M ☐ F	E-mail Address
Street Address	City	State	Zip Code	Cell Phone No. ( )		Home Phone No. ( )
Occupation		Employer				Employer Phone No. ( )

Check Relationship:

☐ Stepfather ☐ Foster Father ☐ Adoptive Father ☐ Legal Custodian

☐ Stepmother ☐ Foster Mother ☐Adoptive Mother ☐ Other

Last Name	First	Middle	Birth Date / /	Sex ☐ M ☐ F	E-mail Address

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Street Address	City	State	Zip Code	Cell Phone No. ( )	Home Phone No. ( )
Occupation		Employer			Employer Phone No. ( )

Siblings	Age	□ full □ half sib paternal □ step sib paternal □ step sib maternal □ half sib maternal □ adoptive sib
		□ full □ half sib paternal □ step sib paternal □ step sib maternal □ half sib maternal □ adoptive sib
		□ full □ half sib paternal □ step sib paternal □ step sib maternal □ half sib maternal □ adoptive sib
		□ full □ half sib paternal □ step sib paternal □ step sib maternal □ half sib maternal □ adoptive sib

Consent for Treatment and Financial Agreement

As this child's legal custodian, I authorize Mark Barnes, Ph.D. to provide these services:
Psychological Services □ Yes □ No

_____ ___/___/____ __/__/____
Signature of Patient or Financial Guarantor **SS Number** **Date**

_____Parent/Intact Marriage

Divorced/Legally Separated/Estranged, Never-Married Parents: ____ Joint Legal Custody ____Sole Legal Custody
(Please provide legal documentation regarding custodial status)

Other Legal Relationships – please be specific: _____

I realize that it is **solely** my responsibility to pay for services at the time of service. By signing this Financial Agreement I agree to accept an invoice or superbill should I wish to present it to my insurance company for reimbursement to me directly. I agree to accept whatever my insurance will pay to me regardless of the amount charged. The relationship between my insurance company and I is solely my responsibility and does not reflect on my payment to Dr. Barnes. Furthermore I agree to make payment at the time of service and will not request Dr. Barnes to bill my insurance. I understand that this account may be subject to finance charges of 1.5% per month (18% per annum) of the unpaid balance after 90 days. Furthermore, I agree to speak with Dr. Barnes if my ability to pay is compromised such that a payment arrangement needs to be made. If the account becomes delinquent and referred to an attorney or collection agency, I will be held responsible for actual attorney fees and collection expenses.

_____ _____
Signature of Patient or Financial Guarantor **Date**

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Office Policies

MEDICAL/MENTAL HEALTH RECORD KEEPING: The privacy of your medical and mental health information is extremely important to us and we are committed to protecting your privacy. We create a record of care which includes dates of service and type of treatment provided. Dr. Barnes maintains paper records and also makes use of electronic record keeping and electronic billing. All records, whether paper or digital, are maintained by Dr. Barnes in full compliance with state, federal, and professional regulations.

LEGAL CONSENT TO TREATMENT: Any individual over the age of eighteen, who is not legally prohibited from doing so, consents to their own treatment. For minors under the age of eighteen, it is Dr. Barnes policy that legal guardians provide written consent. In situations of joint legal custody, it is Dr. Barnes policy that both legal guardians must consent to treatment. A parent having sole legal custody may consent to treatment. It is my policy to request proof of legal custody or guardianship. There are no exceptions to the above policy.

CONFIDENTIALITY: To maximize the benefit of evaluation and treatment trust must be developed between patient and therapist; you must be open and honest. Information disclosed within therapy is confidential and may not be revealed to anyone without your written consent except where disclosure is required by law. Dr. Barnes will discuss issues of confidentiality and will ask for your consent to communicate with anyone considered essential for appropriate evaluation and treatment. Children and adolescents also have the right to confidentiality with their therapist. Sharing helpful information between parents and children is necessary in the treatment of adolescents and children. Your therapist will discuss what is needed and appropriate with you and your child and request your consent.

LIMITS OF CONFIDENTIALITY: Dr. Barnes is a mandated reporter in accordance with California State Law. Disclosure may be made or is mandated in the following circumstances: 1) Where there is a reasonable suspicion of a child neglect/abuse, abuse of disabled persons, or elder adult physical abuse/severe neglect. 2) Where the patient is likely to inflict serious self- harm. 3) Where there is a reasonable suspicion that the patient presents a danger of violence to others. Dr. Barnes has a duty to warn persons in a life-threatening situations and must make a report to authorities and the intended victim(s) to prevent serious imminent harm to another or the public. 4) Dr. Barnes is a mandated reporter to the Food and Drug Administration regarding the adverse effects of prescribed medications. 5) Disclosure may also be required pursuant to some legal proceedings, such as custody disputes. The Dr. Barnes will release confidential information in the course of judicial/administrative proceedings as required by law, law enforcement purposes as required by law, a valid court order, or as provided by your specific written consent. 6) In the event of an emergency, confidential information may be disclosed to notify a person responsible for the care of a minor regarding your location, general condition, or medical information. 7) If you are seeking Worker's Compensation, or you are receiving services through Victims of Crime, or any other third-party which is covering payment, it is necessary for Dr. Barnes to disclose confidential information to those agencies either as required by law or contract.

Since agencies vary, if your services are financially supported by a third-party agency, or mandated by court order, you and your clinician will discuss specific limits of confidentiality.

I understand and agree. Please Initial Here _____

USE CONFIDENTIAL INFORMATION: Dr. Barnes will use your mental health records for these purposes. 1.) Treatment: Dr. Barnes will maintain treatment information and records. This information is used to document progress, and record other information relevant to services rendered. 2.) Financial Arrangements/Payment: You must be aware that in the event that your account is in default, limited and specific information may be released to a Credit Collection Agency in order to settle your account. 3.) Dr. Barnes may also obtain services from our business associates such as accounting/legal service providers or our insurers as necessary. Quality assurance consultants, transcriptionists, billing services, practice reviewers, auditors, certification/accreditation agencies, and other professionals may use confidential information. These business associates are required to appropriately safeguard your information and any statistical analyses or data exchanges made are conducted without inclusion of identifying information wherever possible. 4.) As a training institution, clinical records are reviewed by supervisors and their trainees.

I understand and agree. Please Initial Here _____

TRAINING AND RESEARCH: Dr. Barnes for Reserves the right to offer training and research opportunities to others in the field of clinical psychology. He is committed to ongoing training and research in the areas of childhood, adolescent, and family psychopathology, psychological assessment, psychological and psychiatric treatment, treatment outcomes, and mental health service delivery. Dr. Barnes may use case material and mental health records of patients for such purposes. In addition patients may be asked directly to participate in a research study or provide information for research purposes. All personal data is thoroughly disguised for such purposes to assure maintenance of patient confidentiality. Dr. Barnes adheres to all ethical and legal standards for research and research participants outlined by the American Psychological Association and the California Board of Psychology.

I understand and agree. Please Initial Here _____

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PATIENT RIGHTS: Billing and patient care information is maintained in electronic and hardcopy records. If you wish to exercise any of these rights, please contact Dr. Barnes at 5080 North Fruit Avenue Suite 103, Fresno, CA 93711, phone: (559) 978-3339, during normal business hours. You may also contact billing staff at Billing@therapy4kidsfresno.com. Either can assist you in the proper exercising of your rights. The information maintained is available to you in accordance with the following rights.

1. If you would like to limit or restrict the use or disclosure of your health information, you have a right to make such a request in writing. The Dr. Barnes may not unconditionally approve the request, but each request is carefully reviewed.
2. You will receive a hardcopy of the Dr. Barnes "Notice of Privacy Practices for Protected Health Information." You may also access this information on our website, www.therapy4kidsfresno.com
3. By written request, you may request a copy of your health and billing records, although we are not required to approve all such requests. For copies, pre-payment of two-dollars ($2.00) per page, with a thirty-dollar ($30) minimum fee (in order to cover staff and equipment costs to reproduce your record) is requested. Records are available for in-person pickup within 30-days of receipt of pre-payment (delivery alternatives are available and must be requested in writing). In the event Dr. Barnes determines your access to information may be harmful, additional steps are necessary, and you may wish to discuss this in person with Dr. Barnes to better discuss questions you may have concerning request for records.
4. You may request, in writing, that your health record be amended to address incomplete or incorrect information. Not all requests are accepted although you may appeal a denial by providing an appeal request in writing. If your appeal is denied you may file a statement of disagreement and request that this statement be attached to any required future disclosures.
5. By written request, you may obtain an accounting of disclosures of confidential information made without your permission or request.
6. You may revoke, in writing, any previous authorization to disclose confidential information at any time and the revocation will be effective upon receipt for all future disclosures.

Dr. Barnes reserves the right to refuse services to anyone, including the discontinuation of services as established by legal and professional regulations. Dr. Barnes also reserves all rights to modify or amend these policies. You may file written complaints with Dr. Barnes. You may also file a complaint with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Dr. Barnes does not require you to waive your right to file a complaint in order to receive services here.

EMERGENCY PROCEDURES: If a need arises to contact Dr. Barnes therapist between sessions, please call him at (559) 978-3339 and your call will be returned as soon as possible. If you have an emergency, be sure to inform Dr. Barnes of the emergent nature of your call so that your call will be handed as quickly as possible. Of course, if an emergency is life-threatening, please dial 911 or proceed to the nearest emergency room.

APPOINTMENTS: Initial evaluations may take anywhere from thirty minutes to three hours depending on the nature of the assessment. Individual therapy sessions are usually 45 to 50 minutes though longer or shorter sessions may be prearranged with Dr. Barnes. You are expected to arrive to each appointment on-time and Dr. Barnes will not extend sessions to make up for lost time when you are late. Dr. Barnes will make every effort to attend each appointment on-time. There are also situations, where therapy sessions must be delayed, such as in emergency session-extensions. In such situations your Dr. Barnes will attempt to extend your appointment or provide other arrangements to make up for the lost appointment time.

CANCELLATIONS: Scheduling an appointment involves reservation of time specifically for you. A **minimum of twenty-four (24) hours notice is required** for rescheduling or cancellation of an appointment. The full session fee (typically $175.00) will be charged for missed sessions without such notification. Dr. Barnes may waive this fee in the case of emergencies or acute medical illness. Your insurance company or other third party payer will not pay for late cancelled or failure to cancel a session; you will be solely responsible for this expense. This is a busy practice; your cooperation is essential so that we can provide maximum service to all clients. Even if you fail to provide advanced notice, contact Dr. Barnes as soon as possible and explain the mishap. If you fail to communicate about missed sessions for two consecutive sessions or for three-missed sessions within any six (6) month period of time, Dr. Barnes **may** initiate **termination of your services here** and would may refer you to another agency for continued care.

I understand and agree. Please Initial Here _____

PAYMENT FOR SERVICES: Payment is expected at the time of service or if there is a prior agreement with Dr. Barnes. **There may also be fees associated with report preparation, letter writing, and extended telephone consults, that will not be covered by your insurance. Please discuss specific fees or other details with Dr. Barnes prior to having these services performed**. *There will be a $50.00 service charge for any checks returned by your banking institution*. Discuss fees and payment with Dr. Barnes and please notify him if any problems arise during the course of treatment regarding your ability to make timely payments. A Finance Charge of 1.5% per month (18% per annum) of the unpaid balance may be assessed after 90 days.

I understand and agree. Please Initial Here _____

ABOUT THIS PRACTICE: I provide a variety of services including individual, couples, group, psychotherapy, psycho-education, consultation, school counseling, psychological assessment, forensic assessment, and treatment. Dr. Barnes is actively engaged in ongoing continuing education and follow the highest professional and ethical standards. Psychologists like Dr. Barnes have a doctorate degree in psychology, have completed both

pre- and post-doctoral internships, and have completed strict state competency standards for licensure. Psychologist may conduct personality or neurocognitive assessments, forensic assessments, provide psychotherapy, or supervise psychological trainees and interns. Psychiatrists have a medical doctorate and have completed medical school with additional training including residency in Psychiatry. At times Dr. Barnes may employ other mental health clinicians such as Licensed Professional Counselors (LPC), Licensed Clinical Social Workers (LCSW), and Licensed Marriage and Family Therapists (LMFT). All have completed a Bachelors and/or Master's Degree in social work or a related field and can provide psychotherapy, and case management/care coordination. Also, Dr. Barnes may employ Psychology Post-Docs or Psychological Assistants who have completed their doctoral degree and are practicing under the supervision of Dr. Barnes. Psychology Interns are in their final year of doctoral training, and Practicum Students are Master's level trainees. They are registered by the Board of Psychology as Psychological Assistants or by the Board of Behavioral Science as trainees, and are supervised by a Licensed Psychologist, Dr. Barnes.

Psychotherapy and counseling have earned a reputation for enhancing the quality of life of others. Although the vast majority benefit from these services, there are no certainties and each person will experience these services differently. All psychotherapy involves a substantial commitment, and as with most endeavors, the amount of effort you put forth into your treatment will impact the outcome greatly. Psychotherapy often involves an unsteady rate of progress and many people experience periods of depression, anger, resentment, guilt, fear, tension, anxiety, and other feelings during treatment. Services are provided without warranty or guarantee, but it is important to notify Dr. Barnes if you feel you or your child are experiencing any negative effects as a result of treatment.
You can expect Dr. Barnes to share with you:

a. his understanding of the problems you have brought to his attention
b. his approach to those problems
c. other approaches he may be aware of
d. what research says about the advantages and disadvantages of various approaches
e. his assessment of progress or lack thereof and resultant options he may be aware of
f. his best opinion about what may happen without treatment
g. a good faith estimate of expected costs for treatment

Dr. Barnes makes every effort to inform patients of all options for treatment. If you feel that your treatment is not progressing in the way that it should, please discuss this with Dr. Barnes. Sometimes treatment advances most rapidly during moments where you and your therapist directly address such obstacles.

I have read and understand each of the above policies. I agree to follow and abide by them. I understand that I may revoke my consent, by submitting revocation in writing to Dr. Barnes, which will be made effective upon receipt. Your signature below also acknowledges that you have received a copy of these policies and the HIPAA Notice of Privacy Practices.

_____
Signature of Patient or Responsible Party Today's Date

I HEREBY ACKNOWLEDGE REVIEW OR RECEIPT OF THE ABOVE Notice of Office and Privacy Practices, According to HIPAA

Patient Signature: _____ or

Signature of Legal Guardian: _____

Printed Name of Legal Guardian: _____

_____ Parent _____ Other: Specify Legal Relationship _____

Date: _____

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Physical Health Questionnaire

Check if client has or had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Seizures ☐ Head/Neck Injury ☐ Ear/Nose/Throat ☐ Headaches ☐ Skin ☐ Lungs	☐ Chest/Heart ☐ Back ☐ Intestinal ☐ Bladder ☐ Bowel ☐ Circulation	**Any Recent Changes In:** ☐ Weight ☐ Energy Level ☐ Ability to Sleep ☐ Mood Other Pain/Discomfort:
Childhood Illnesses: ☐Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations: ☐ Tetanus ☐ Pneumonia ☐ Hepatitis ☐ Chickenpox ☐ Influenza ☐ MMR		
List Any Medical Problems or Conditions (Include Diagnosis and Diagnosing Doctor's Name if Known):		
Surgeries/Hospitalizations Year Reason Hospital		
Exercise ☐ Sedentary ☐ Mild Exercise ☐ Occasional Vigorous Exercise ☐Regular Vigorous Exercise		
Diet: Is client dieting? ☐Yes ☐ No If yes, is this a physician prescribed diet? ☐ ☐ Yes ☐ No Estimate Salt Intake: ☐ Hi ☐ Med ☐ Low ☐ Estimate Fat Intake: ☐ Hi ☐ Med ☐ Low Estimate Sugar Intake: ☐ Hi ☐ Med ☐ Low ☐Estimate Caffeine Intake: ☐ Hi ☐ Med ☐ Low		

List All Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Medication	**Dosage**	**Reason/Purpose**	**Age when first Prescribed**	**Age when Discontinued**	**Prescribed Doctor**

Allergies to Medications (provide the name of drug and the reaction that occurred):
Please describe any family history of medical conditions:
Please describe any family history of mental illness, including drug/alcohol abuse and domestic violence:

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Briefly describe what services you are seeking and your expectations for treatment.

Please Circle All That Describe the Client:

Very unhappy	Irritable	Temper outbursts	Withdrawn	Sleeping problems	Hallucinates	Day-wetting	Overeating
Fearful	Clumsy	Overactive	Slow	Short attention	Nightmares	Daydreaming	Worrisome
Distractible	Phobic	Lacks initiative	Impulsive	Undependable	Stomachaches	Suicide talk	Pessimistic
Peer conflict	Stubborn	Disobedient	Infantile	Mean to others	School anxiety	Sickly	Agitated
Destructive	Rocking	Trouble with law	Shy	Running away	Poor hygiene	Soiling	Forgetful
Fire setting	Stealing	Sexual trouble	Lying	Self-mutilation	Anorexic	Bedwetting	Abusive
Head-banging	Truancy	Strange behavior	Drug use	Strange thoughts	Hyperactive	Alcohol use	Cruel

☐ Yes Plays with matches, set fires, use firecrackers, bombs, or explosives?

☐ Yes Ever made a serious threat or attempt to cause serious injury/harm/killing of self?

☐ Yes Or, made a serious threat or attempt to cause serious injury/harm/killing another

☐ Yes Threaten attempt, or engaged in serious destruction of property, including fire setting.

☐ Yes Preoccupied with death, dying or morbid thoughts? Draws vivid morbid or angry pictures?

☐ Yes Inappropriate sexual conversations, behaviors, or sexual activity?

☐ Yes Complaint/reports of inappropriate sexual activity with another?

☐ Yes Any access to guns, rifles, weapons in home or friend/relatives home (whether locked up or not)?

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Please check yes if any of these symptoms are apparent to you. You can offer elaboration of details upon interview.

☐☐ Yes Recent changes in vision, balance, hearing, or coordination?
☐☐ Yes Require hearing aid, have tubes in ears or frequent ear infections or hearing loss?
☐☐ Yes Wears glasses, contact lenses, hearing aid or a prosthesis?
☐☐ Yes Needs/uses leg braces, crutches, prescription shoes, etc?
☐☐ Yes Excessive shakiness, arm or leg tremors?
☐☐ Yes Difficulty sleeping, falling asleep, or difficulty waking up in morning?
☐☐ Yes Frequent or disturbing nightmares? Night sweats/terror?
☐☐ Yes Difficulty eating, excessive eating, or forced vomiting?
☐☐ Yes Appear to be depressed?
☐☐ Yes Unusually lethargic, tired, bored, or apathetic? Cries frequently?
☐☐ Yes Panics when stressed?
☐☐ Yes Ever attempted or threatened to attempt suicide?
☐☐ Yes Ever seriously thought about hurting themselves?
☐☐ Yes Been to a counselor or therapist?
☐☐ Yes Any history of a seizure or epileptic attack?
☐☐ Yes Ever been in a car during a serious car accident?
☐☐ Yes Any history of head injury or black-outs?
☐☐ Yes Recent dizziness spells?
☐☐ Yes Recent surgery or hospitalizations?
☐☐ Yes Loss of simple movement of various body parts (Paralysis).
☐☐ Yes Increased difficulty in concentration or attention
☐☐ Yes Increased moodiness or irritability
☐☐ Yes Negative changes in personality or social behaviors
☐☐ Yes Increased difficulty in distinguishing left from right.
☐☐ Yes Increased difficulty with doing mathematics
☐☐ Yes Increased difficulties with eye and hand coordination
☐☐ Yes Hallucinations: visual, auditory, or olfactory (smell)
☐☐ Yes Decreased school performance?
☐☐ Yes Suspicion of the misuse of over the counter/prescription medications?
☐☐ Yes Has numerous rituals or specific routines and becomes very agitated when altered?
☐☐ Yes Refuses to sleep in own room or alone in own bed
☐☐ Yes Has begun to wet the bed again yet stopped previously?
☐☐ Yes Suspicions of drug and alcohol abuse?

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Prenatal & Early Developmental History

The client is the mother's ☐ 1st born ☐ 2nd born ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ Other: _____th

1.) Does mother have history of previous: ☐ Miscarriage ☐ Abortion ☐ Stillbirth

2.) During the pregnancy, were there any complications, unusual symptoms, high emotional stress, or physical injuries? _____

Approximate month problems began: Any hospitalizations during term?

3.) Any use of ☐ Tobacco ☐ Coffee/Soda/Caffeine ☐ Alcohol ☐ Opiates ☐ Stimulants
Exposure to: ☐ Marijuana ☐ Methamphetamine/Stimulants ☐ Crack/Cocaine ☐ Other: _____
Also, please list any prescription medications used during pregnancy:

4.) Was the pregnancy full-term (40 weeks)? ☐☐ Yes ☐☐ No, born premature during _____ week, due to: _____

5.) During delivery were there any complications, unusual symptoms, or problems that occurred?
_____

6.) Delivery was: ☐ C-Section ☐ Vaginal ☐ Head First ☐ Feet First ☐ Breech ☐ Forceps ☐ Vacuum
Birth weight: _____ Pounds _____ Ounces Birth length: _____ Inches

Developmental Milestones

	Age		Age
Hold Head Up	_____	Stood Independently	_____
Rolled over	_____	Walked Independently	_____
Sat up	_____	First word	_____
Crawled	_____	Combined words	_____
		Toilet trained	_____

Any additional information of significance regarding early development.

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Legal Issues: (list the attorneys and who they represent)	Address:	Dates Seen:
Current or Assigned Psychotherapist:	Address:	Dates Seen:
Previous Psychotherapists:	Address:	Dates Seen:
Speech Therapist:	Address:	Dates Seen:
Occupational Therapist:	Address:	Dates Seen:
Previous Psychiatrists:	Address:	Dates Seen:
Primary Care Physician:	Address:	Dates Seen:
Previous Psychological Testing/Educational Testing:	Address:	Dates Seen:
Previous Mental Health Agencies Involved:	Facility:	Therapist
Previous Residential Mental Health or Hospital Mental Health Services:	Facility:	Therapist

If there is anything else that you would like to comment upon, please make a notation below and continue on the back of this paper.

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EDUCATIONAL HISTORY

List all schools attended with the district, academic years and grades attended schools. Beginning with current year and grade back to preschool.

School	District	Grades Attended	Academic Years Attended

Has the child ever been diagnosed with a Learning Disability? □ Yes □ No

Has the child ever received Special Education services □ Yes □ No
Be specific as to when and what type

_____

_____

_____

Academic Performance Currently: Excellent Adequate Poor

_____

Any history of CPS Involvement:

Describe any current litigation involving the patient:

Describe any involvement with the Juvenile Justice System:

History of Drug/Alcohol Abuse: Please list types of drugs, how much and how often: