Diane Prince Goula LCSW Board Certified Diplomate in Clinical Social Work
14362 N. Frank Lloyd Wright Blvd. #2151, Scottsdale, AZ 85260
e-mail: Diane@DianeGoula.com, www.DianeGoula.com
O: (480)991-0296, Fax: (480)436-6666

NEW CLIENT INFORMATION-CHILD

Minor's Name:_____Sex: Male Female DOB:_____Age:____SSN:_____

Mother's Name:_____Address:_____City:_____State:____Zip:_____

DOB:_____Mobile:_____Home:_____Work:_____Fax:_____E-Mail:_____

To permit text appointment reminders please list your mobile carrier:_____/ OK to e-mail? Yes No / OK to fax? Yes No
Authorization to leave messages with family members or on home answering machine? Yes No On work voicemail? Yes No Initials_____

Father's Name:_____Address:_____City:_____State:____Zip:_____

DOB:_____Mobile:_____Home:_____Work:_____Fax:_____E-Mail:_____

To permit text appointment reminders please list your mobile carrier:_____/ OK to e-mail? Yes No / OK to fax? Yes No
Authorization to leave messages with family members or on home answering machine? Yes No On work voicemail? Yes No Initials_____

Joint or Sole Custody?_____Name of Primary Custodial Parent:_____

If Sole Custody, can contact with the non-custodial parent be obtained? Yes No Signature:_____

Name of Emergency Contact:_____Phone #:_____Relationship:_____

****

Referred by: Insurance Work EAP Friend Other:_____Auth. #:_____

#of sessions authorized _____ Co-pay amount _____Has your deductible been met? Yes No N/A

Name of Primary Insured:_____DOB:_____SSN:_____

Name of Insurance Plan:_____ID #:_____Group/ Account #:_____

Number to check benefits/ eligibility on back of card_____Name of Employer:_____

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Name of Secondary Insured:_____DOB:_____SSN:_____

Name of Insurance Plan:_____ID #:_____Group/ Account #:_____

Number to check benefits/ eligibility on back of card_____Name of Employer:_____

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REPORT OF ABUSE: I understand that state laws require that Diane Goula report all cases of physical or sexual abuse or neglect of minors or the elderly and, in all cases in which the patient presents as a danger to themselves or others.

Signature:_____Date:_____

Please list any medical conditions: _____

What medications is your child currently taking? N/A

NAME	DOSAGE	WHEN TAKEN	WHO IS PRESCRIBING?

Do you or others close to you have concerns about your child's drinking or use of prescription/ illegal drugs? Yes No

If you answered yes, please explain: _____

_____

Has he/she ever received treatment for alcohol abuse or substance abuse? Yes No If you answered yes, list date(s) and who you saw for treatment?

_____

Does your child smoke? Yes No If you answered yes, how many cigarettes per day? _____

Previous counseling: List date(s) and name of provider(s): _____

_____

_____

Why are you seeking counseling at this time? _____

_____

_____

If counseling were to be helpful what changes would you like to see in your child? This will become part of your treatment plan.

1. _____
2. _____
3. _____
4. _____

Signature _____ **Date** _____

Therapist signature _____ **Date** _____

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FINANCIAL AGREEMENT

AUTHORIZATION FOR DIRECT PAYMENT - RELEASE OF RECORDS: I hereby authorize insurance payments to be made directly to Diane Goula. I authorize Diane Goula to release necessary information to my insurance company to secure the payment of benefits.

I understand that I, not my insurance company, am financially responsible for any charges which become ineligible or are denied by my insurance carrier. If, for some reason, the information regarding my insurance coverage changes or my coverage is terminated, I will immediately notify Diane Gouda.

If I fail to pay an outstanding balance within 60 days, Diane Goula will refer this to a collection agency and will charge me for the cost of collection in addition to my balance.

Signature:_____Date_____

CANCELLATION POLICY: I understand that by making an appointment I am contracting for Diane Goula's time. Therefore, prior notice, by 5:00 pm the day preceding my appointment, is required for all cancellations and that I may cancel my appointment by notifying the answering service, Diane@DianeGoula.com or Diane Goula's voicemail, 480-991-0296, available 24 hours per day. I understand that insurance will not pay for missed appointments and that I will be held responsible for payment of missed appointments or late cancellations of a non-emergency nature as missing my appointment doesn't allow the time to schedule another client. This charge will be $60.00 for the first missed appointment and $100.00 thereafter. I understand that if I Fail to Show or Late Cancel my first appointment, I will be required to put a credit/ debit card on hold before I can schedule another appointment.

Signature:_____Date_____

I authorize Diane Goula, L.C.S.W. to keep my signature on file and to charge my credit/debit account for:

- **Recurring charges/ co-pays (on-going treatments) of $_____every session from_____ (onset of therapy to _____(end of therapy).**
  (fee) (date) (date)
- **Balances of charges not paid to me or from insurance within 90 days and not to exceed $_____ for:**
  This visit only_____ All visits_____
- **No Show/ Non-emergent late cancellations (not made prior to 5:00 pm on the day preceding scheduled appointment).**

I understand that I may revoke this agreement at any time by providing a request in writing.
Client's Name_____ Cardholder's Name_____
Cardholder's address_____
City_____State_____Zip_____
_____Visa _____Mastercard (American Express or Discover not accepted)

Account Number_____Expiration date_____CCV Code:_____

Signature_____ Date_____

I agree to only charge for services rendered; failure to show for appointment or for non-emergent cancellations if appointment is not cancelled by 5:00 pm on the day preceding your scheduled appointment.

Diane Goula, L.C.S.W._____Date_____

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RELEASE OF INFORMATION

To: (Name of your Primary Care Physician, treating psychiatrist or behavioral health clinician)

Name/Agency____
Address____
City, State, Zip______________________________________
Telephone:____________________ Fax:____________________

CLIENT:____________________________________ DOB____________

PERMISSION TO RECEIVE, RELEASE, OR EXCHANGE INFORMATION

The agency and/or individual above is authorized to:

- □ receive the type(s) of information indicated below from Diane Goula, LCSW.
- □ release and transmit the type(s) of information indicated below to Diane Goula, LCSW.
- □ exchange and transmit the type(s) of information indicated below with Diane Goula, LCSW.

It is understood that this information may be shared through verbal and/or written means for treatment planning.

□ Medical History	□ Psychosocial History	□ Teacher Observations
□ Hospital Records	□ Psychological Evaluation	□ Educational Tests
□ Psychiatric Exam	□ Counseling Progress Notes	□ School Records
□ __________	□ __________	□ __________

It is understood that records are protected under federal confidentiality regulations and cannot be released without the permission of the client unless otherwise provided for in the regulations.

By signing this consent form, I voluntarily waive the confidentiality of the above noted information which would otherwise be protected by law. Unless revoked earlier, it is mutually understood that this consent expires in ninety days or on the day of my discharge from treatment with Diane Goula, LCSW (whichever is later).

________________________________Date____________
Signature of Client

____
Signature of Parent or Guardian (if client is a minor)

****

I decline the sharing of counseling information with my Primary Care Physician.

____
Signature of Client Date

(This release of information is designed to satisfy federal confidentiality guidelines)
A photo copy of this release is valid.

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NOTICE OF PRIVACY POLICIES

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as **Protected Health Information** (**"PHI"**). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and professional codes of ethics. It also describes your rights regarding how you may gain access and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice. I reserve the right to change the terms of this Notice at any time. Any new Notice will be effective for all PHI that I maintain at that time. I will provide you with a copy of any revised Notice of Privacy Practices at your request.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care and for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment: I may use and disclose PHI so that I can receive payment for the treatment provided to you only with your authorization. This may include determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review practices. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

Your PHI will also be used by my scheduler to call/leave appointment reminders UNLESS YOU REQUEST IN WRITING THAT THIS NOT BE DONE. You will be asked for a telephone number where we can reach you or leave a reminder message.

I may call you by name in the waiting room when I am ready to see you for your appointment.

When communicating by telephone, I will provide information to you only, regarding your care, or to the parents/legal guardians of minors. Exceptions to this are noted elsewhere in this Notice.

Required by Law: Under the law I must make disclosure of your PHI to you upon your request. In addition I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR CONSENT

I may use your PHI without your consent in the following situations: a) when disclosure is required by federal, state, or local law; b) when abuse or neglect is suspected: c) for judicial and administrative proceedings: d) in the event of a patient's death; e) in emergency situations; f) in situations where a family member is involved in your care; g) if health oversight is suspected: h) if requested by law enforcement agencies or national security agencies; j) for Workman's Compensation purposes; k) if it is my duty to warn that you are a danger to yourself, others, or the property of others; l) mandatory government audits or investigations; m) court orders; n)for research purposes.

Verbal Permission: I may use or disclose your information to family members who are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me. You may incur reasonable charges for these requests.

a) You have the right to inspect and copy PHI that may be used to make decisions about your care. Your right will be restricted only in those situations where there is compelling evidence that access would cause you serious harm to you. Psychotherapy notes have special protection under HIPAA. Psychotherapy notes are intended for the my sole use. The right to view or get copies of your PHI does **not** include access to psychotherapy notes.
b)You have the right to ask me to amend any information in your PHI that you feel is incorrect or incomplete, although I am not required to agree to the amendment.
c) You have the right to request an accounting of certain disclosures that I make of your PHI. The list will not include disclosures to which you have already consented or disclosure you made prior to April 15, 2003. I may require a reasonable fee if you request more than one accounting per 12-month period.
d) You have the right to request a limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. I am not required to agree to your request.
e) You have the right to request that your PHI be sent to you at an alternate address or by an alternate method, provided this can be done without my undue inconvenience.
f) You have the right to keep a copy of this Notice.

COMPLAINTS

If you wish to submit a comment or complaint about my privacy practices or you feel that your privacy rights have been violated, please tell me about it in person. If this isn't resolved to your satisfaction, please submit a written complaint to me at my office address. I will **not** penalize or retaliate against you for filing a complaint.

I HAVE READ DIANE GOULA'S PRIVACY NOTICE ON THIS DATE OF _____
AND KNOW THAT I MAY RECEIVE A COPY UPON REQUEST.

Signed_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)
☐	☐	☐	☐	☐	☐	☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL. / NPI	J. RENDERING PROVIDER ID. #
1									
2									
3									
4									
5									
6									

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. / b.	a. / b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

We now would like you to tell us about your child's current problem(s). Please place an 'X' on one number for each problem listed, telling how significant that problem is at present.

		No Problem	Mild Problem	Moderate Problem	Serious Problem	Extreme Problem
PROBLEMS WITH EATING AND SLEEPING	Doesn't eat right	1	2	3	4	5
	Refuses to go to bed	1	2	3	4	5
	Trouble falling asleep	1	2	3	4	5
	Nightmares	1	2	3	4	5
	Wakes up very early	1	2	3	4	5
PHYSICAL PROBLEMS	Doesn't speak well	1	2	3	4	5
	Not fully toilet trained (wet bed, soils, etc.)	1	2	3	4	5
	Tired most of the time	1	2	3	4	5
	Has aches and pains	1	2	3	4	5
	Clumsy or accident prone	1	2	3	4	5
	Fakes being sick	1	2	3	4	5
SCHOOL PROBLEMS	Has problems learning in school	1	2	3	4	5
	Is afraid to go to school	1	2	3	4	5
	Won't obey school rules	1	2	3	4	5
	Often skips school	1	2	3	4	5
RELATIONSHIPS WITH OTHER CHILDREN	Picks on other children	1	2	3	4	5
	Has few or no friends	1	2	3	4	5
	Is picked on by other children	1	2	3	4	5
	Plays alone most of the time	1	2	3	4	5
	Fights with other children	1	2	3	4	5
	Has sex play with other children	1	2	3	4	5
	Hangs around with a 'bad crowd'	1	2	3	4	5
BEHAVIOR PROBLEMS	Uses drugs	1	2	3	4	5
	Runs away from home	1	2	3	4	5
	Lies	1	2	3	4	5
	Steals	1	2	3	4	5
	Sets fires	1	2	3	4	5
	Breaks things	1	2	3	4	5
SOCIAL SKILLS	Afraid of many things	1	2	3	4	5
	Very shy	1	2	3	4	5
	Poor loser	1	2	3	4	5
	Demands too much attention	1	2	3	4	5
OTHER PROBLEMS WITH RELATIONSHIPS	Talks back to grown-ups	1	2	3	4	5
	Disobeys parents	1	2	3	4	5
	Can't be trusted	1	2	3	4	5
	Has a chip on the shoulder	1	2	3	4	5
	Doesn't trust other people	1	2	3	4	5
EMOTIONAL PROBLEMS	Is sad or unhappy much of the time	1	2	3	4	5
	Cries a lot	1	2	3	4	5
	Has temper tantrums	1	2	3	4	5
	Mood changes quickly or without reason	1	2	3	4	5
OTHER PROBLEMS	Has threatened or attempted suicide	1	2	3	4	5
	Hurts self on purpose	1	2	3	4	5
	Acts younger than real age	1	2	3	4	5
	Can't sit still	1	2	3	4	5
	Acts without thinking	1	2	3	4	5
	Wants things to be perfect	1	2	3	4	5
	Says or does strange or peculiar things	1	2	3	4	5
	Is often confused or in a daze	1	2	3	4	5
	Daydreams alot	1	2	3	4	5
	Doesn't finish things (short attention span)	1	2	3	4	5

PREGNANCY During the pregnancy, did this child's mother:

	Yes	No		Yes	No
Have German measles?			Have any severe emotional problems?		
Have anemia? (low iron)			Have any vaginal infection, discharge, or bleeding?		
Have diabetes?			Has this child's mother ever experienced a miscarriage?		
Have any kidney problems?			Was the miscarriage from: last pregnancy before this child?		
Use any drugs or medicine?			: next pregnancy after this child?		
Have high blood pressure?			: any other pregnancy?		
Have a high fever (103 or higher for 3 days or more)					

BIRTH

	Hours			Pounds	Ounces	
About how long was this child's mother in labor?			How much did the baby weigh at birth?			
	Yes	No			Yes	No
Was anesthetic used during delivery?			Were there any injuries to the baby at birth?			
Did the baby have any problems breathing at birth?			Was an operation performed to deliver the baby?			
Did the baby need blood at birth?			Were any instruments used to deliver the baby?			
Was the baby placed in an incubator?			Did the baby have yellow jaundice at birth?			

MEDICAL HISTORY Has your child ever had the following:

	Yes	No		Yes	No
Measles?			Asthma?		
Mumps?			Blow on the head?		
Chicken pox?			High fever (104 or higher for 3 days or more)		
Scarlet fever?			Medication for behavior problem?		
Rheumatic fever?			Seizures or convulsions?		
Allergies to food?			Anemia (low iron or sickle cell)?		
Other allergies?			Repeated or prolonged hospitalization?		
Spells of vomiting?			Tics and twitches?		

DEVELOPMENT At about what age did your child first:

	Years	Months
Sit up?		
Crawl?		
Stand alone?		
Walk by self?		
Feed self?		
Dress self? (except for buttoning or tying knots)		
Speak first real words?		
Speak first real sentences?		
Become completely toilet trained?		
Help with household tasks?		
Ride a tricycle?		
Ride a bicycle?		
Tie own shoes?		

CHILD BEHAVIOR CHECKLIST FOR AGES 4-18

For office use only
ID #:

CHILD'S NAME

SEX ☐ Boy ☐ Girl

AGE

ETHNIC GROUP OR RACE

TODAY'S DATE
Mo. _____ Date _____ Yr. _____

CHILD'S BIRTHDATE
Mo. _____ Date _____ Yr. _____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the spaces provided on page 2.

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK: _____

MOTHER'S TYPE OF WORK: _____

THIS FORM FILLED OUT BY:

☐ Mother (name): _____

☐ Father (name): _____

☐ Other—name & relationship to child: _____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do not include listening to radio or TV.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Don't Know	Less Active	Average	More Active
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

V. 1. About how many close friends does your child have? (Do not include brothers & sisters) ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do not include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	About Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work by himself/herself?	☐	☐	☐	

VII. 1. For ages 6 and older—performance in academic subjects. If child is not being taught, please give reason _____

	Failing	Below average	Average	Above average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
Other academic subjects—for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., etc. e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

2. Is your child in a special class or special school? ☐ No ☐ Yes—what kind of class or school?

3. Has your child repeated a grade? ☐ No ☐ Yes—grade and reason

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe

When did these problems start?

Have these problems ended? ☐ No ☐ Yes—when?

Does your child have any illness, physical disability, or mental handicap? ☐ No ☐ Yes—please describe

What concerns you most about your child?

Please describe the best things about your child:

Below is a list of items that describe children and youth. For each item that describes your child **now or within the past 6 months**, please circle the **2** if the item is **very true or often true** of your child. Circle the **1** if the item is **somewhat or sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Allergy (describe): _____
_____
0 1 2 3. Argues a lot
0 1 2 4. Asthma
0 1 2 5. Behaves like opposite sex
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Day-dreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Eats or drinks things that are not food — *don't* include sweets (describe): _____
_____
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe):
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired
0 1 2 55. Overweight
56. Physical problems without known medical cause:
0 1 2 a. Aches or pains (*not* headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (describe): _____
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Please see other side

0 = Not True (as far as you kn) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____

0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much

0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy

0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids

0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____

0 1 2 67. Runs away from home
0 1 2 68. Screams a lot

0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):

0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires

0 1 2 73. Sexual problems (describe): _____

0 1 2 74. Showing off or clowning

0 1 2 75. Shy or timid
0 1 2 76. Sleeps less than most kids

0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____

0 1 2 78. Smears or plays with bowel movements

0 1 2 79. Speech problem (describe): _____

0 1 2 80. Stares blankly

0 1 2 81. Steals at home
0 1 2 82. Steals outside the home

0 1 2 83. Stores up things he/she doesn't need (describe): _____

0 1 2 84. Strange behavior (describe): _____

0 1 2 85. Strange ideas (describe): _____

0 1 2 86. Stubborn, sullen, or irritable

0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot

0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language

0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____

0 1 2 93. Talks too much
0 1 2 94. Teases a lot

0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much

0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking

0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Trouble sleeping (describe): _____

0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy

0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud

0 1 2 105. Uses alcohol or drugs for nonmedical purposes (describe): _____

0 1 2 106. Vandalism

0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed

0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex

0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries

113. Please write in any problems your child has that were not listed above:

0 1 2 _____

0 1 2 _____

0 1 2 _____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS. UNDERLINE ANY YOU ARE CONCERNED ABOUT

D3 | **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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