INFORMED CONSENT NOTICE, PRIVACY PRACTICES AND FEE AND PAYMENT AGREEMENT

Before we begin psychological services together, there are some things that you, as parent/legal guardian, ought to know about the therapy process and about my office. This is called "Informed Consent". This information contained here will help you understand better what to expect and will explain privacy practices and some limitations about what we will be doing together.

A BRIEF HIPAA OVERVIEW:

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with our privacy practices for use and disclosure of PHI for treatment, payment or health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information before this session. When you sign this document, it will also represent an Agreement between us. You may revoke this Agreement in writing at any time.

CONFIDENTIALITY

All of our work together, our conversations, your child's records and any information that you provide, is protected by legal privilege. This means that the law protects you from having information about you given to anyone. This office respects your privacy and intends to honor your privilege. However, there are some exceptions to your privacy that you should understand.

LIMITS ON CONFIDENTIALITY

We may use or disclose your child's protected health information (PHI) for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"

  - Treatment is when we provide, coordinate or manage your child's health care and other services related to your child's health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another clinician or psychologist.

  - Payment is when we help you obtain reimbursement for your child's healthcare. Examples of payment are when we disclose your child's PHI to your health insurer to assist you in obtaining reimbursement for your child's health care or to determine eligibility or coverage.

  - Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies your child.
- "Disclosure" applies to activities outside of our office such as releasing, transferring, or providing access to information about your child to other parties.

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations (of PHI) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. <u>Since this provider is out of network with all insurance plans, typically this does not apply.</u>

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners of Social Workers, they have the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your child's diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when your child is being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by your child to self or others, or there is a probability of immediate mental or emotional injury to your child, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

CLIENT RIGHTS:

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about your child. However, we are not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations –** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy –** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about your child for as long as the PHI is maintained in the record. We may deny access to PHI under circumstances, but in some cases you may have this decision reviewed. You may examine and/or receive a copy of your child's Psychotherapy Notes unless we determine that release would be harmful to your child's physical, mental or emotional health. On your request, we will discuss with you the details of the request and denial process.
- **Right to Amend –** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- **Right to an Accounting –** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, we will discuss with you the details of the accounting process.
- **Right to a Paper Copy –** You have the right to obtain a paper copy of the notice from us upon request.

CLINICIAN DUTIES:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We are required to keep PHI for five years past your child's legal age of consent.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you in writing by mail.

- The procedures for selecting, giving, and scoring the screening tests, interpreting and storing the results, and maintaining your child's privacy will be carried out in accord with the rules and guidelines of HIPAA, the American Psychological Association and other professional organizations.
- Screening tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.) These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
- Screening tests and results will be kept in a locked, safe place either onsite for one year and/or at a secure offsite location for five years past your child's legal age of consent.
- You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents.

COMPLAINTS

If you are concerned that your rights have been violated, or you disagree with a decision we made about access to your records, you may contact the Privacy Officer for Nancy Peskin, LCSW in writing to: Privacy Officer c/o Nancy Peskin, LCSW, 2217 Park Avenue, Pearland TX 77581. You may also file a complaint to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, 1301 Young Street, Suite 1169 Dallas, TX 75202 or calling (214) 767-4056.

UNDERSTANDING OF TREATMENT SERVICES

I, ____hereby seek and consent for my child to take part in the face to face or telehealth psychological treatment and authorize Nancy Peskin, LCSW to perform an initial interview, therapy and/or brief psychological screeners on my child(name)____.

Services may also include the clinician's time required for the reading of prior records, consultations with other providers and professionals, scoring, interpreting results, report writing and any other activities to support these services. I agree to help as much as I can by supplying full answers, making an honest effort and working as best as I can to make sure that the findings are accurate.

Additionally, I am aware that the practice of psychotherapy or counseling is not an exact science and that the predictions of the effects are not precise nor guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures by this treating therapist. Further, I understand that evaluation and treatment will involve discussion of personal events in my child's and/or my child's families own history which, at times, can be discomforting and is at times very personal. I am aware that I may terminate my child's treatment at any time without consequence, but that I will remain responsible for payment for services that I have received.

MISSED APPOINTMENT POLICY

The policy concerning missed appointments has been explained to me. I understand that if I miss a confirmed appointment for my child and do not call to reschedule within 14 days, this office will accept this as your notice that you have terminated this agreement and that you wish to discontinue services with our office. I understand that I may be charged for my child's missed appointment equal to the fee of the appointment. I also understand after two late cancelled or missed appointments, we may be referred out to another clinic.

EMAIL CORRESPONDENCE
Professional, clinical advice will not normally be provided electronically. Administrative staff will not utilize email. Should you initiate email contact via my website:

● Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

● No one can diagnose or treat your condition from email or other written communications, and communication via website or email cannot replace the relationship you have with a healthcare practitioner.

● Emails are checked during business hours only. If you have a crisis matter that requires urgent immediate attention after hours, please call 911 or visit a local emergency room.

● Communications via email or other non-portal text are not encrypted, but are still considered part of your health record.

● Any text or email initiated by yourself is an implicit consent to receive electronic communications from our office and provider within the same medium (i.e. sending an email to Nancy Peskin, LCSW's gmail account implies agreement to receive a reply via gmail).

Do you consent to electronic/email communication? (i.e. via gmail or other non-encrypted accounts)
Y or N

Would you like to receive email appointment reminders as a courtesy? **Y or N**
(please be advised that these emails may go into your spam/junk folder)

Email:____
Please provide your email address only if you consent to email correspondence.
(**please print neatly**)

I have read, understood, and agree to the above guidelines on electronic communications.

Signature: ____________________________________ Date: __________________

FEES AND PAYMENTS

The parent/legal guardian of client assumes 100% responsibility for all services, including any and all balances from pre-approved out of network insurance coverage. Unless other arrangements have been made, I understand that the fee for this (these) service(s) will be $225 for the up to 90 minute initial clinical interview and $175 per 50 minute session for subsequent therapy appointments. Payment in full is due at the time of services.

The rate of **out of network** insurance reimbursement varies according to individual insurance contracts and I understand that I may be reimbursed based on my own health plan benefits and that I can request a "superbill" (a more detailed statement) from this office so that I may submit bills to my insurance company for any benefits. Though my health insurance may repay me for some of these fees, I understand that I am fully responsible for full payment for these services. I also understand that once services have been provided, (initial interview, testing, therapy, and other requested services) no refunds (credit card or checks) will be issued. Additionally, I am aware that missed appointments may be subject to a charge equal to the fee of the therapy appointment.

Occasionally, clients (or their parents/guardians) receiving services will request that the clinician respond to frequent emails/calls, review letters/records, write letters, call attorneys and other professionals. If these requests become time consuming, we will collect payment of $175/hr pro-rated or an administrative retainer of $500.

Additionally, if we are asked to make copies of sizable quantity of records, there may be a fee of $1 per page (up to $20) and .50 cents per page after. Additional hourly fees ($175/hr) may apply for record review prior to copying records. Shipping charges, if applicable, will be included in the fee. We ask that you provide us with copies of pertinent records, not the originals.

Acknowledgement and Consenting signatures will be obtained during our initial consultation together.

I look forward to meeting you!

_____Original to client's chart

_____ Copy of HIPAA document to client

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Upon complete review of all documents in this packet, pages 1-17, your therapist will provide an Acknowledgement and Consent form to be signed by you (the parent/legal guardian) and your therapist during the initial sessions.

I (the parent/legal guardian of client) understand that pages 1-17 (Excluding Signature Page, page 6) of this packet are available to me anytime online at www.pearlandcounselingcenter.com or by request. This request can be made in person at Pearland Counseling Center, 2217 North Park Avenue, Pearland, Texas 77581.

I (the parent/legal guardian of the client) understand that my signature is required on the Acknowledgement and Consent form before services can be provided. I (the parent/legal guardian of the client) understand that **if I choose NOT to sign the Acknowledgement and Consent form counseling services will not be provided.**

IMPORTANT: It is required the Acknowledgement and consent form is signed by you (the parent/legal guardian of the client) and witnessed prior to the start of counseling services.

CLIENT REGISTRATION PAGE

TODAY'S DATE: ________________

Patient Name: ____ DOB: __ __ - __ __ - __ __ __ __ Age: ___ Gender: ___

SS#: __ __ __ - __ __ - __ __ __ __ DL#(if appliable): __ __ __ __ __ __ __ __ __

Address: ____ APT#: ___________________

City: ___________________________________ State: ___________________ Zip: ____________________

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

May we contact your home #? _____ May we contact your work #? _____ May we contact your cell #? _____

May we leave a message? Y N May we leave a message? Y N May we leave a message? Y N

E-Mail Address: ____

Employer: ____ Occupation: _________________________________

Emergency Contact

Name: ____ Relationship: ________________________________

Home: __ __ __ - __ __ __ - __ __ __ __ Work: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ - __ __ __ __

Name of person responsible for this client: __________________________ Relationship: _______________

MEDICAL HISTORY

Reason for seeking Counseling: ____

____

Other physicians treating you: ___________________________________ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: ___________________________________ Phone #: __ __ __ - __ __ __ - __ __ __ __

Other physicians treating you: ___________________________________ Phone #: __ __ __ - __ __ __ - __ __ __ __

Current physical problems (describe): ____

____

Current Medications: ____

____

POLICY FOR NO SHOW/LATE CANCEL AND OUTSTANDING BALANCE DUE

We are very committed to serving our clients and strive to accommodate all of our clients by making appointments available as soon as possible.

When an appointment is reserved for you, we require that the appointment be cancelled by **1:00 pm the day prior to the appointment.** We understand that emergencies happen, and we will be happy to work with you in those situations. If you have any questions, please feel free to speak with our office manager.

****

I understand that I will be responsible for a **missed appointment fee equal to the same amount of an attended appointment** and that my credit card will be charged if I am unable to provide the proper notice that I will not keep my or my child's scheduled appointment. Note: This policy may also apply to sessions provided by Employee Assistance Programs (EAP).

I also understand that I will be responsible for any outstanding balance for services rendered and that my credit card will be charged to pay for the outstanding balance.

If you choose to provide your flexible spending account information, an additional credit or debit card number is required as the situation may occur that your flex account holds insufficient funds or its balance has become depleted.

We accept the following debit/credit cards: Visa, Discover, American Express and MasterCard.

FOR FLEX CARD:

Name As Appears On Card: ____

Credit Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: ____

FOR CREDIT/DEBIT CARD:

Name As Appears On Card: ____

Credit Card Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: ____

I have read, understand and agree to the Policy above and give my permission for my card to be charged if a violation occurs.

Print Name: ____

Signature: ____ Date: ____________________

I ________________________________ (CREDIT CARD HOLDER NAME) understand that by providing my Credit Card information I am consenting to being financially responsible for ________________________________ (CLIENT NAME) regarding any violation of the Policy stated above.

Print Name: ____

Signature: ____ Date: ____________________

You may revoke this consent at any point, by submitting a request in writing which MUST include:
Date of request, client's name, your name, signature, copy of your current Driver's License, and an explanation of the information to be removed. If you are mailing your request, please keep in mind there could be charges to your card until your request is received by our office.

OFFICE USE ONLY: DATE OF REVOKE REQUEST: ____________ DATE REQUEST REC'D (EFF. DATE OF REVOKE): ____________

Nancy L. Peskin, LCSW

The River Oaks Tower | **Pearland Counseling Center**
3730 Kirby Drive | **2217 Park Ave**
Houston, TX 77098 | **Pearland, TX 77581**
(713) 521-7575 | **(281) 997-8400**

npeskinlcsw@gmail.com

CHILD/ADOLESCENT HISTORY

Today's Date: ______________________________

Name of Child: ____ Sex: (M) ____ (F) ____

Date Of Birth: _______________________ Place of Birth: ________________________ Age: ______

Address (number and street): ____

City: _____________________ State: __________ Zip Code: ______________

Telephone: ( )________________Email:____

Education (grade): _____________________ Present School: ___________________________________

Referral Source: ____

Mother's Name: ____ DOB: __________________

Home Phone: _________________________ Address: ____

Employed as: _________________________ Work Phone: _____________________________________

Father's Name: ____ DOB: __________________

Home Phone: _________________________ Address: ____

Employed as: _________________________ Work Phone: _____________________________________

Step-Parent's Name: ____ DOB: __________________

Home Phone: _________________________ Address: ____

Employed as: _________________________ Work Phone: _____________________________________

CHIEF CONCERNS

Presenting Problems: (check all that apply)

___ Very unhappy
___ Irritable
___ Temper outbursts
___ Withdrawn
___ Daydreaming
___ Fearful
___ Clumsy
___ Overactive
___ Slow
___ Short attention span
___ Distractible
___ Lacks initiative
___ Undependable
___ Peer conflict
___ Phobic
___ Dependency on illegal, prescribed, or over the counter drugs

___ Impulsive
___ Stubborn
___ Disobedient
___ Infantile
___ Mean to others
___ Destructive
___ Trouble with the law
___ Running away
___ Self-mutilating
___ Head banging
___ Rocking
___ Shy
___ Strange behavior
___ Strange thoughts
___ Suicide talk
___ Binging and/or Purging (vomiting and/or laxative use)

___ Restricting Food
___ Excessive exercising
___ Lying or Stealing
___ Sexual trouble
___ School performance
___ Truancy
___ Bed-wetting
___ Soiled pants
___ Body image Issues
___ Sleeping problems
___ Sickly
___ Tobacco use
___ Alcohol use
___ Learning problems
___ Hiding Food

Explain:

How long have these problems occurred? (number of weeks, months, years)

____

What happened that makes you seek help ***at this time***? ___________________________

____

Problems perceived to be: ____ very serious _____ serious _____ not serious

What are your expectations of your child? ______________________________
____

What changes would you like to see in your child? ________________________
____

What changes would you like to see in yourself? __________________________
____

What changes would you like to see in your family? ________________________
____

Religion or cultural affiliations that may affect therapy _____________________
____

Current Family Situation:

Mother – Relationship to child:

__ natural parent __ relative
__ stepparent __ adoptive parent

Occupation: ______________________________

Education: ______________________________ Religion: ________________________

Birthplace: ______________________________ Birthdate: ________________________

Age: ________

Father – Relationship to child:

__ natural parent __ relative
__ stepparent __ adoptive parent

Occupation: ______________________________

Education: ______________________________ Religion: ________________________

Birthplace: ______________________________ Birthdate: ________________________

Age: ________

Marital History of Parents:

Natural Parents: __ married when _____________ age ______ ______
__ separated when _____________
__ divorced when _____________
__ deceased Mother or Father ____________

Stepparents:
__ married when _____________
__ married when _____________

If child is adopted:

Adoption source: ____

Reason and circumstances: ____

Age when child first in home: ____

Date of legal adoption: ____

What has the child been told? ____

Living Arrangements: Places Dates

Number of moves in child's life ________________ ___________________
________________ ___________________
________________ ___________________

Present Home __ renting __ buying ________________ ___________________
__ house __ apartment ________________ ___________________

Does your child share a room with anyone else? __ Yes __ No

If yes, with whom? ____________________

If no, how long has he/she had own room? ____________________

Was your child ever placed, boarded, or lived away from the family? __ Yes __ No
Explain: ____________________

What are the major family stresses at the present time, if any? ____________________
____

Brothers and Sisters: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug abuse (yes or no)
1.							
2.							
3.							
4.							
5.							
6.							

List all other extended family members by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Others living in the home (and their relationship):

1. ____________________
2. ____________________

Health of Family Members: (excluding patient)

Name	Relationship to child	Type of illness	When occurred	Length of illness
1.				
2.				
3.				
4.				

Does or did any member of your child's family have any problems with:
____ reading ____ spelling ____ math ______ speech
(If yes, please explain)

Is there any history in your child's family of:
____ mental illness ____ epilepsy ____ birth defects ______ schizophrenia
(If yes, please explain)

Child Health Information: Note all health problems your child has had or has now.

	AGE		AGE
__ High fevers	_____	__ Dental problems	_____
__ Pneumonia	_____	__ Weight problems	_____
__ Flu	_____	__ Allergies	_____
__ Encephalitis	_____	__ Skin problems	_____
__ Meningitis	_____	__ Asthma	_____
__ Convulsions	_____	__ Headaches	_____
__ Unconsciousness	_____	__ Stomach problems	_____
__ Concussions	_____	__ Accident-prone	_____
__ Head injury	_____	__ Anemia	_____
__ Fainting	_____	__ High or low blood press.	_____
__ Dizziness	_____	__ Sinus problems	_____
__ Tonsils out	_____	__ Heart problems	_____
__ Vision problems	_____	__ Hyperactivity	_____
__ Hearing problems	_____	__ Other illnesses (explain)	_____
__ Earaches	_____		
__ Infectious diseases (explain)			

Has your child ever been hospitalized? ___ Yes ___ No
(If yes, please explain)

Age How Long Reason

________ _________________ ____

Has your child ever been seen by a medical specialist? ___ Yes ___ No

Age How Long Reason

________ _________________ ____

Has your child ever taken, or is he/she taking presently, any prescribed medications? ___ Yes ___ No

Age How Long Reason

________ _________________ ____

Name of Pediatrician/PCP: ____

Developmental History:

PRENATAL – Child wanted? ___ Yes ___ No Planned for? ___ Yes ___ No
Normal pregnancy? ___ Yes ___ No

If mother was ill or upset during pregnancy, please explain:

Length of pregnancy: ____

BIRTH – Length of active labor: ______ hrs. _____ Easy _____ Difficult

Full term: ____ Yes ___ No

If premature, how early: ____

If overdue, how late: ____

Birth weight: ______ lbs. _____ oz.

Type of delivery: __ spontaneous __ cesarean __ with instruments
__ head first __ breech

Was it necessary to give the infant oxygen? ___ Yes ___ No If yes, how long? _____

Did infant require blood transfusion? ___ Yes ___ No

Did infant require x-ray? ___ Yes ___ No

Physical condition of infant at birth:

(If yes, explain)			
	anorexia	___ Yes	___ No
	trauma	___ Yes	___ No
	other complications	___ Yes	___ No

Did mother use/abuse alcohol/drugs during pregnancy? ___ Yes ___ No

NEWBORN PERIOD –

			How Long?
Irritability	___ Yes	___ No	_______________
Vomiting	___ Yes	___ No	_______________
Difficulty breathing	___ Yes	___ No	_______________
Difficulty sleeping	___ Yes	___ No	_______________
Convulsions/twitching	___ Yes	___ No	_______________
Colic	___ Yes	___ No	_______________
Normal weight gain	___ Yes	___ No	_______________
Was child breast-fed	___ Yes	___ No	_______________

DEVELOPMENTAL MILESTONES – Age at which child:

Sat up: ________________________ Bladder trained: ____________________

Crawled: _______________________ Bowel trained: ______________________

Walked: ________________________ Weaned: ___________________________

Spoke single words: _____________ Sentences: _____________________

Describe the manner in which toilet training was accomplished:

EARLY SOCIAL DEVELOPMENT –

Relationship to siblings and peers:

____ individual play ____ group play
____ competitive ____ cooperative
____ leadership role ____ a follower

Describe special habits, fears, or idiosyncrasies of your child:

Educational History:

Name of School	City/State	Dates Attended: From	To	Grades completed at this school

Preschool ____

Elementary ____

Junior High ____

High School ____

Type of classes:
___ regular ___ learning disability
___ continuation ___ opportunity
___ emotionally handicapped ___ other

Did your child skip a grade? ___ Yes ___ No Repeat a grade? ___ Yes ___ No
(If yes, please explain in detail.)

____

Did your child have any specific learning difficulties? ___ Yes ___ No

Has your child ever had a tutor or other special help with schoolwork? ___ Yes ___ No

Does your child attend school on a regular basis? ___ Yes ___ No

Does your child appear motivated for school? ___ Yes ___ No

Has your child ever been suspended or expelled? ___ Yes ___ No

Academic Performance:

Highest grade on last report card? ________________________

Lowest grade on last report card? ________________________

Favorite subject? _____________________________________

Least favorite subject? ________________________________

Does your child participate in extracurricular activities? ___ Yes ___ No (explain)

In school, how many friends does your child have? ___ a lot ___ a few ___ none

What are your child's educational aspirations?
___ quit school
___ graduate from high school
___ go to college

Has your child had special testing in school? (If yes, what were the results?)

Psychological ___ Yes ___ No Vocational ___ Yes ___ No

List your child's special interests, hobbies, skills:

____

____

____

____

Has your child ever had difficulty with the police? ___ Yes ___ No
(if yes, explain)

Has your child ever appeared in juvenile court? ___ Yes ___ No
(if yes, explain)

Has your child ever been on probation? ___ Yes ___ No

From To Reason Probation Officer

____

____

____

Has your child ever been employed? ___ Yes ___ No

Job Employer How long?

____

____

____

This was a lot of information! Be we wrap up, any additional comments you wish to share about your child's unique and special interests or talents? Any other concerns not addressed above? Feel free to write them here:

Thank you! I'm looking forward to working with your child.