

FINANCIAL RESPONSIBILITY AND FEE AGREEMENT

Thank you for choosing Carole Kunkle-Miller, Ph.D. and Associates. In order to better serve you we ask you to understand and agree to the following. The fee for service is \$300.00 for initial visit and \$200.00 for Individual and Family visits. Except for brief phone contacts, you will be charged for phone therapy, report writing, emails or other professional services (letters, phone, and faxes to outside parties) at the rate of \$200.00 per hour. Your insurance company will not reimburse for these services. Legal testimony fees differ from the therapy fees.

To pay for these services, you may select one of the following payment plans:

- Payment in full after each session. Our providers do not participate in all insurance plans, under these plans, payment is required in full at the time of service. You may request a receipt to submit to your insurance company.
- Payment by insurance company. Your health insurance may cover a portion of the fee. **Deductible and co-payment amounts are your responsibility and are due at each session.** Due to variation from one policy to another, we cannot guarantee insurance reimbursement. You are responsible for any fees not covered or not paid by insurance regardless of the reason and for denied claims that exceed your benefit limit. Your signature below grants our office permission to file claims and collect payments on your behalf.

Members Responsibilities:

- Pay Co-payments and deductible at the time of service.
- Give at least 24 hours notice of cancellation of an appointment
- Contact your insurance company to determine your benefit limitations and financial obligations (co-payment, deductibles, authorizations, limit of number of visits per year, etc) and to verify that the provider participates with your insurance.
- Obtain authorization for office visits. If your insurance requires a pre-authorization at the time of your visit, we must have it on record. If you fail to obtain proper authorization, you are responsible for payment of any denied claim.
- Notify this office immediately of any changes in the status of your insurance coverage to ensure proper billing.

IMPORTANT OFFICE POLICIES AND PROCEDURES

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure required by law.

Cancellations/No Shows

A minimum of 24 hours notice is required (48 hours notice is preferred) of ANY appointment that you need to cancel. You will be charged \$50.00 for appointments forgotten or cancelled without 24 hours advanced notice. After two Late Cancels or No Show appointments, you will be charged the full fee typically paid to us by your insurance. Insurance companies will not reimburse for missed appointments; therefore you will be responsible for the total fees.

_____ INITIAL

Payment

Please understand that prompt payment for our services is necessary part of your treatment plan. Payments may be made in cash, check or credit card. A fee of \$35.00 will be charged for each returned check. Accounts left delinquent more than 90 days could result in the account being turned over to a professional collection service. There is a \$10 fee if payment is not made at the time of the visit.

_____ INITIAL

Minor Patients of Separated or Divorced Parents

The adult accompanying the patient must pay at the time of services regardless of who the responsible party is. We cannot become involved in the mediation of financial arrangements between parents. Unaccompanied minors should be provided with payment for their visit and will be expected to be responsible for scheduled appointments. **We MUST have permission from BOTH parents.** This will be discussed at length at the evaluation session.

_____ INITIAL

Contact/Emergencies

Due to our schedules, the telephone is answered by voice mail or an answering service. Patients with emergencies should call the answering service at 412-571-5989, and ask the operator to page YOUR therapist. We will get back in touch with you as soon as possible.

I CERTIFY THAT I HAVE READ THE ABOVE AND AGREE TO MY FINANCIAL RESPONSIBILITIES.

Parent (mother) Signature

Parent (father) Signature

Child

Date

MEDICAL HISTORY

Has your child had any hospitalizations, operations or serious medical problems in the past year? Please specify:

Has your child or any blood relatives had the following:

	Child	Mother	Father	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Brothers	Sisters	Children	Other
Alcoholism											
Drug Addiction											
Anemia											
Asthma											
Cancer											
Diabetes											
Epilepsy											
Heart Disease											
High Blood Pressure											
Low Blood Pressure											
Stroke											
Hepatitis											
Kidney Disease											
Hospitalized for Psychiatric Treatment											
Suicide attempts											
Depression											
Manic Depression											
Anxiety, Fears, Phobias											
ADHD, ADD											
Learning disabilities											
Behavior problems											

MEDICATIONS

Prescribing Physician: _____ Telephone: _____

Physician Address: _____

Start Date	Name of Medication	Dosage	Patient Response

MEDICAL HISTORY Cont.

Illnesses (Please Specify and Give Dates)

Dates

HOSPITALIZATIONS

Reasons for hospitalization

Hospital

Dates (mo./yr.)

Other medical treatment in or out of hospital (give circumstances and dates):

Has the child ever been in an accident? _____

Has the child ever had any broken bones? _____

Is there a history of problems regarding any of the following? Please describe.

Eating: _____

Sleeping: _____

Vision: _____

Hearing: _____

Speech: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE CHILD'S BIOLOGICAL PARENTS:

MOTHER

Name: _____ Date of Birth _____

Family members' mother grew up with: _____

Family members' mother did not live with: _____

Education level completed: _____

Past and current types of employment (including dates): _____

Previous marriages (dates and duration): _____

Date of marriage to child's father (if applicable): _____

Date of separation to child's father (if applicable): _____

Date of current marriage: _____

Number of pregnancies: _____ living children _____ deceased children _____ miscarriages _____ abortions _____

FATHER

Name: _____ Date of Birth: _____

Family members' father grew up with: _____

Family members' father did not live with: _____

Education level completed: _____

Past and current types of employment (including dates): _____

Previous marriages (dates and duration): _____

Date of marriage to child's mother (if applicable): _____

Date of separation to child's mother (if applicable): _____

Date of current marriage: _____

Children from other marriages or relationships (please include birth dates and/or current ages, deceased children should also be listed):

MOTHER'S MEDICAL HISTORY DURING PREGNANCY:

Was the pregnancy planned? Yes _____ No _____

What was the mother's health during pregnancy? _____

Illness: (For example: kidney diseases, German measles, high blood pressure, etc.) _____

Medication, X-rays, special diet _____

Accidents/Falls _____

Emotional stress _____

Alcohol use _____

Drug use _____

Cigarette smoking _____

Caffeine use _____

BIRTH HISTORY

Was the child full term? Yes _____ No _____

If no, how many weeks premature was delivery? _____

Labor was: Easy _____ Difficult _____ Duration of labor: _____ Child's birth weight _____

Other special circumstances of delivery: (natural childbirth, cesarean, breech, medications, etc.)

Infant required oxygen _____ blood transfusions _____ had difficulty breathing _____ vomited _____ was listless _____?

Were mother and infant discharged from the hospital together? Yes _____ No _____

Patient Name

CHILD DEVELOPMENT HISTORY

Family Members
Name

D.O.B.

Relationship to Child

Where Currently Living

Family Members Name	D.O.B.	Relationship to Child	Where Currently Living

Is your child foster or adopted? _____ If so, when? _____ If adopted, does the child know? _____

Infant was breast fed _____ until age _____ / Infant was bottle fed _____ until age _____.

How did the child adjust to weaning? _____

Was the child restless? _____ "good Baby"? _____ "fussy Baby"? _____ happy? _____

Any problems with vomiting _____ constipation _____ colic _____ rash _____

At what age (in months) did the child achieve the following developmental milestones:

Rolled over _____ walked _____ sat up _____ crawled _____ talked _____

Toilet training: Bladder – Begin/complete _____ / _____

Bowel – Begin/ complete _____ / _____

Did the child revert to soiling or wetting (during the day or night)? _____

Specify any problems _____

Has the child ever been separated from either parent for more than one day or an evening? Yes _____ No _____

If Yes, give dates and reasons _____

Who cared for the child during these times? _____

Did the child ever lose any person with whom he/she seemed to have a close relationship, such as father, mother, sister, brother, grandparent, or others? (Specify relationship to child, type of loss/death/relocation/divorce and date this occurred.)

Has the child reached puberty? Yes _____ No _____ If Yes, at what age: _____

If female, when did menstruation begin? _____

Please list any other medical problems or handicaps the child has had:

What is the chief concern you have about the child? _____

What is the child's attitude toward his/her problem? _____

When did their problems begin or how long have they been present? _____

EDUCATIONAL HISTORY

Preschool or School

Dates Attended

Highest Grade Completed

Has the child ever repeated a grade? Yes _____ No _____

If Yes, please state which grade and for what reason: _____

Special classes attended? _____

Has IEP or Service Agreement? _____

School suspension and why: _____

Attitude toward school (enthusiastic, indifferent, poor) _____

Any problems experienced in school? _____

SOCIAL FUNCTIONING

Please list any and all groups or organizations to which your child has belonged, such as scouts, clubs, church groups, etc.)

Group

Time period attended

Frequency

Please list any areas of special concern in addition to referral problem (e.g., making friends, temper, not telling the truth, taking things that belong to others, mood changes, drug/alcohol use, acting younger than age)

In general, how does your child express feelings? _____

What manner of discipline do you employ (time out, going to room, etc.) _____

How does child occupy his/her time? _____

LIFESTYLE (for children age 12 and older, ask him or her to complete)

Do you smoke cigarettes? Yes No If so, indicate how many per day: _____

Do you drink caffeine? Yes No If so, indicate how many servings per day: _____

Do you drink alcohol? Yes No

If so, please indicate what kind you drink and how many drinks you have per week:

Do you use drugs recreationally? Yes No

If yes, please indicate the type of drug and how often it is used: _____

Do you exercise? Yes No

If yes, please indicate the type of activity and times per week that you engage in the activity: _____

Do you have what you consider to be a weight or eating problem? Yes No

If so, please describe: _____

Do you have any hobbies or special interests? Yes No

If yes, please indicate what type and the amount of time per week spent engaged in this interest: _____

How do you typically spend your free time? _____

CHILD BEHAVIOR CHECKLIST FOR AGES 4-16 (To be completed by parent)

<p>I. Please list the sports your child most likes to take part in. For example, swimming, baseball, skating, skateboarding, etc.</p> <p><input type="checkbox"/> None</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>	<p>Compared to other children of the same age, about how much time does he/she spend in each?</p> <table border="0"> <tr> <td>Don't Know</td> <td>Less than average</td> <td>Average</td> <td>More than average</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Don't Know	Less than average	Average	More than average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Compared to other children of the same age, how well does he/she do each one?</p> <table border="0"> <tr> <td>Don't Know</td> <td>Below average</td> <td>Average</td> <td>Above Average</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Don't Know	Below average	Average	Above Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Don't Know	Below average	Average	Above Average															
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															

<p>II. Please list your child's favorite hobbies, activities and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include TV)</p> <p><input type="checkbox"/> None</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>	<p>Compared to other children of the same age, about how much time does he/she spend in each?</p> <table border="0"> <tr> <td>Don't Know</td> <td>Less Than Average</td> <td>Average</td> <td>More Than Average</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Don't Know	Less Than Average	Average	More Than Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Compared to other children of the same age, how well does he/she do each one?</p> <table border="0"> <tr> <td>Don't Know</td> <td>Below Average</td> <td>Average</td> <td>Above Average</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Don't Know	Below Average	Average	Above Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Don't Know	Below Average	Average	Above Average															
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															

<p>III. Please list any organizations, clubs, Teams, or groups your child belongs to:</p> <p><input type="checkbox"/> None</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>	<p>Compared to other children of the same age, how active is he/she in each?</p> <table border="0"> <tr> <td>Don't Know</td> <td>Less active</td> <td>Average</td> <td>More active</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Don't Know	Less active	Average	More active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't Know	Less active	Average	More active						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

<p>IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, etc.</p> <p><input type="checkbox"/> None</p> <p>a. _____</p> <p>b. _____</p> <p>c. _____</p>	<p>Compared to other children of the same age, how well does he/she carry them out?</p> <table border="0"> <tr> <td>Don't Know</td> <td>Below average</td> <td>Average</td> <td>Above average</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Don't Know	Below average	Average	Above average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't Know	Below average	Average	Above average						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

V. About how many close friends does your child have? None 1 2 or 3 4 or more

About how many times a week does your child do things with them? Less than 1 2 or 3 4 or more

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

	Worse	About the Same	Better
a. Get along with his/her brothers & sisters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name

- b. Get along with other children?
- c. Behave with his/her parents?
- d. Play and work by himself/herself?

VII. 1. Current school performance – for children aged 6 and older?

- Does not go to school
- | | Failing | Below Average | Average | Above Average |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Reading or English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Writing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Arithmetic or Math | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Spelling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Is your child in a special class?
 No Yes-what kind? _____
3. Has your child ever 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? _____

VIII. Below is a list of items that describe children. 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**.

- | | | | | | | | |
|---|---|---|--|---|---|---|---|
| 0 | 1 | 2 | 1. Acts too young for his/her age | 0 | 1 | 2 | 26. Eats or drinks things that are not food (describe) _____ |
| 0 | 1 | 2 | 2. Argues a lot | | | | _____ |
| 0 | 1 | 2 | 3. Behaves like the opposite sex | | | | |
| 0 | 1 | 2 | 4. Bowel movements outside toilet | 0 | 1 | 2 | 27. Fears certain animals, situations, or places, other than school (describe): _____ |
| 0 | 1 | 2 | 5. Bragging, boasting | | | | _____ |
| 0 | 1 | 2 | 6. Can't concentrate or pay attention long | | | | _____ |
| 0 | 1 | 2 | 7. Can't get his/her mind off certain thoughts, obsessions (describe): _____ | 0 | 1 | 2 | 28. Fears going to school |
| | | | _____ | 0 | 1 | 2 | 29. Fears he/she might think or do something bad |
| | | | _____ | 0 | 1 | 2 | 30. Feels he/she has to be perfect |
| 0 | 1 | 2 | 8. Can't sit still, restless, or hyperactive | 0 | 1 | 2 | 31. Feels/complains no one loves him/her |
| 0 | 1 | 2 | 9. Clings to adults or too dependent | 0 | 1 | 2 | 32. Feels others are out to get him/her |
| 0 | 1 | 2 | 10. Complains of loneliness | 0 | 1 | 2 | 33. Feels worthless or inferior |
| 0 | 1 | 2 | 11. Confused or seems to be in a fog | 0 | 1 | 2 | 34. Gets hurt a lot (accident prone) |
| 0 | 1 | 2 | 12. Cries a lot | 0 | 1 | 2 | 35. Gets in many fights |
| 0 | 1 | 2 | 13. Cruel to animals | 0 | 1 | 2 | 36. Gets teased a lot |
| 0 | 1 | 2 | 14. Cruelty, bullying, or meanness to others | 0 | 1 | 2 | 37. Hangs around with children who get in trouble |
| 0 | 1 | 2 | 15. Day-dreams or gets lost in her/her thoughts | 0 | 1 | 2 | 38. Hears things that aren't there (describe): _____ |
| 0 | 1 | 2 | 16. Deliberately harms self or attempts suicide | | | | _____ |
| 0 | 1 | 2 | 17. Demands a lot of attention | | | | |
| 0 | 1 | 2 | 18. Destroys his/her own things | 0 | 1 | 2 | 39. Impulsive or acts without thinking |
| 0 | 1 | 2 | 19. Destroys things belonging to others | 0 | 1 | 2 | 40. Likes to be alone |
| 0 | 1 | 2 | 20. Disobedient at home | 0 | 1 | 2 | 41. Lying or cheating |
| 0 | 1 | 2 | 21. Disobedient at school | 0 | 1 | 2 | 42. Bites fingernails |
| 0 | 1 | 2 | 22. Doesn't eat well | 0 | 1 | 2 | 43. Nervous, high-strung, or tense |
| 0 | 1 | 2 | 23. Doesn't get along with other children | 0 | 1 | 2 | 44. Nervous movements or twitching _____ |
| 0 | 1 | 2 | 24. Doesn't seem to feel guilty after misbehaving | | | | (describe); _____ |

Patient Name

- | | | | | | | | |
|---|---|---|--|---|---|---|---|
| 0 | 1 | 2 | 45. Nightmares | 0 | 1 | 2 | 76. Smears or plays with bowel movements |
| 0 | 1 | 2 | 46. Not liked by other children | 0 | 1 | 2 | 77. Speech problem (describe) _____ |
| 0 | 1 | 2 | 47. Constipated, doesn't move bowels | | | | _____ |
| 0 | 1 | 2 | 48. Too fearful or anxious | 0 | 1 | 2 | 78. Stares blankly |
| 0 | 1 | 2 | 49. Feels dizzy | 0 | 1 | 2 | 79. Steals at home |
| 0 | 1 | 2 | 50. Feels too guilty | 0 | 1 | 2 | 80. Steals outside the home |
| 0 | 1 | 2 | 51. Overeating | 0 | 1 | 2 | 81. Stores up things he/she doesn't need
(describe): _____ |
| 0 | 1 | 2 | 52. Overtired | 0 | 1 | 2 | 82. Strange behavior (describe) _____ |
| 0 | 1 | 2 | 53. Overweight | | | | _____ |
| 0 | 1 | 2 | 54. Physical problems without known
medical causes: | 0 | 1 | 2 | 83. Strange ideas (describe): _____ |
| | | | a. Aches or pains | | | | _____ |
| 0 | 1 | 2 | b. Headaches | 0 | 1 | 2 | 84. Stubborn, sullen, or irritable |
| 0 | 1 | 2 | c. Nausea, feels sick | 0 | 1 | 2 | 85. Sudden changes in mood or feelings |
| 0 | 1 | 2 | d. Problems with eyes (describe) | 0 | 1 | 2 | 86. Sulks a lot |
| | | | _____ | 0 | 1 | 2 | 87. Suspicious |
| 0 | 1 | 2 | e. Rashes or other skin problems | 0 | 1 | 2 | 88. Swearing or obscene language |
| 0 | 1 | 2 | f. Stomachaches or cramps | 0 | 1 | 2 | 89. Talks about killing self |
| 0 | 1 | 2 | g. Vomiting, throwing up | 0 | 1 | 2 | 90. Talks or walks in sleep (describe): |
| 0 | 1 | 2 | h. Other (describe) | | | | _____ |
| | | | _____ | 0 | 1 | 2 | 91. Talks too much |
| 0 | 1 | 2 | 55. Physically attacks people | 0 | 1 | 2 | 92. Teases a lot |
| 0 | 1 | 2 | 56. Picks nose, skin or other parts of body
(describe) _____ | 0 | 1 | 2 | 93. Temper tantrums or hot temper |
| | | | _____ | 0 | 1 | 2 | 94. Thinks about sex too much |
| 0 | 1 | 2 | 57. Plays with own sex parts in public | 0 | 1 | 2 | 95. Threatens people |
| 0 | 1 | 2 | 58. Plays with own sex parts too much | 0 | 1 | 2 | 96. Thumb-sucking |
| 0 | 1 | 2 | 59. Poor school work | 0 | 1 | 2 | 97. Too concerned with neatness or
cleanliness |
| 0 | 1 | 2 | 60. Poorly coordinated or clumsy | 0 | 1 | 2 | 98. Trouble sleeping (describe) _____ |
| 0 | 1 | 2 | 61. Prefers playing with older children | | | | _____ |
| 0 | 1 | 2 | 62. Prefers playing with younger children | 0 | 1 | 2 | 99. Truancy, skips school |
| 0 | 1 | 2 | 63. Refuses to talk | 0 | 1 | 2 | 100. Underactive, slow moving, lacks energy |
| 0 | 1 | 2 | 64. Repeats certain acts over and over;
compulsions (describe) _____ | 0 | 1 | 2 | 101. Unhappy, sad, or depressed |
| | | | _____ | 0 | 1 | 2 | 102. Unusually loud |
| 0 | 1 | 2 | 65. Runs away from home | 0 | 1 | 2 | 103. Uses alcohol or drugs (describe): _____ |
| 0 | 1 | 2 | 66. Screams a lot | | | | _____ |
| 0 | 1 | 2 | 67. Secretive, keeps things to self | 0 | 1 | 2 | 104. Vandalism |
| 0 | 1 | 2 | 68. Sees things that aren't there (describe) | 0 | 1 | 2 | 105. Wets self during the day |
| | | | _____ | 0 | 1 | 2 | 106. Wets the bed |
| 0 | 1 | 2 | 69. Self-conscious or easily embarrassed | 0 | 1 | 2 | 107. Whining |
| 0 | 1 | 2 | 70. Sets fires | 0 | 1 | 2 | 108. Wishes to be of opposite sex |
| 0 | 1 | 2 | 71. Sexual problems (describe): _____ | 0 | 1 | 2 | 109. Withdrawn, doesn't get involved with
others |
| | | | _____ | | | | _____ |
| 0 | 1 | 2 | 72. Showing off or clowning | 0 | 1 | 2 | 110. Worrying |
| 0 | 1 | 2 | 73. Shy or timid | 0 | 1 | 2 | 111. Please write in any problems you child |
| 0 | 1 | 2 | 74. Sleeps less than most children | | | | _____ |
| 0 | 1 | 2 | 75. Sleeps more than most children during day
and/or night (describe) _____ | | | | _____ |
| | | | _____ | | | | _____ |

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS

UNDERLINE ANY YOU ARE CONCERNED ABOUT

Please use this space to provide any additional family or personal information which might be helpful in assessing your child for treatment:

Date

Signature of person completing form/relationship to child