Compass Point

CHILD REGISTRATION & ASSESMENT

Welcome to Compass Point Counseling Services. Please note that this packet is intended to be filled out by the parent or guardian of children aged 0-11. This new client packet contains all of your child's paperwork for both the front office registration and a clinical assessment that will ultimately help your clinician better serve you and your child. Please take the time to fill out everything completely and to the best of your ability.

We request that the entirety of this packet be completed *before* arriving at your appointment time to ensure that filling it out does not cut into your first session. Also, please be aware that the first appointment is only for the parent or guardian to attend to provide information openly and honestly without your child, the client, being present.

The last page of the packet is a symptom measurement questionnaire. When completing this page please keep in mind that is just for the past two weeks and the questions are about your child aged 0-11.

Here at Compass Point we respect your privacy and confidentiality and are HIPAA compliant. To read more about HIPAA and how it helps us serve you, you can review the policy on our website under printable forms and titled "Notice of Privacy Practices."

If you would like us to speak with your Primary Care Physicians, Psychiatrist, Therapist, or anyone besides the client and their guardians, we will need you to print a release of information for each person to be completed in addition to this packet. You can find our release of information on our website under "printable forms."

Compass Point

CHILD REGISTRATION (AGES 0-11)

FULL NAME _____ GENDER _____
FIRST MI LAST

AGE _____ BIRTH DATE _____ SCHOOL _____ GRADE LEVEL _____

CHILD LIVES WITH: ☐ Both Parents ☐ Mother ☐ Father ☐ Legal Guardian ***If separated or divorced, who has custody?** _____

*Please provide documentation of custody arrangements in the form of most recent court order or divorce decree. Please bring this document to the first appointment.

MOTHER'S INFORMATION

FULL NAME _____ BIRTH DATE _____
FIRST MI LAST

SS# _____ ADDRESS _____
STREET/APT CITY STATE ZIP CODE

HOME PHONE_____ CELL PHONE_____ EMAIL _____

*is it okay to call or leave a message at home? ☐Yes ☐No *is it okay to send email? ☐Yes ☐No

*is it okay to call or leave a message on your cell? ☐Yes ☐No *is it okay to send text message? ☐Yes ☐No

EMPLOYER _____ WORK PHONE _____ *is it okay to call at work? ☐Yes ☐No

List the people who live in mother's home:

NAME AGE RELATIONSHIP NAME AGE RELATIONSHIP

NAME AGE RELATIONSHIP NAME AGE RELATIONSHIP

NAME AGE RELATIONSHIP NAME AGE RELATIONSHIP

FATHER'S INFORMATION

FULL NAME _____ BIRTH DATE _____
FIRST MI LAST

SS# _____ ADDRESS _____
STREET/APT CITY STATE ZIP CODE

HOME PHONE_____ CELL PHONE_____ EMAIL _____

*is it okay to call or leave a message at home? ☐Yes ☐No *is it okay to send email? ☐Yes ☐No

*is it okay to call or leave a message on your cell? ☐Yes ☐No *is it okay to send text message? ☐Yes ☐No

EMPLOYER _____ WORK PHONE _____ *is it okay to call at work? ☐ Yes ☐ No

List the people who live in father's home:

NAME AGE RELATIONSHIP NAME AGE RELATIONSHIP

NAME AGE RELATIONSHIP NAME AGE RELATIONSHIP

NAME AGE RELATIONSHIP NAME AGE RELATIONSHIP

CLIENT NAME _____ DATE _____

INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO CLIENT_____DOB _____
FIRST MI LAST

_____
STREET/APT CITY STATE ZIP CODE

SS#_____NAME OF EMPLOYER_____UNION ORLOCAL# _____

INSURANCE COMPANY _____ MEMBER ID# _____

GROUP #_____ PROVIDER SERVICE PHONE (Located on back side of card) _____

Does the client have any additional insurance? ☐ NO ☐ YES, please complete the following:

NAME OF INSURED_____ RELATIONSHIP TO CLIENT_____DOB _____
FIRST MI LAST

_____
STREET/APT CITY STATE ZIP CODE

SS# _____ NAME OF EMPLOYER_____ UNION OR LOCAL# _____

INSURANCE COMPANY _____ MEMBER ID# _____

GROUP #_____ PROVIDER SERVICE PHONE (Located on back side of card) _____

ADDITIONAL INFORMATION

How did you learn about us? (If online, did you use a search engine?) _____

Name and phone number of person to be contacted in case of emergency:

Name_____ Phone number _____ Relationship _____

*Name of Primary Care Physician _____ Phone_____ Date of Last Visit _____

*Name of Psychiatrist_____ Phone_____ Date of Last Visit _____

*Is the client seeing any other therapist? ☐ NO ☐ YES, If yes who? _____

* Please provide a completed release of information form, found on our website, for each additional therapisy, psychiatrist or primary care physician with whom we may need to consult

List any medication the client is now taking, the amount and why they're taking it:

Briefly describe your reason for seeking counseling services for the child/adolescent:

How long has this been a problem? What have you done to resolve it:

What do you hope to accomplish in therapy:

Has your child ever required hospitalization? If they have, please specify.

Is there any history of physical, sexual or emotional abuse? If there is, please specify.

CLIENT NAME _____ DATE _____

Please check any and ALL of the following areas in which you believe your child/adolescent to be experiencing problems:

- ☐ Nervousness
- ☐ Shyness
- ☐ Separation
- ☐ Drug Use
- ☐ Anger
- ☐ Unhappiness
- ☐ Relaxation
- ☐ Legal Matters
- ☐ Energy
- ☐ Loneliness
- ☐ School Behaviors
- ☐ Grades
- ☐ Stomach Discomfort
- ☐ Bed wetting/Soiling
- ☐ Weight
- ☐ Depression
- ☐ Sexual Problems
- ☐ Divorce
- ☐ Alcohol Use
- ☐ Sleep
- ☐ Stress
- ☐ Headaches
- ☐ Memory
- ☐ Making Decisions
- ☐ Inferiority Feelings
- ☐ Health Problems
- ☐ Defiant Behavior
- ☐ Family of Origin Issues
- ☐ Thoughts
- ☐ Fighting
- ☐ Fears
- ☐ Suicidal Thoughts/Attempts
- ☐ Homicidal Thoughts
- ☐ Friends
- ☐ Self-Control
- ☐ Work
- ☐ Tiredness
- ☐ Grief/Loss
- ☐ Spiritual Concerns
- ☐ Concentration
- ☐ Nightmares
- ☐ Appetite
- ☐ Bowel Troubles
- ☐ Abuse/Neglect
- ☐ Distractibility

How would you describe your child's approach to new situations?

- ☐ Positive, jumps right in
- ☐ Cautious, slow to warm up
- ☐ Withdrawn, tends not to participate

How would you generally describe your child's overall mood?

- ☐ Positive (happy, laughing, upbeat, hopeful)
- ☐ Negative (depressed, cranky, angry, hostile)
- ☐ Mixed but more positive, than negative
- ☐ Mixed but more negative, than positive

Is your child currently receiving special services in school?

☐ No ☐ Yes , _____

Developmental History

Health of mother: ☐ Good ☐ Fair ☐ Poor ☐ Unknown

Did the mother use any of the following during pregnancy?

☐ Alcohol ☐ Marijuana ☐ Crack/Cocaine ☐ Cigarettes ☐ Coffee

☐ Other, _____

Were there any concerns during pregnancy ? ☐ No ☐ Yes, _____

What was your child's estimated age when he/she began:

_____ Walking _____ Single Words _____ Short Sentences _____ Potty Trained

Overall was their development ☐ Slow ☐ Normal ☐ Rapid

CLIENT NAME _____ DATE _____

During the first 3 years of your child's life were/did they:

☐ Accident Prone ☐ Avoid Cuddling ☐ Colic ☐ Destructive ☐ Easily Distracted

☐ Restless ☐ Overactive ☐ Uncoordinated ☐ Withdrawn ☐ Restless

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Is your child ☐ Prepubescent ☐ Pubescent, if yes age of onset : _____

To the best of your knowledge, is your child sexually active? ☐ No ☐ Yes

If yes - ☐ Using Contraception ☐ History of Pregnancy ☐ History of Abortion ☐ Fathered a Child

Do you or your child have any concerns regarding their sexual development or sexual orientation? ☐ No ☐ Yes, _____

Significant Life Events

☐ Change of School ☐ Loss ☐ Divorce / Separation ☐ Moved/Moving ☐ Family Changes

☐ Frightening Past Incidence ☐ Serious Illness/Injury to Family or Friend ☐ Other, _____

Medical History

_____ Height _____ Weight

Does your child have the following eating or sleeping problems?

☐ Dieting ☐ Recent Weight Gain ☐ Recent Weight Loss ☐ Refusing to Eat ☐ Overeating

☐ Vomiting ☐ Picky Eater ☐ Trouble Staying Asleep ☐ Restless When asleep ☐ Soiling

☐ Nightmares ☐ Oversleeping ☐ Bedwetting

How would you describe the nutritional value of your child's diet: ☐ Good ☐ Fair ☐ Poor

Has your child had any surgeries/accidents/conditions requiring hospitalization or same day surgery: ☐ No ☐ Yes, _____

Has your child been diagnosed and/or currently being related for any of the following:

☐ ADHD ☐ Anemia ☐ Cancer ☐ Diabetes ☐ Ear Infection

☐ Encephalitis ☐ Epilepsy ☐ Fever ☐ HIV/AIDS ☐ Hearing problems

☐ Heart Problems ☐ Hydrocephalus ☐ Lead poisoning ☐ Meningitis ☐ Loss of Consciousness

☐ Seizures ☐ Vision Problems ☐ Muscular – Skeletal Condition

Play History:

☐ Cooperative ☐ Independent ☐ Onlooker ☐ Takes Turns ☐ Leader ☐ Follower

Has your child ever:

- ☐ Physically harm another person, pet, or small animal
- ☐ Received medication in the past for emotional, learning, or behavioral problems
- ☐ Threatened to physically harm anyone
- ☐ Run away from home
- ☐ Started a fire

Has your child/adolescent ever experienced or witnessed:

- ☐ Domestic Violence
- ☐ Emotional Abuse
- ☐ Physical Abuse
- ☐ Rape/Sexual Assault
- ☐ Sexual Abuse
- ☐ Other Significant Trauma

Daily Life

Describe involvement in activities outside of the home : _____

_____

Has your child's leisure time increased/decreased over the past 6 months: ☐ No ☐ Yes , _____

Is your child having difficulties with:

- ☐ Adapting to Changes
- ☐ Goal Setting
- ☐ Attending to Tasks
- ☐ Learning
- ☐ Problem Solving
- ☐ Following A Routine

Do you have any concerns regarding your child's screen time: ☐ No ☐ Yes, _____

Does your child have the opportunity to earn spending money: ☐ No ☐ Yes, _____

Any spiritual/religious concerns that need consideration: ☐ No ☐ Yes, _____

Any cultural/ethnic/racial issues that need consideration: ☐ No ☐ Yes, _____

School Related Issues

- ☐ Academic Problems
- ☐ Advanced a Grade
- ☐ Behavior
- ☐ Detention
- ☐ Held Back a Grade
- ☐ Homework
- ☐ Peer Relationships
- ☐ Requires Special Help
- ☐ Suspension/Expulsion
- ☐ Bullying
- ☐ Transportation

Have any family members had problems with substance abuse or with mental/emotional problems? ☐ No ☐ Yes, _____

_____

_____

To your knowledge has your child used/tried drugs and/or alcohol? ☐ No ☐ Yes, if yes describe what you know about your child's

Alcohol/drug use: _____

Have others expressed concerns about your child's alcohol/tobacco/drug use: ☐ No ☐ Yes

Has your child/ adolescent had any troubles with the legal system: ☐ No ☐ Yes

Are they on probation: ☐ No ☐ Yes

Does your child have any current legal charges? ☐ No ☐ Yes

Is there anything else you think we need to know about your child/adolescent?

_____

_____

_____

_____

Please list your child's providers and other people in their life with whom the therapist may need to communicate:
(EX: Non-custodial parent, Case worker, School Counselor, Lawyer, Other)

_____

_____

_____

Child/Adolescent Custody Information
Compass Point Counseling Services has the policy of obtaining the consent of both parents whenever treating a minor. We make an effort to communicate with both parents regarding the child's treatment. For this reason , we seek the consent of both parents, even if the custody order does not require it.

Please indicate your child's current custody arrangement:

☐ Parents married equal rights to child

☐ Parents never married, separated, or divorced. Explain custody: _____

_____

☐ Only one parent present, explain _____

_____

☐ Other, please explain _____

_____

Please note that refusing to provide releases of information to relevant parties may result in the therapist choosing not to see your child. This is for legal and best practice reasons and will be discussed on a situational basis.

The therapist's role in working with minor children and their families is to provide assessment, therapeutic support, and treatment as needed. It is out of the scope of practice to complete other duties such as custody, visitation, guardianship, and abuse evaluations. Therapists do not perform these evaluations, and it would be out of the scope of practice to make a recommendation as to custody, visitation, or guardianship.

My signature below indicates that I understand the role of the therapist in working with my child, and that I attest to this information provided above being true to the best of my knowledge. I also agree to update the therapist immediately upon any changes.

_____ _____ Date: _____

Name Relationship to client

CLIENT NAME _____ DATE _____

CONSENT TO TREATMENT

The undersigned, client/client's legal guardian, voluntarily consent to outpatient treatment for mental health, co-occurring, and/or substance use and authorize Compass Point Counseling Services (CPCS) to provide such outpatient treatment that is determined to be medically necessary or otherwise appropriate. These services may include individual or group counseling/therapy, Diagnostic Assessment, and Psychological Testing.

MEDICARE PAYMENT

I, the undersigned, certify that any information given by me in applying for payment under Title XVII of the Social Security Act is complete, accurate, and current. As a Medicare Beneficiary, I have the right to receive Medicare covered services. I acknowledge that I have the right to be involved in any decisions about my treatment and services and who will pay for them.

WAIVER OF LIABILITY FOR NON-APPROVED SERVICES

Ohio law requires CPCS to inform the undersigned that if your insurance company did not give prior approval for therapy services and you choose to have services provided, you would be required to pay for the services. My signature acknowledges I have read and understand the above. If my insurance company denies payment, I agree to be personally and fully responsible for the payment of all services incurred. These services include both formal and informal letters, appearances in court, reports, and extended phone calls.

EXPLANATION OF SERVICES

- We see clients Monday through Saturday.
- We share this suite with our colleagues and we provide ongoing supervision for each other.
- We provide Individual, Family and Group Counseling and are happy to discuss these options with you.
- If a crisis occurs when we are not in the office you may call our main number (513) 939-0300 and you will be directed as to how we may be reached.
- We make the assumption that you can change and grow, and that some of this change can occur within a relatively short period of time. We strive to do brief and effective treatment.
- Our fee is $120 per hour for a regular 45-55 minute session and $160 for the initial session for an LPCC/LISW, $180 per hour for a regular 45-55 minute session and $120 for the initial session for an LSW/LPC and $75 per session for a regular 30 minute session and $300 for the initial session for an MD
- Payment is expected at the time of service. You are responsible for the charges. If you are paying through your insurance, you are responsible for your co-pay or deductible at time of service and for any amount left unpaid by your insurance.
- Additional fees will be charged for letters, appearances in court, reports, no sow or late cancel charges and extended phone calls. These things are not covered by insurance. Your therapist will discuss any additional fee with you before it is charged.
- We view the therapeutic relationship as a partnership that is principally dedicated to your growth and to finding solutions. Part of our job is to remind you of your own strengths and abilities while you go about the business of creating more of the type of life that you want.
- As with nearly any type of treatment, there is the chance that it may not be helpful. The "fit" between client and therapist is important to good treatment outcome. In the beginning of treatment, you may feel worse before you feel better. Therefore, we want to hear from you throughout our work together about how we are doing – so that we can make any needed adjustments to help you more effectively.
- Information discussed within the therapy setting is held confidential and will not be shared without written permission except under limited situations which under reasonable circumstances would be discussed with you before disclosure is made. These situations include revelations of *unreported* child or elder abuse, imminent suicide or harm to others, or reports of exploitation by a therapist.

LATE CANCELLATIONS, MISSED APPOINTMENTS

I understand that I am required to provide at least 24 hours notice if I (or the client named below) are unable to keep a scheduled appointment. In the event that I do not provide 24 hours advance notice, I acknowledge that CPCS has the right to charge me for the scheduled appointment. If I fail to cancel a scheduled appointment, and do not come to set appointment at my (or the client's) scheduled appointment time, I understand that CPCS will charge me $50.00 for the scheduled appointment. I agree to pay CPCS $50.00 for late cancellation or missed appointment charges incurred.

RETURNED CHECK FEE: CPCS charges a fee for any check returned by my financial institution, regardless of reason. In such event, I agree to pay CPCS the returned check fee of up to $50.00.

DELINQUENT ACCOUNT: I understand that CPCS may turn my account over to a collection agency if I do not pay on a timely basis. CPCS has a separate collection policy, which will be provided to me if I ask for it. I also understand that if my account is sent to a collection agency a 35-50% surcharge will be applied to the balance by the collection agency.

ANCILLARY SERVICES

These are any extra services not covered by your insurance.

- Letter or Report writing- $150 per hour prorated. Payment is required prior to writing letter.
- Telephonic Services- $40 per 15 minute increments. Coaching calls will not apply
- Court Related Charges-Your therapist will not go to court voluntarily. Please understand that when your therapist goes to court other clients have to have their appointments canceled for the week. The Magistrate or Judge hearing your case must subpoena the therapist.
- The office must receive a retainer cost of $500.00 prior to therapist blocking out their schedule to appear in court.
    - $150 per hour from portal to portal
    - Any additional charges over that will be billed to you following the hearing.
    - In the event the therapist believes that testifying in court would be detrimental to the therapy process the therapist may hire their own attorney to have the subpoena overruled. Any legal fees resulting from this action will be charged to the client that has requested the therapist's appearance.
- Testing- Prices for testing vary and are available upon request.
- Medical Record request: Prices are based on Ohio regulations and are subject to change
    - $18.61 initial fee for record search
    - $1.22 per page for the first 10 pages, then $0.63 per page 11 – 50, $0.26 per page 51 & higher
    - Actual cost of postage to send records
    -

CLIENT NAME _____ DATE _____

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of services received or to be received, the undersigned requests that payment of authorized insurance benefits, including Medicare, if the client is a Medicare beneficiary, be made on the client's behalf to CPCS for any services provided to the client. It is my responsibility to notify CPCS of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined by CPCS and/or my mental health care insurer if the submitted claims or any part of them are denied for payment. The undersigned acknowledges that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

Compass Point Counseling Services appreciates the trust you have in choosing us to provide mental health care services to you, or a client of the office for whom you have responsibility. Our client-and family-centered treatment philosophy requires that we openly communicate our policies and expectations about payment for our services before treatment is initiated. Please take a moment to familiarize yourself with these policies.

I acknowledge that I am financially responsible for all charges associated with mental health services provided by CPCS to me (or the client named below). I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance and/or EAP benefits. I also hereby authorize payment of insurance and/or EAP benefits otherwise payable to me directly to the therapist/CPCS.

AUTOMATIC BILLING OR PAY AT TIME OF SERVICE

Accounts with Compass Point Counseling Services may enroll to automatically have account balances billed to your credit card. If you wish to take advantage of this service please complete the lines below. By providing your billing information you acknowledge consent for us to automatically process charges to the credit card you have provided below.

We will **only** charge services rendered to your card. Your card will **NOT** be charged in the event that you are assessed a charge for canceling within 24 hours of an appointment or for not keeping a scheduled appointment. However, we do ask that you pay these charges in a timely manner.

I understand that I have given Compass Point Counseling Services permission to charge my credit card. I also understand that if my insurance applies any amount to my deductible or denies payment, the full amount of the visit will be billed to my credit card.

EMAIL REMINDERS

We can send you an appointment reminder by email. The appointment reminder will include only the date and time of your appointment and your clinician name. These emails are not encrypted. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, we need you to confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

By providing your email you acknowledge consent for us to send you appointment reminders to the email you have provided below.

Part of our mission here at CPCS is to provide excellent training to upcoming professionals. All of our professionals in training work under the close supervision of qualified supervisors. We sometimes use audio/video recording for training purposes. Those present are made aware and always have the option to refuse. These recordings are used strictly for training purposes. Without exception, the staff at CPCS is trained in and expected to adhere to privacy practices. (Please check the appropriate box)

☐ I agree and consent to participate in supervised training sessions **with audio/video recordings** upon my permission.

☐ I agree and consent to participate in supervised training sessions **without audio/video recordings**.

☐ **I do not consent** to participate in supervised training sessions.

OTHER INFORMATION

I, the undersigned, agree to abide by CPCS's policies and procedures and recognize that my compliance will minimize the danger of accidents or injury to myself, other Clients and employees of CPCS. I, the undersigned, acknowledge responsibility for myself and my actions and liability arising or resulting from my actions/omissions while I am being treated at CPCS. I, the undersigned, acknowledge that CPCS is not responsible to me or my property for the actions/omissions or any liability arising from the actions/omissions of any other clients at CPCS.

☐ I read and understood the Client Responsibility agreement.

- ☐ Please bill all of my appointments to the insurance or EAP that I have provided you.
- ☐ I prefer to be billed for all appointments at the agreed upon private pay rate, whether or not I have insurance coverage.

☐ I read and understand the supervised training consent

☐ I read and understand the email reminders. Email: _____

☐ I read and understand the Credit Card Automatic Billing ***OR*** ☐ I will pay the expected amount at the time of service

Client Name:_____ Cardholder Name:_____

Credit Card Number:_____ Expiration Date:_____ Security code:_____

I, the undersigned, understand that at any time I may elect to participate in other services or refuse any services, treatment or therapy upon full explanation of the expected consequences of such refusal.

I have received a copy of the NOTICE OF PRIVACY PRACTICES (HIPPA) which includes the client's rights and grievance policy.

NAME	RELATIONSHIP TO CLIENT	DATE	SIGNATURE

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			