Child Paperwork

Nemeth Counseling and Consultation

Fee Policy

Case Initiation (for costs associated with client registration)
Administrative Fee - $10
(*does not apply to EAP-initiated cases)*

Diagnostic Assessment
60 Minutes - $110

Individual Counseling
60 Minutes - $90
45 Minutes - $80

Family and Couples Therapy
50 Minutes - $90

Group Therapy
60 Minutes - $20

FIT Assessment
60 Minutes per Assessment - $110

60-Minute Clinical Team Consultation*
$60 per Clinician

No-Show/Late Cancellation Fee
$50

One-Time Consultation
30 Minutes - $60
60 Minutes - $110

Mediation
60 Minutes for One Individual - $135
60 Minutes for Two Individuals - $165

ADHD & Youth Wellness Testing
60 Minutes - $135
(in-person time with clinician, test administration, processing, scoring, and report write-up)

Participation in Legal Activity
60 Minutes - $200
(court appearances, research, communication, document preparation, consultation, etc.)

Case Management Phone Calls/Document Preparation
$1.55 per minute (8-minute minimum)
(including but not limited to contact with schools, physicians, GALs, children services, disability, FMLA)

An **optional service for families whose members see different clinicians and would like their clinicians to consult **with one another** as a group in one-hour meetings. Consistent with best practices, this service ensures that each clinician has a holistic view of the family while strictly maintaining the confidentiality of all members.*

Billing insurance is a privileged service. The client is responsible for any fees that insurance companies do not cover. The client must give 24 hours notice when cancelling an appointment. **A $50 no-show/late cancellation fee** applies to missed appointments and those cancelled within 24 hours of appointment time. As a courtesy, the client will be provided a **one-time fee waiver** for a no-show or late cancellation. Clients using forms of Medicaid are not subject to this fee. However, after missed appointments or late cancellations, Nemeth Counseling reserves the right to reevaluate the scheduling of services. After three such appointments, services may be terminated and client referred.

I have read, understand and agree to the above policy for payment of professional fees.

_____ _____ _____

Signature of client (or person acting for client) | Printed name | Date

Nemeth Counseling and Consultation
Financial Agreement

Payment for services: Payment is due at the time of service. For clients using insurance, this includes co-payments and co-insurance rates as determined by deductibles, out-of-pocket maximums, HRAs and HSAs. These rates are set by the individual insurance plan and not by Nemeth Counseling; per our contract with the insurance company, we are not permitted to waive these fees for any reason. Self-pay clients are responsible for paying the self-pay rates in full at the start of every session.

For clients using insurance: Billing insurance is a privileged service. The client is responsible for any fees that the insurance company does not cover. Nemeth Counseling is in network with most major insurance companies and will submit claims for services received at our office. We will also bill most secondary insurance companies. Clients seeing a clinician who is not in network with their insurance (an out of network provider) are required to pay the full self-pay rate at the time of service. Our office is not set up to submit out of network claims. Clients whose insurance requires a referral or a pre authorization, are responsible for assuring that one is available to our office prior to or at the time of service. If this is not done, the client will be responsible for payment in full. Although our administrative staff will do their best to check each client's insurance benefits prior to the first visit, it is ultimately the client's responsibility to know whether or not their plan covers our services. Please note that any insurance information quoted is not a guarantee of payment; clients are responsible for any amount allowed but not paid by their insurance.
It is the client's responsibility to inform Nemeth Counseling of any and all changes in insurance coverage.

Non-covered Services: Any services not covered by a client's existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. Nemeth Counseling is not responsible for claims that are denied as a result of individual policy exclusions.

Missed Appointments: Clients must give 24 hours notice when canceling an appointment. A $50 no-show/late cancellation fee applies to all appointments. Missed appointment fees are not billable to insurance. The client will be provided a one-time fee waiver to waive one $50 no-show/late cancellation fee.
**Clients using forms of Medicaid are not subject to the cancellation fee. However, after two appointments that are either missed or cancelled with less than 24 hours notice, Nemeth Counseling reserves the right to reevaluate the scheduling of services. After three appointments that are either missed or cancelled with less than 24 hours notice, services may be terminated.*

Past due Balances: Payments, including co-pays and co-insurance rates (as determined by deductibles, out-of-pocket maximums, HRAs and HSAs) are due at the time of service. Any outstanding balances over 30 days past due are subject to be sent to an outside collection agency.

The client is ultimately responsible for payment of all professional fees.

My signature below indicates that I understand and will adhere to this agreement.

_____	_____	_____
Signature of client (or person acting for client)	Printed name	Date

Nemeth Counseling and Consultation
Confidentiality, Client Rights, and Non Discrimination Policy

About Confidentiality

I will treat with great care all the information you share with me. It is your legal right that my records of our sessions are kept private. In general, I will tell no one about the information you share with me, nor will I reveal that you are receiving treatment from me. I will ask you to sign a Release of Information before I speak with anyone regarding your case or share any of your records, with anyone outside of Nemeth Counseling and Consultation LLC. In all but a few rare situations, your privacy is protected by federal and state laws and by my professional code of ethics. The most common situations in which confidentiality is not protected are listed below:

1. If your therapy has been ordered by a court or an employer, the court or employer will require a report from me. In this situation, please speak with me before revealing any information you do not want the court or your employer to receive. You have a right to tell me only as much as you are comfortable revealing.
2. If you are involved in any kind of legal proceeding and you alert the court that you are participating in therapy, I may be ordered to provide the court with your records. Please consult your attorney with any further questions.
3. If you make a serious threat to harm either yourself or another person, I am legally required to protect you and others by contacting the authorities. I cannot promise to keep private any threats that you make.
4. If I believe a child has been or will be abused or neglected, I am legally required to report this to the authorities.

It may be beneficial for me to confer with your primary care physician with regard to your psychological treatment or to discuss any medical issues for which you are receiving treatment. In addition, insurance companies require that I notify your physician by telephone or in writing concerning services that are being provided unless you request otherwise.

Please check only ONE of the following:

❑ I authorize you to contact my **primary care physician** to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis and treatment. I am willing to sign a Release of Information giving my consent to do so.

❑ I do not authorize you to contact my primary care physician with regard to the treatment that I am receiving while under your care or to obtain information concerning my medical diagnosis and treatment.

Email and Texting Restrictions:

I understand that I am able to email or text my therapist for the purposes of scheduling and/or canceling appointments. If I use email or text for purposes other than appointment requests, I understand and waive my right to complete confidentiality, as there are limits to what can be kept private over the internet and phone. I understand that my therapist will not give advice or consultation via email or text due to confidentiality restrictions.

Please initial here to indicate your understanding of this policy: _____

Client Bill of Rights

You have the right to:

- Receive helpful and respectful treatment.
- A safe treatment environment, free from sexual, physical, and emotional abuse.
- Report any immoral or illegal behavior by a clinician.
- Receive information regarding my qualifications, including my license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Receive written information regarding fees, methods of payment, insurance coverage, estimated number of sessions, substitute therapists (in cases of vacation and emergencies), and cancellation policies.
- Refuse to answer any question or give any information with which you are uncomfortable.
- Be aware of whether your therapist will discuss your case with others (for instance, supervisors or students).
- Ask your therapist to inform you of your progress.

Statement of Principles and Complaint Procedures

It is my intention to fully abide by the rules of the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board.

Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me at once. Our work together will be slower and more difficult if your concerns with are not voiced. I will make every effort to seek solutions to any complaints you may have. If you feel that I have treated you unfairly or have broken a professional rule, alert me. You can also contact the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board regarding any concerns.

In my practice as a therapist, I do not discriminate against clients because of age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This commitment is both personal and required by federal, state, and local laws and regulations. I promise to always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

Our Agreement

I, the client (or his or her parent or guardian), understand I have the right to decline to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about the subjects discussed in this agreement, I can talk with my therapist about them, and he or she will do his or her best to answer them. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with my therapist before ending treatment.

I understand that no specific promises have been made to me by my therapist about the results of treatment, the effectiveness of the procedures used, or the number of sessions necessary for therapy to be effective. I have read, or have had read to me, the issues and points in this form. I have discussed points I did not understand, and have had any questions fully answered. I agree to act according to the points covered in this agreement. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my abilities.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

Relationship to client: ❑ Self ❑ Parent ❑ Legal guardian ❑ Health care custodial parent of a minor (less than 14 years of age) ❑ Other person authorized to act on behalf of the client – specify: _____

I, the therapist, have met with this client (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this form. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client.

_____ _____

Signature of therapist Date

_____ _____

Signature of therapist's supervisor, *if applicable* Date

❑ Copy accepted by client ❑ Copy kept by therapist

Nemeth Counseling and Consultation

Consent to Treatment

I acknowledge that I have received and read (or have had read to me) all intake forms and have been informed of services provided by Nemeth Counseling and Consultation. All of my questions have been answered.

I hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no guarantees have been made as to the results of treatment or procedures provided by this therapist.

I am aware that I may end my treatment with this therapist at any time. I understand that I am responsible for paying for services I have already received. I understand that I may lose other services or incur other problems if I end treatment before it is recommended. (For example, if my treatment has been court-ordered, I must answer to the court.)

I am aware that I must call to cancel or reschedule an appointment at least 24 hours (1 day) before the time of the appointment to avoid a $50 cancellation fee. If I do not attend my appointment and do not give notice, I will be charged $50 for that appointment. Due to high demand for appointments, the only exception to this policy is a weather emergency. I understand that I will be provided a one-time fee waiver to waive one $50 no-show/late cancellation fee.

I am aware that services may be terminated and/or I may be referred out for additional services, if at any time during treatment, it is revealed there is ongoing domestic violence; when alcohol or other drugs is a primary concern; or refusal to disclose an ongoing infidelity in couples therapy. I am also aware services may be terminated if I am involved with any violence towards staff, other clients, or patrons of Nemeth Counseling and Consultation, LLC.

I am aware that an agent of my insurance company_____ or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive, including but not limited to any medical records and treatment summaries as needed. I understand that if payment for the services I receive here is not made, the therapist may end treatment.

My signature below shows that I understand and agree with all of the above statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

_____ _____

Signature of therapist's supervisor, *if applicable* Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Disclosure or transfer is expressly prohibited by law.

Nemeth Counseling and Consultation

Client Information Form (Child/Adolescent)

Date: _____

Note: If your child has been a patient here before, please fill in only the information that has changed.

I. Identification

Child

Name: _____ Date of Birth: _____ Age: _____ Nicknames: _____

Gender Identity ❑ Female ❑ Male ❑ Female-to-Male ❑ Male-to-Female ❑ Other: _____

Sexual Orientation ❑ Straight ❑ Gay ❑ Lesbian ❑ Bisexual ❑ Questioning ❑ Other: _____

Your Child's Ethnicity/National Origin: _____ Your Child's Race: _____

Home Address: _____ Apt. Number: _____

City: _____ State: _____ Zip Code: _____

Child's Contact Number (if applicable): _____May we leave a voicemail? ❑ Yes ❑ No

Calls will be discreet, but please indicate any restrictions: _____

To receive appointment reminders, please provide an email address: _____

Parent/Legal Guardian

Name: _____ Date of Birth: _____

Address (if different from above): _____ _____

Best Contact Number: _____ (Cell/Work/Home) May we leave a voicemail? ❑ Yes ❑ No

Calls will be discreet, but please indicate any restrictions: _____

Employer: _____

To receive appointment reminders, please provide an email address: _____

Parent/Legal Guardian

Name: _____ Date of Birth: _____

Home Address (if different from above): _____

Best Contact Number: _____ (Cell/Work/Home) May we leave a voicemail? ❑ Yes ❑ No

Calls will be discreet, but please indicate any restrictions: _____

Employer: _____

To receive appointment reminders, please provide an email address: _____

Stepparent/Significant Other

Name: _____ Date of Birth: _____

Home Address (if different from above): _____

Best Contact Number: _____ (Cell/Work/Home) May we leave a voicemail? ❑ Yes ❑ No

Calls will be discreet, but please indicate any restrictions: _____

Employer: _____

To receive appointment reminders, please provide an email address: _____

Stepparent/Significant Other

Name: _____ Date of Birth: _____

Home Address (if different from above): _____

Best Contact Number: _____ (Cell/Work/Home) May we leave a voicemail? ❑ Yes ❑ No

Calls will be discreet, but please indicate any restrictions: _____

Employer: _____

To receive appointment reminders, please provide an email address: _____

Other Adult in the Home
Name: _____ Date of Birth: _____
Home Address (if different from above): _____
Best Contact Number: _____ (Cell/Work/Home) May we leave a voicemail? ❑ Yes ❑ No
Calls will be discreet, but please indicate any restrictions: _____
Employer: _____
To receive appointment reminders, please provide an email address: _____
Parents are: ❑Married ❑Divorced ❑Remarried ❑Never Married ❑Other: _____
With whom does the child reside? _____
Address (if different from above): _____

II. Chief Concern: Please describe the main reason your child is coming to see us:

_____
_____
_____
_____

III. Referral: How did you hear about Nemeth Counseling?
Name: _____ Contact Number: _____

IV. Religious Identification
Your Child's Current Religious Denomination/Affiliation: ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑Buddhist ❑ Hindu
❑ Other (specify): _____ ❑ None
Involvement: ❑ None ❑ Some/Irregular ❑ Active
How important is faith/spirituality to your child's life? _____
What, if any, church, synagogue, temple, or meeting is your child involved with? _____
Is there any other important way by which your child identifies? _____

V. Child's Medical Care
Doctor: _____ Contact Number: _____
Address: _____

VI. Emergency Contact Information: If an emergency arises while your child is in our office, who should we call? Please list someone who will not be present with the child.
Name: _____ Phone: _____
Relationship to Child: _____

VII. Residences
Homes

Began	Ended	Location	With who?	Reason for moving	Adjustment Concerns

Residential Placements, Institutional Placements, or Foster Care

Began	Ended	Location	Reason for Placement	Adjustment Concerns

VIII. Education

Began	Ended	School	Adjustment Concerns

IX. Employment Experience (if applicable)

Began	Ended	Employer	Job Title	Reason for Leaving

X. Family History

	Name	Age (Or Age at Death)	Significant Mental and/or Physical Illnesses (Or Cause of Death) *Example: depression, anxiety, diabetes*	Deceased?
Parent				
Parent				
Sibling				
Sibling				
Sibling				
Sibling				
Other				
Other				

Please describe your child's relationship with each parent: _____

_____

_____

_____

Please describe your child's relationship with any other adults present in the home:

_____

_____

_____

_____

Please describe your child's relationship with any siblings: _____

_____

_____

_____

XI. Relationships (Significant Others or Close Friends)

Name of Other Person	Person's Age at Beginning of Relationship	Child's Age at Beginning of Relationship	Child's Age at End of Relationship	Reasons for Ending Relationship

Please describe any significant relationships your child has had here. These can include romantic relationships or close friends:

_____
_____
_____
_____

XII. Abuse History

❑My child has never been abused in any way. ❑My child has been abused. ❑My child has witnessed abuse.

Physical Abuse: beating, striking, or other infliction of pain

Sexual Abuse: molesting, fondling, intercourse

Emotional Abuse: humiliation, criticism, name-calling, bullying

Neglect: failure to feed, shelter, or protect

Type of Abuse	Age	By Who?	Effects on Child	Who did your child tell?	Consequences of Telling	Witnessed Only?
Physical						
Sexual						
Emotional						
Neglect						

XIII. Mental Health Treatment History

Has your child ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑ Yes ❑ No

When	Where	Reason	Results

Has your child ever been given a mental health diagnosis? ❑ Yes ❑ No

If yes, please indicate: _____

Has your child ever taken medications for psychiatric or emotional issues? ❑ Yes ❑ No

Medication	Prescribed When?	Prescribed By	Reason	Results	currently taking?

XIV. Medical History

Starting with early childhood and proceeding to the present, please list all diseases, serious illnesses, accidents, injuries, surgeries, hospitalizations, periods of loss of consciousness, seizures, or any other medical conditions your child has had.

Age	Ailment	Treatment Received	Treated By (Physician, Hospital, None, etc.)	Resulting Complications/Current Status

XV. Development

Was your child premature? ❑ Yes ❑ No

Please indicate any prenatal health issues your child may have experienced: _____

_____

_____

During your child's birth, were there any complications? _____

_____

_____

Was your child breastfed? If so, for how long? _____

_____

_____

Did your child experience any sleep-related issues during early childhood? _____

_____

_____

Please describe your child's temperament during early childhood: _____

_____

_____

Did your child achieve developmental milestones (crawling, walking, potty-training, language development, etc.) on schedule? If no, please explain: _____

_____

_____

XVI. Special Skills or Talents

Does your child have any special skills or interests? These can include hobbies, sports, music, TV, etc. _____

_____

_____

_____

XVII. Other

Is there anything else that is important for us to know about your child in order to provide him or her with the best possible service?

_____

_____

_____

_____

Nemeth Counseling and Consultation
Child/Adolescent Checklist of Characteristics and Concerns

Name: _____ Date: _____

Person completing this form: _____ Relationship to Child: _____

Please review the follows child and adolescent characteristics and concerns, and check all that apply to your child.

- ❑ Affectionate
- ❑ Argues, "talks back," smart-alecky, defiant
- ❑ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- ❑ Cheats on schoolwork
- ❑ Cruel to animals
- ❑ Concerned for others
- ❑ Conflicts with parents over rule-breaking, money, chores, homework, grades, music, clothes, hair, friends, etc.
- ❑ Complains
- ❑ Cries easily, feelings are easily hurt
- ❑ Dawdles, procrastinates, wastes time
- ❑ Difficulties with parent's new relationship
- ❑ Dependent, immature
- ❑ Developmental delays
- ❑ Disrupts family activities
- ❑ Disobedient, uncooperative, refuses, noncompliant, breaks rules
- ❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ❑ Dropping out of school
- ❑ Drug or alcohol use
- ❑ Eating—poor manners, refusal to eat, appetite increase or decrease, overeating
- ❑ Exercise problems
- ❑ Extracurricular activities interfere with academics
- ❑ Failure in school
- ❑ Fearful
- ❑ Fighting, hitting, violence, aggression, hostility, threatening, destructive
- ❑ Fire-setting
- ❑ Friendly, outgoing, social
- ❑ Hypochondriac, always complains of feeling sick
- ❑ Immature, "clowns around," has only younger playmates
- ❑ Imaginary playmates, fantasy

- ❑ Independent
- ❑ Interrupts, talks out, yells
- ❑ Lacks organization, unprepared
- ❑ Lacks respect for authority, insults, dares, provokes, manipulates
- ❑ Learning disability
- ❑ Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ❑ Likes to be alone, withdraws, isolates
- ❑ Lying
- ❑ Low frustration tolerance, irritability
- ❑ Mental retardation
- ❑ Moody
- ❑ Mute, refuses to speak
- ❑ Nail biting
- ❑ Nervousness
- ❑ Nightmares
- ❑ Need for high degree of supervision at home over play/chores/schedule
- ❑ Obedient
- ❑ Obesity
- ❑ Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- ❑ Oppositional, resists, refuses, does not comply, negativism
- ❑ Prejudiced, bigoted, insulting, name-calling, intolerant
- ❑ Pouts
- ❑ Recent move, new school, loss of friends
- ❑ Relationships with siblings or friends are poor—competition, fights, teasing, provoking, assaults
- ❑ Responsible
- ❑ Rocking or other repetitive movements
- ❑ Runs away
- ❑ Sad, unhappy
- ❑ Self-harming behaviors—biting or hitting self, head banging, scratching self
- ❑ Speech difficulties
- ❑ Sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ❑ Shy, timid
- ❑ Stubborn
- ❑ Suicidal remarks or attempts
- ❑ Swears, blasphemes, foul language
- ❑ Temper tantrums, rages

❑Thumb-sucking, finger-sucking, hair-chewing

❑Tics—involuntary rapid movements, noises, or word productions

❑Teased, picked on, victimized, bullied

❑Truant, avoids school

❑Underactive, slow-moving or slow-responding, lethargic

❑Uncoordinated, accident-prone

❑Wetting or soiling the bed or clothes

❑Work problems

❑Any other important characteristics or concerns: _____

Please look back over this list and select the issue you would most like your child to have assistance with:

_____

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. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	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			