____
Date

____

____

____

RE: ____

Dear Parent/Guardian:

We are pleased that you are considering the services of the Child Study Center for your child. In order to process you application, please provide us ALL of the information requested below:

_____ 1. Patient Information
_____ 2. Child and Family Information
_____ 3. NICHQ Vanderbilt Assessment Scale – Parent Informant
_____ 4. School Questionnaire & Vanderbilt Scale – **from EACH of your child's teachers**
_____ 5. Copy of Insurance Card – **Must have both sides copied**
_____ 6. Financial Information – **Include tax return if applying for sliding scale**
_____ 7. Patient Consent for Disclosure of Information
_____ 8. Patient Authorization to Consent to Medical/Psychological Treatment of a Minor
_____ 9. Authorization for Use & Disclosure to Health Information to Child Study Center
_____ 10. Authorization for Use & Disclosure to Health Information to the Parent
_____ 11. Authorization for Use & Disclosure to Health Information to the Physician
_____ 12. Copies of Custody Papers: **Must have judge's signature**
_____ 13. Other: **Copies of <u>all</u> previous educational testing and medical records**

<u>We will be unable to schedule appropriate services for your child until ALL completed information has been received.</u>

A Client Services specialist may be reached at **(817) 390-2900** for any questions regarding your application. Please leave your name, the child's name, and a number where you may be reached. Your call will be returned promptly -- this line is monitored regularly for messages.

PLEASE NOTE: After receiving all of your information, your application will be reviewed by our medical director. The Child Study Center focuses on the evaluation and treatment of children with developmental disabilities. If your child's needs are not within the scope of our services, we will provide you with a list of appropriate community resources.

Mail Completed Application To: **Client Services Specialist**
Child Study Center
1300 West Lancaster Avenue
Fort Worth, TX 76102

Visit us online at: www.cscfw.org

CHART # ____________________

PATIENT INFORMATION

PLEASE PRINT IN BLACK INK

HAS THIS CHILD BEEN SEEN HERE BEFORE? ☐YES ☐NO TODAY'S DATE: ___________________

CHILD INFORMATION

LAST NAME______________________________ FIRST___________________________ MIDDLE____________

DATE OF BIRTH________________ AGE_________ GENDER________ SS#________-________-____________

ADDRESS____ CITY______________________ STATE_______

ZIP CODE____________ COUNTY___________________ LENGTH AT CURRENT ADDRESS___________________

HOME PHONE_______________ RACE/ETHNICITY________ LANGUAGE SPOKEN BY THE CHILD__________________

REFERRAL DOCTOR INFORMATION

CHILD REFERRED BY____ PHONE#_________________________

DOCTOR'S ADDRESS_______________________ CITY_______________ STATE_______ ZIP CODE___________

PARENT/GUARDIAN INFORMATION

WHO DOES THE CHILD LIVE WITH? ____

IS THIS THE LEGAL GUARDIAN? ☐YES ☐NO RELATIONSHIP TO CHILD________________________

MOTHER/GUARDIAN FULL NAME_______________________________________ MARITAL STATUS___________

DATE OF BIRTH_____________ SS#________________________EMPLOYER_____________________________

PHONE#____WORK/CELL#_____________________________

EMAIL____ ☐YES, I would like to be added to your email list for updates about the Child Study Center. I understand my information will be kept confidential, and I can unsubscribe at any time.

FATHER/GUARDIAN FULL NAME_______________________________________ MARITAL STATUS___________

DATE OF BIRTH_____________ SS#________________________ EMPLOYER_____________________________

PHONE#____WORK/CELL#_____________________________

EMAIL____ ☐YES, I would like to be added to your email list for updates about the Child Study Center. I understand my information will be kept confidential, and I can unsubscribe at any time.

EMERGENCY CONTACT (NEAREST RELATIVE NOT LIVING WITH YOU):

NAME___________________________________ RELATIONSHIP_____________ PHONE#___________________

HOUSEHOLD MEMBERS

NAME__________________________AGE_______RELATIONSHIP__________________ CSC CLIENT ☐YES☐NO

NAME__________________________AGE_______RELATIONSHIP__________________ CSC CLIENT ☐YES☐NO

NAME__________________________AGE_______RELATIONSHIP__________________ CSC CLIENT ☐YES☐NO

NAME__________________________AGE_______RELATIONSHIP__________________ CSC CLIENT ☐YES☐NO

NAME__________________________AGE_______RELATIONSHIP__________________ CSC CLIENT ☐YES☐NO

PLEASE CIRCLE FAMILY INCOME (FOR UNITED WAY PURPOSES ONLY)

Below $17,000 $17,000-$25,000 $25,001-$35,000 $35,001-$50,000 $50,001-$75,000 $75,001-$100,000 $100,001 and over

NAME OF INSURANCE COVERAGE FOR CHILD:_________________________________

CHART # ____________________

CHILD AND FAMILY INFORMATION

PLEASE COMPLETE IN BLACK INK

CHILD'S NAME: ____ BIRTHDATE: ____/____/_____

PARENT/GUARDIAN'S NAME: ____

HOME PHONE: _____/_____________________ DAY TIME PHONE NUMBER: ______/_________________

I. WHAT ARE THE MAIN CONCERNS THAT YOU HAVE FOR YOUR CHILD?

(Please describe why you are applying and what questions you have about your child)

1. Please check the following reasons you are applying to the Child Study Center:
   - ☐ For an evaluation of my child's attention or hyperactivity problems.
   - ☐ For an evaluation of my child's learning problems (including dyslexia, math, writing).
   - ☐ For an evaluation of my child's developmental delays (language, social skills, motor skills).
   - ☐ For an evaluation to determine if my child has autism or Asperger's disorders.
   - ☐ To talk to a doctor about my child's current medications.
   - ☐ For a second opinion of my child's diagnosis (which is _________________________).
   - ☐ I am interested in the ABA behavioral program for children ages 3-8 who have autism.
   - ☐ I am interested in the Jane Justin special education school for children ages 3-12 years old.
   - ☐ Other reasons (describe): ____
2. Please mark if your child has:
   ☐ Tried to hurt/kill him/herself ☐ Tried to hurt/kill others ☐ Had extreme temper tantrums or meltdowns
3. When did your child's problems begin? ____
4. What is your child's medical or psychiatric diagnosis? ____
5. What medications does your child take regularly? ____
6. Does your child receive special education? ☐ YES ☐ NO If yes, what is the classification:
   ☐ Autism ☐ Mental Retardation ☐ PPCD ☐ Speech Impairment ☐ Specific Learning Disability
   ☐ Other Health Impaired ☐ Emotional Disturbance ☐ Behavioral Disturbance ☐ Traumatic Brain Injury
7. Is your child currently receiving any of the following?
   - ☐ ECI ☐ ABA
   - ☐ Speech Therapy ☐ Physical Therapy
   - ☐ Occupational Therapy ☐ Counseling
   - ☐ 504 Accommodations ☐ Attends Private School ______________________________
8. Do you want your child to see a specific doctor? If yes, which doctor? ______________________

II. PREGNANCY AND BIRTH HISTORY

1. Was this child adopted? ☐YES ☐NO If yes, how old when you took him/her home?__________
2. Length of pregnancy: ___________ weeks Birth weight: _________ lbs. _________oz.
3. Mother's age at time of pregnancy: ________ Father's age at time of pregnancy: _________
4. Number of pregnancies of child's biological mother: _________
5. Prenatal care began: ☐1st trimester ☐2nd trimester ☐ 3rd trimester ☐ none
6. How much weight did the mother gain during pregnancy _________ lbs.
7. Problems with pregnancy
   - a. Bleeding/spotting....................................... ☐ YES
   - b. Diabetic state in pregnancy (sugar in urine) ☐ YES
   - c. High blood pressure......................... .... ☐ YES
   - d. Alcohol used... ☐ YES
   - e. Tobacco used.. ☐ YES
   - f. Toxic exposures............................... .... ☐ YES If yes, explain: ____________________
   - g. Infections.. ☐ YES If yes, explain: ____________________
   - h. Prescribed medications.............................. ☐ YES If yes, explain: ____________________
   - i. Other drugs used...................................... ☐ YES If yes, explain: ____________________
   - j. Other problems: ____
8. Labor: ☐Induced ☐Spontaneous How long was the labor? _________ hours
9. Delivery: ☐Vaginal ☐Forceps Used ☐Vacuum Assisted ☐Caesarean
10. If Caesarean, why? ☐Scheduled ☐Failure to Progress ☐Emergency ______________________
11. At what hospital was the baby born? ____
12. The baby stayed in the: ☐Regular Nursery ☐NICU Discharged at: ____________ days of life
13. Problems in the nursery:

☐Problems Breathing	______________	☐Infections/sepsis	______________
☐High Blood Sugar	______________	☐Seizures	______________
☐Low Blood Sugar	______________	☐Feeding Problems	______________
☐Jaundice	______________	☐High Temperature	______________
☐Heart Problems	______________	☐Low Temperature	______________

EXPLAIN ANY OTHER IMPORTANT INFORMATION ABOUT YOUR CHILD'S BIRTH:

III. HEALTH/MEDICAL HISTORY

1. Who is your child's doctor? Doctor's Name ______________________________
2. Does your child see a neurologist? ☐YES ☐NO If yes, name ______________________
3. Does your child see a psychiatrist? ☐YES ☐NO If yes, name ______________________
4. Does your child see a counselor? ☐YES ☐NO If yes, name ______________________
5. Does your child currently take medications (prescription and non-prescriptions) on a regular basis?
   If yes, what medications:
6. What other medications has your child previously taken?
7. Has your child been hospitalized? ☐YES ☐NO If yes, describe ______________________
8. Has your child had any surgeries? ☐YES ☐NO If yes, describe ______________________
9. Are there other medical problems? ☐YES ☐NO If yes, describe ______________________
10. Has your child had any serious injuries, especially with loss of consciousness? ☐YES ☐NO
    If yes, describe:
11. Does your child have respiratory allergies or asthma? ☐YES ☐NO If yes,________________
12. Does your child have allergies to medications or foods? ☐YES ☐NO If yes,________________
13. Are your child's shot current and up-to-date? ☐YES ☐NO If yes,________________
14. Does your child have eating problems, especially if it requires modification of the diet? ☐YES ☐NO
    If yes, describe:

IV. REVIEW OF SYSTEMS

Please check if your child has any history of:

☐Seizures	____________	☐Sleep difficulties	____________
☐Staring episodes	____________	☐Headaches	____________
☐Motor/vocal tics	____________	☐Vision problems	____________
☐Bowel problems	____________	☐Hearing problems	____________
☐Bladder problems	____________	☐Drooling	____________
☐Ear infections	____________	☐Chewing problems	____________
☐MRI or CT scan	____________	☐Swallowing difficulties	____________

Previous hearing/audiology test results: ☐Normal ☐Abnormal

Previous seeing/vision test results: ☐Normal ☐Abnormal

EXPLAIN ANY OTHER IMPORTANT MEDICAL HISTORY OF YOUR CHILD:

V. FAMILY HISTORY

1. HISTORY OF BIOLOGICAL MOTHER

Education: ☐ Did Not Graduate ☐ GED ☐ High School ☐ Some College ☐ Associate's ☐ Bachelor's ☐ Advanced

Mother's Occupation:______________________________

Please indicate if the child's biological mother had/has a history of:

☐ Speech Problems ☐ Learning Problems ☐ Dyslexia ☐ Attention Problems ☐ Depression ☐ Anxiety ☐ Bipolar Disorder

2. HISTORY OF BIOLOGICAL FATHER

Education: ☐ Did Not Graduate ☐ GED ☐ High School ☐ Some College ☐ Associate's ☐ Bachelor's ☐ Advanced

Father's Occupation:______________________________

Please indicate if the child's biological father had/has a history of:

☐ Speech Problems ☐ Learning Problems ☐ Dyslexia ☐ Attention Problems ☐ Depression ☐ Anxiety ☐ Bipolar Disorder

3. PARENT'S MARITAL STATUS / VISITATION

Child's Parents Are: ☐ Never Married ☐ Separated ☐ Divorced ☐ Married to Each Other

If separated or divorced, who has primary custody?______________________________

How often does the child see the non-custodial parent? ☐ Regularly ☐ Sometimes ☐ Rarely ☐ Never

4. CHILD'S CURRENT LIVING SITUATION: Who is the primary caretaker? ______________________

How long at the current address? _________ years ☐ House ☐ Apt ☐ Own ☐ Rent

How many people live in the home? _________ How many siblings live in the home? _________

5. DO ANY BIOLOGICAL SIBLINGS have learning, speech, behavior or other problems? ☐ YES ☐ NO

If yes, describe______________________________

6. STRESSORS Mark if your child has experienced:

☐ Parent Separation or Divorce
☐ Moves to Different Homes
☐ Moves to Different Schools
☐ Family Financial Difficulties
☐ Multiple Absences/Tardies
☐ Social Problems or Bullying
☐ Loss/Death of Family Member
☐ Loss/Death of Friend or Pet

7. FAMILY HISTORY Mark if anyone on child's mother OR father's side of the family has a history of:

☐ Learning Disabilities/Dyslexia
☐ Attention Deficit Hyperactivity (ADHD)
☐ Slow Learners
☐ Mental Retardation
☐ Speech/Language Disorders
☐ Autism/Asperger's/PDD-NOS
☐ Seizures
☐ Alcoholism
☐ Drug Abuse
☐ Anxiety/Extreme Worrying
☐ Depression
☐ Bipolar Disorder (Manic-Depression)
☐ Schizophrenia
☐ Intermarriage between Relatives
☐ Genetic Syndromes
☐ Neurological Problems

VI. DEVELOPMENTAL HISTORY

Please indicate the age when your child was able to do the following:

1. COMMUNICATION

Used gestures (bye-bye, peek a boo)	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Used ma-ma/da-da to mean the person	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Used words to communicate wants/needs	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Asked "why" questions	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Put sentences in small paragraphs	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Speech understood by the parent	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Speech understood by strangers	Age: ________	OR	☐On Time	☐Late	☐Cannot Do

2. LARGE MOTOR SKILLS

Sat alone	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Took first steps	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Ran with good coordination	Age: ________	OR	☐On Time	☐Late	☐Cannot Do

3. FINE MOTOR SKILLS

Picked up small objects with finger/thumb	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Scribbled with a crayon	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
Draw a face or a person	Age: ________	OR	☐On Time	☐Late	☐Cannot Do

4. TOILET TRAINED

During the day	Age: ________	OR	☐On Time	☐Late	☐Cannot Do
During the night	Age: ________	OR	☐On Time	☐Late	☐Cannot Do

5. FUNCTIONAL AGE

Do you think your child functions at his or her age level? ☐YES ☐NO

If not, at what age level does he or she seem to function? Like a ________________ year old child.

VII. BEHAVIOR CHECKLIST

	Please tell us how often in the last MONTH your child....	NOT AT ALL Never, Seldom	JUST A LITTLE Occasionally	PRETTY MUCH TRUE Often, Quite a bit
1	Had difficulty staying focused on tasks at home or school	0	1	2
2	Was easily distracted	0	1	2
3	Interrupted or intruded on others	0	1	2
4	Was excessively motor active	0	1	2
5	Was aggressive towards people or animals (harmful)	0	1	2
6	Maked poor eye contact	0	1	2
7	Had trouble with language use	0	1	2
8	Hadtrouble interacting with other children	0	1	2
9	Acted as if he or she is in his or her own world	0	1	2
10	Was destructive of property	0	1	2
11	Seriously violated rules	0	1	2
12	Hurt him/herself	0	1	2
13	Refused to comply with adults' requests/rules	0	1	2
14	Was angry and resentful	0	1	2
15	Seemed sad, blue or depressed	0	1	2
16	Made suicidal statements, plans or attempts	0	1	2

VIII. SCHOOL INFORMATION

School: ______________________________ School District: ______________________

Grade: ______________________ Repeated Grades: ____________________________

1. What are your child's current grades? ☐Failing ☐Below Average ☐Average ☐Above Average
2. Has there been a change in your child's grades? ☐YES ☐NO If yes, explain:
3. Is your child's work modified in any way? ☐YES ☐NO If yes, explain:
4. Has your child fail any sections of the TAKS test? ☐YES ☐NO If yes, explain:
5. Has your child been required to attend summer school? ☐YES ☐NO If yes, explain:
6. Please mark your child's WEAKEST academic areas:

☐Phonics/Learning Letter Sounds ☐Reading Single Words
☐Reading Fluency (smoothly) ☐Reading Comprehension
☐Spelling ☐Handwriting
☐Written Expression ☐Copying from the Board
☐Learning Numbers ☐ Basic Math Skills (adding, subtracting, multiplying, division)
☐Math Reasoning (word problems) ☐ Speech/Language Difficulties

IX. SOCIAL HISTORY

1. Are you concerned about your child's ability to make friends and get along with others? ☐YES ☐NO
   If yes, explain:
2. Does your child have a best friend? ☐YES ☐NO
3. Does your child have good eye contact with others? ☐YES ☐NO
4. Does your child show interest in other children? ☐YES ☐NO

_______________________________________ ____________________

Parent / Guardian Signature Date

____

Relationship to Child

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: __________ Child's Name: ________________________________ Date of Birth: ____________

Parent's Name: ________________________________ Parent's Phone Number: ____________________

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

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

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

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

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HE0350

Today's Date: ___________ Child's Name: ____ Date of Birth: _______________

Parent's Name: ____ Parent's Phone Number: ______________________________

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

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

Comments:

For Office Use Only

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

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

Total Symptom Score for questions 1–18: ______________________

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

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

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

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

Average Performance Score: ______________________

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11-19/rev1102

SCHOOL QUESTIONNAIRE

To be filled out by EACH of your child's teachers

PLEASE COMPLETE IN BLACK INK

CHILD'S NAME: ____ BIRTHDATE: ____/____/_____

SCHOOL: ____________________________ GRADE: _____ SCHOOL DISTRICT: ______________________

ADDRESS: ____________________________________ CITY/STATE/ZIP: ___________________________

SCHOOL PHONE NUMBER: _____/____________ DATE FORM FILLED OUT: ______/_______/__________

Name of person completing form: ___________________________ Title: _________________________

1. Is this child in a Special Education program? ☐YES ☐NO If yes, explain:
2. Does this child receive any interventions? ☐YES ☐NO If yes, explain:
3. Does this child receive any classroom modifications? ☐YES ☐NO If yes, explain:
4. Does this child have problems with handwriting? ☐YES ☐NO If yes, explain:
5. Does this child have problems copying from the board? ☐YES ☐NO If yes, explain:
6. Does this child have difficulties making friends? ☐YES ☐NO If yes, explain:
7. Does this child have problems making eye contact? ☐YES ☐NO If yes, explain:
8. Does this child have problems expressing his/her thoughts? ☐YES ☐NO If yes, explain:
9. In your opinion, is this child functioning at capacity? ☐YES ☐NO If yes, explain:
10. Have you discussed these problems with his/her parents? ☐YES ☐NO

Please describe what concerns you most about this student

PLEASE COMPLETE THE ATTACHED NICHQ VANDERBILT ASSESSMENT SCALE

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: ______________________________ Class Time: ___________________ Class Name/Period: ________________

Today's Date: ___________ Child's Name: ______________________________ Grade Level: ______________________________

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: ___________.

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

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil

Consumer & Specialty Pharmaceuticals

HE0351

Teacher's Name: ______________ Class Time: ______________ Class Name/Period: ______________

Today's Date: __________ Child's Name: ______________ Grade Level: ______________

Symptoms (continued)	**Never**	**Occasionally**	**Often**	**Very Often**
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance ***Academic Performance***	**Excellent**	**Above Average**	**Average**	**Somewhat of a Problem**	**Problematic**
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	**Excellent**	**Above Average**	**Average**	**Somewhat of a Problem**	**Problematic**
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: ______________

Mailing address: ______________

____

Fax number: ______________

For Office Use Only

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

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

Total Symptom Score for questions 1–18: ______________

Total number of questions scored 2 or 3 in questions 19–28: ______________

Total number of questions scored 2 or 3 in questions 29–35: ______________

Total number of questions scored 4 or 5 in questions 36–43: ______________

Average Performance Score: ______________

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11-20/rev0303

CHILD'S NAME:__________________________ CHART # ______________

FINANCIAL INFORMATION

*** ALL INFORMATION MUST BE COMPLETED FOR APPLICATION TO BE PROCESSED***

*****APPLICATION WILL NOT BE PROCESSED WITHOUT COPY OF INSURANCE CARD*****

PRIMARY INSURANCE

INSURANCE COMPANY: ______________________________ PHONE#:______________________________

INSURED NAME:______________________________ RELATIONSHIP TO CHILD:______________________

SS NUMBER OF INSURED:______________________________ DATE OF BIRTH:______________________________

EMPLOYER NAME: ______________________________ PHONE#:______________________________

STREET ADDRESS OF EMPLOYER:____

CITY: ______________________________ STATE:__________________ ZIP CODE:______________________

SIGNATURE OF INSURED____ DATE:________________________
(REQUIRED)

SECONDARY INSURANCE

INSURANCE COMPANY: ______________________________ PHONE#:______________________________

INSURED NAME:______________________________ RELATIONSHIP TO CHILD:______________________

SS NUMBER OF INSURED:______________________________ DATE OF BIRTH:______________________________

EMPLOYER NAME: ______________________________ PHONE#:______________________________

STREET ADDRESS OF EMPLOYER:____

CITY: ______________________________ STATE:__________________ ZIP CODE:______________________

SIGNATURE OF INSURED____ DATE:________________________
(REQUIRED)

IF THERE IS NO INSURANCE COVERAGE ON THE CHILD Please sign the following statement:

I **DO NOT** HAVE PRIVATE INSURANCE, MEDICAID OR CHIP: ____
SIGNATURE OF RESPONSIBLE PARTY
(PARENT/GUARDIAN RESPONSIBLE FOR PAYMENT)

You have the option to apply for our **SLIDING SCALE FEE PROGRAM**.
This program is an optional program designed to assist our clients who are unable to pay the full amount for the services they will receive here at the Child Study Center. This program is based on the number of people and the total income of the household. If you would like to apply for this program you will need to send your tax return for the previous year**.** Please contact Client Services at 817-390-2900 for further information on this program.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: In consideration for the services to be rendered, I promise to pay for those services in accordance with the rates and terms now in effect at the Child Study Center. I hereby assign to the Child Study Center any and all benefits and all interest and rights (including cause of action and the right to enforce payment) for services rendered under any insurance policies or any reimbursement or prepaid healthcare plan, if applicable. I acknowledge that any balance not covered or paid by such policy or plan is my responsibility. I understand that failure to pay will result in suspension of service.

____ ________________________ ____________________________
Signature of Parent/Guardian Responsible for Payment Social Security Number Relationship to Child
****REQUIRED****

RELEASE OF INFORMATION: I consent and authorize the Child Study Center to release all information contained in my financial and medical records, including diagnoses and test results, to my insurance company or health plan, their agents or independent contractors, or any other person or entity that is responsible for paying or processing for payment any portion of my bill, or to any person or entity with the Child Study Center for the purposes of administration, billing and operations. This consent applies to all records created in the course of and relating to all services rendered at or for the Child Study Center.

____ ______________________
Signature of Parent/Guardian Responsible for Payment Date
****REQUIRED****

PATIENT CONSENT FOR DISCLOSURE OF INFORMATION

I have read the *NOTICE OF PRIVACY PRACTICES* brochure that was sent in my application, and I have had any questions answered by this office. I understand that by signing this form I consent to the following:

a) **Sharing Information for Purposes of Treatment:** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in my insurance plan;

b) **Sharing of Information for Purposes of Payment:** You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicaid) and their representatives, including (but not limited to benefit determination and utilization review), as well as your representatives involved in the billing process, including (but not limited to) claims representatives, data warehouses, and billing companies;

c) **Sharing of Information for Purposes of Operations:** You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation, and compliance with all federal and state laws.

My consent is freely given with any exceptions marked in the three paragraphs above entitled the **"Patient Consent for Disclosure of Information"**. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

______________________________	______________
Patient's Name (printed)	Chart #
______________________________	______________
Patient/Legal Guardian Signature	Date
______________________________	______________
Witness	Date

PARENT AUTHORIZATION TO CONSENT TO MEDICAL AND/OR PSYCHOLOGICAL TREATMENT OF A MINOR

My name is **(Parent/Guardian)**____, and I live at:

____

My telephone numbers are: Home ( )__________________; Work ( )__________________

Cell ( ) __________________

This Consent applies to the following child(ren) under the age of eighteen (18).

(Patient Name) ____________________________________

____

____

____

I have the authority to consent to medical and/or psychological treatment of the foregoing child(ren) in that I am the parent of the child(ren).

I HAVE RECEIVED A COPY OF AND UNDERSTAND MY RIGHTS AS A PATIENT OF THE CHILD STUDY CENTER.

_______________________________________ ______________________
Signature Date

WITNESS TO SIGNATURE

____
Signature of Witness

Child Study Center
1300 W. Lancaster
Fort Worth, TX 76102 817.336.8611
Street Address/ City/State/Zip

AUTHORIZATION FOR USE & DISCLOSURE (RELEASE) OF PROTECTED HEALTH INFORMATION

(ALL INFORMATION MUST BE COMPLETED TO BE VALID)

Chart # ___________________

Client's Name ____ Date of Birth __________________

I authorize ____ to release protected health information from the medical record of the above named client to:

Child Study Center
Attn: CLIENT SERVICES
1300 W. Lancaster
Fort Worth, Texas 76102
Phone Number: (817) 336-8611

The specific purpose(s) for this disclosure is/are (check (✓) your selection(s):
( ) Sharing with other health care providers; ( ) Medication Management; ( ) Treatment Planning; ( ) Other (please describe):

____

_____ **I WANT /** ______ **I DO NOT WANT** (✓ check one) the specified information to be released to include history, diagnosis and/or treatment for HIV testing, AIDS, communicable diseases, drugs/alcohol and mental health diseases if any.

SPECIFY EXACT INFORMATION TO BE RELEASED: (1) Place a check (✓) next to the specific information needed, (2) list the specific dates of service. (3) List the clinician name.

	INFORMATION	DATES OF SERVICE		INFORMATION	DATES OF SERVICE
	Admission Note			Doctor's Office Records	
	History and Physical			Birth Records	
	Social History			Discharge Summary	
	Educational Testing			Outpatient Clinic Notes	
	ISD Testing			Psychiatric Evaluation	
	Teacher's Questionnaire			Lab and X-Ray Reports	
	Verbal Communication			Other:	

______ I understand that my records cannot be disclosed without my written authorization, except as otherwise provided by law.

______ I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it.

______ In any event this authorization will expire in 180 days from the date of my signature unless otherwise specified by date, event or condition as follows:
____.

______ I understand that a photocopy or facsimile of this authorization is as valid as the original.

____________________ ______________________________________ ____________________
Date Signature of Patient, Parent, or Legal Guardian Relationship to Patient

____
Printed Name of Patient, Parent, or Legal Guardian

AUTHORIZATION FOR USE & DISCLOSURE (RELEASE) OF PROTECTED HEALTH INFORMATION
(NOTE: All items must be completed to be valid)

This form, if signed, will authorize Child Study Center (CSC) to use and disclose certain health care information about the person's name below. All items must be completed and the authorization signed to be valid. I understand this authorization is voluntary, I may refuse to sign this authorization and I understand that CSC may not withhold treatment because I refuse to sign this authorization.

1. I authorize the Child Study Center to disclose health information, as described below, from the medical record of:

   Client's Name ____________________ Date of Birth ____________ Chart # ____________

2. The information specified below may be released to: **(PARENT/GUARDIAN)**

   Parent Name: ______________________________

   Address: ______________________________ Telephone: ____________________

   City: ______________________________ State: ____________ Zip: ______________

3. The specific purpose(s) for this disclosure is/are (check (✓) your selection(s):
   ( ) My personal records; ( ) Sharing with other health care providers; ( ) Eligibility for services;
   ( ) Sharing with educational professionals; ( ) Other (please describe):
   ____

4. ( ) **I WANT** ( ) **DO NOT WANT** (check your preference) the specified information to be released to include history, diagnosis and/or treatment for HIV testing, AIDS, communicable diseases, drugs/alcohol and mental health disease.

5. **SPECIFY EXACT INFORMATION TO BE RELEASED:** (1) Place a check (✓) next to the specific information needed, and (2) list the specific dates of service.

	INFORMATION	DATES OF SERVICE		INFORMATION	DATES OF SERVICE
	Audiology Reports			Psychiatric Evaluation	
	Case Summary			Psychology Evaluation	
	Treatment Plans			Rapid Intake Assessment	
	Clinic Notes/Recalls			School Progress	
	Discharge Summary			Social Work Assessment	
	Educational Evaluation			Speech and Language Assessment	
	History and Physical			Occupational Therapy	
	Physical Therapy			Verbal Communication	
	Other:			Other:	

6. I acknowledge the following statements:
   - I understand I may revoke this authorization at any time by notifying CSC in writing at ATTN: Child Study Center, Medical Records Department, of my intent to revoke this authorization, except that if I do notify CSC in writing of my intent to revoke this authorization, such revocation will not have any effect on any actions by taken before the revocation.
   - Unless otherwise revoked, I understand this authorization will expire 180 days from the date this form is signed.
   - I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and federal privacy laws or regulations may not protect the information.
   - I understand that I may inspect and receive a copy for the information to be disclosed pursuant to this authorization form before I sign this form if I ask to do so. If authorization is requested from CSC I understand that, upon my request, CSC will give me a copy of this authorization form after I sign it.
   - I understand I will be charged for any copies of my records or my child's record I request for myself or for use by others. I understand fees for copies are due and payable before copies are released.
   - I understand that I may be asked to show proof that I have the authority to sign authorization to review and/or receive copies of the above named patient's medical records which I am requesting.
   - I agree that a facsimile or photocopy of this authorization is as valid as the original.

7. ______________ ______________________________ ______________

   Date | Signature of Patient, Parent, or Legal Guardian | Relationship to Patient

   ____

   Printed Name of Patient, Parent, or Legal Guardian

AUTHORIZATION FOR USE & DISCLOSURE (RELEASE) OF PROTECTED HEALTH INFORMATION
(NOTE: All items must be completed to be valid)

Child Study Center

This form, if signed, will authorize Child Study Center (CSC) to use and disclose certain health care information about the person's name below. All items must be completed and the authorization signed to be valid. I understand this authorization is voluntary, I may refuse to sign this authorization and I understand that CSC may not withhold treatment because I refuse to sign this authorization.

1. I authorize the Child Study Center to disclose health information, as described below, from the medical record of:
   Client's Name ____________________ Date of Birth ____________ Chart # ____________
2. The information specified below may be released to: **(PCP/REFERRING DOCTOR)**
   Parent Name: ______________________________
   Address: ______________________________ Telephone: ____________________
   City: ______________________________ State: __________ Zip: ______________
3. The specific purpose(s) for this disclosure is/are (check (✓) your selection(s):
   ( ) My personal records; ( ) Sharing with other health care providers; ( ) Eligibility for services;
   ( ) Sharing with educational professionals; ( ) Other (please describe):
   ____
4. ( ) **I WANT** ( ) **DO NOT WANT** (check your preference) the specified information to be released to include history, diagnosis and/or treatment for HIV testing, AIDS, communicable diseases, drugs/alcohol and mental health disease.
5. **SPECIFY EXACT INFORMATION TO BE RELEASED:** (1) Place a check (✓) next to the specific information needed, and (2) list the specific dates of service.

	INFORMATION	DATES OF SERVICE		INFORMATION	DATES OF SERVICE
	Audiology Reports			Psychiatric Evaluation	
	Case Summary			Psychology Evaluation	
	Treatment Plans			Rapid Intake Assessment	
	Clinic Notes/Recalls			School Progress	
	Discharge Summary			Social Work Assessment	
	Educational Evaluation			Speech and Language Assessment	
	History and Physical			Occupational Therapy	
	Physical Therapy			Verbal Communication	
	Other:			Other:	

6. I acknowledge the following statements:
   - I understand I may revoke this authorization at any time by notifying CSC in writing at ATTN: Child Study Center, Medical Records Department, of my intent to revoke this authorization, except that if I do notify CSC in writing of my intent to revoke this authorization, such revocation will not have any effect on any actions by taken before the revocation.
   - Unless otherwise revoked, I understand this authorization will expire 180 days from the date this form is signed.
   - I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and federal privacy laws or regulations may not protect the information.
   - I understand that I may inspect and receive a copy for the information to be disclosed pursuant to this authorization form before I sign this form if I ask to do so. If authorization is requested from CSC I understand that, upon my request, CSC will give me a copy of this authorization form after I sign it.
   - I understand I will be charged for any copies of my records or my child's record I request for myself or for use by others. I understand fees for copies are due and payable before copies are released.
   - I understand that I may be asked to show proof that I have the authority to sign authorization to review and/or receive copies of the above named patient's medical records which I am requesting.
   - I agree that a facsimile or photocopy of this authorization is as valid as the original.
7. ______________ ______________________________ ______________
   Date   Signature of Patient, Parent, or Legal Guardian   Relationship to Patient

   ____
   Printed Name of Patient, Parent, or Legal Guardian