DEVELOPMENTAL ENHANCEMENT
BEHAVIORAL HEALTH

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Intake Packet - Adult

Welcome to Developmental Enhancement Behavioral Health and thank you for scheduling an appointment with one of our professional staff. We appreciate the opportunity to work with you. Our goal is to provide you with the highest quality services possible. This letter confirms your appointment and provides valuable information about our office policies.

Preparing for this visit

Please complete these forms and bring them with you to your appointment. Completing this information ahead of time allows us to see you in a timely manner upon arrival at our office, and ensures we have the information necessary to address your needs.

In addition, please bring the following items:

- -Insurance Card
- -Copayment or agreed upon payment amount

If you need to cancel or reschedule your appointment, please contact us at least 24 hours in advance to **avoid a no-show fee of $55.00** and allow us the courtesy of offering your appointment time to another patient. Our telephone number is (616) 244-2246.

Your appointment has been scheduled with ___________________________________.

Your appointment date is _________________ at ___________.

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Client Demographics

Client Name: ____ DOB: _______________

Marital Status: ☐Divorced ☐Married ☐Separated ☐Single ☐Widowed

Gender: ☐Male ☐Female ☐Other

Home Address: ____

Legal Status: ☐Minor ☐Emancipated Minor ☐Adult ☐Guardianship ☐Ward

Home Phone Number: _____________________ Cell/Work Phone Number:_____________________

Legal Custody: ____
Name Phone Relationship

Guardian/Wardship:____
Name Phone Relationship

Insurance Information:

Policy Holder:____ DOB: _______________

Primary Insurance:________________________________ Employer: _________________________

Contract Number_______________________________________ Group Number: _______________

Policy Holder's SSN: ________________________________

Home Address: ____

Phone Number on Card: _____________________ Cell/Work Phone Number:____________________

Secondary Insurance:

Policy Holder:____ DOB: _______________

Primary Insurance:________________________________ Employer: _________________________

Contract Number_______________________________________ Group Number: _______________

Policy Holder's SSN: ________________________________

Home Address: ____

Phone Number on Card: _____________________ Cell/Work Phone Number:____________________

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Developmental Enhancement Payment Policy

Developmental Enhancement, PLC collects all payments and copays for therapy services at the time of service as stated in the Financial Policy and Guarantor Agreement. Payment for evaluations will be collected at the time of the feedback session or last testing session. You have the option of paying by cash, check, or credit card at the front desk. Any exceptions to this policy must be made in advance with the therapist. **Clients with active Medicaid will not be charged co-pays, cancellation fees, or any amount beyond what Medicaid pays. If the client's Medicaid status is considered inactive at any time, the client will be responsible for any balances accrued during that time.**

Clients must **check in at the front desk prior to each appointment** and make payments at that time. Please notify the office staff any time you have a change in insurance coverage.

If you have insurance other than those we are paneled with, you will be responsible for the cost of services. We are able to provide you with a receipt that can be submitted to your insurance company or that can be retained for tax purposes.

We are able to directly bill Traditional and PPO Blue Cross/Blue Shield of Michigan, MESSA, Cofinity, Aetna, Cigna, ASR, Priority Health, and Blue Care Network, among select others. Please remember that if for any reason your insurance carrier does not cover the charges, you will be responsible for the full amount.

We appreciate your cooperation with the payment policy. If you have questions, please discuss them with your therapist.

I understand that I am responsible for any health insurance deductibles and coinsurance and that any amounts not paid by insurance are my responsibility. If this account is delinquent, I agree to pay all expenses including, but not limited to, collection agency fees, along with any court costs and actual attorney fees incurred by Developmental Enhancement, PLC in collecting this account.

____ ______________________

Signature of Guarantor | Date

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Financial Policy and Guarantor Agreement

Please read the Financial Policy and Guarantors Agreement carefully so that you fully understand our financial policy, fees for our services, and your financial responsibility. We would be happy to discuss or answer any questions you may have pertaining to this policy. In order to receive services from Developmental Enhancement, PLC, the Guarantor must guarantee payment to Developmental Enhancement, PLC, for all services provided.

The Guarantor agrees to the following:

1. The Guarantor guarantees that Developmental Enhancement, PLC, will be paid for all amounts owed by the client for services provided by Developmental Enhancement, PLC. All payments are due at the time of service.

2. Developmental Enhancement, PLC is able to bill many insurance companies directly. Clients are responsible for paying the copay and/or deductible at the time of services. The Guarantor remains ultimately responsible for any charges not reimbursed by insurance companies for any reason. Self-paying clients are required to pay the full cost of services at the time services are provided unless a payment plan has been previously approved.

3. Developmental Enhancement, PLC's current fee schedule can be found on the following page. Based on the current fee schedule, amounts expected to be paid by the client for services provided are included, but not limited to, this list. Rates may be subject to change by Developmental Enhancement, PLC at any time.

4. Payment in full is due at the time of service, unless otherwise arranged for ahead of time with your clinician. Developmental Enhancement, PLC, is able to accept cash, check, or credit card for payment.

5. Unless otherwise arranged in advance, any balances owed by the Guarantor not paid within 30 days will receive a billing charge of 1.5%. Guarantor agrees to pay all expenses including, but not limited to, collection agency fees, along with any court costs and actual attorney fees incurred by Developmental Enhancement, PLC in collecting this account.

    a. The Guarantor will be billed a **$55 Missed Appointment Fee** for all unexcused sessions that were not canceled or rescheduled within 24 hours of the scheduled time.
    b. There will be a **$35 Returned Check Fee** for any checks returned for insufficient funds.

6. The guarantee contained in this agreement is a continuing and unconditional guarantee and may only be withdrawn by the Guarantor by giving written notice to Developmental Enhancement, PLC. All amounts owed prior to Developmental Enhancement, PLC, receiving the withdrawal of guarantee remain the obligation of the guarantor.

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7. If the agreement is signed by more than one person, all persons signing the agreement as Guarantor acknowledge that their obligation is joint and several, that revocation of the agreement by one guarantor does not affect the liability of any other Guarantor, and that Developmental Enhancement, PLC, may proceed against each or any one of the persons signing this agreement as guarantor.

8. This agreement is not revoked by the death of a client or Guarantor and will continue in force until all financial obligations owed by the client are fully paid.

9. This agreement shall be construed and enforced according to Michigan law. The Guarantor consents to the jurisdiction of any Michigan court in the event it becomes necessary to institute legal proceedings to enforce the agreement, and waives any objection to personal jurisdiction or venue in such proceedings.

10. The terms of this agreement cannot be changed unless Developmental Enhancement, PLC, consents to the changes in writing.

By signing below, I agree to be the Guarantor and to accept the conditions of this agreement.

Guarantor: ____ Date: ______________

Home Address: ____

Home Phone Number: ____________________ Cell/Work Phone Number:____________________

Additional Guarantor: _______________________________________ Date: ______________

Home Address: ____

Home Phone Number: ____________________ Cell/Work Phone Number:____________________

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Fee Schedule – Developmental Enhancement, PLC's Charges

Mental Health Assessment and Therapy
90791- Initial Assessment/Therapy Intake, $195.00
90832- Individual Therapy (30 minutes), $80.00
90834- Individual Therapy (45 minutes), $110.00
90837- Individual Therapy (60 minutes), $155.00
90846- Family Therapy-patient not present, $110.00
90847- Family Therapy-patient present, $110.00
90853- Group Therapy, $55.00
96130- Psychological Testing (First 60 minutes), $175.00
96131- Psychological Testing (Additional 60 minutes), $175.00
93136/96137-Testing Administration/Scoring (First 30 minutes/Additional 30 minutes), $75.00 per unit

Applied Behavior Analysis (ABA Therapy)-codes vary by insurance
Direct Therapy with Tutor (per 15 minutes), $18.00
BCBA Supervision (per 15 minutes), $32.50
Initial Assessment with BCBA (per hour), $145.00
Re-Assessment, Treatment Plan (per hour), $135.00
Family/Parent Training (per 15 minutes), $25.00

Consultation, Self-Pay Only
15 minutes, $27.50
30 minutes, $55.00
45-60 minutes, $110.00

Additional Charges
Missed Appointment Fee, $55.00
Returned Check Fee, $35.00
Telephone Consultation (per 15 minutes), $30.00
Treatment Summaries/Other Reports (per 15 minutes), $30.00

Additional services may be offered at mutually agreed upon rates. Services and fees agreed upon for this agreement include the following:

____

____

Rates may be subject to change by Developmental Enhancement, PLC at any time. Please contact your insurance company to confirm your actual codes and cost.

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Consent for Treatment

I hereby give consent for staff at Developmental Enhancement, PLC, to provide psychological, developmental, and educational services including treatment, evaluation, and consultation for:

____ __________________________

Client Name DOB

____ __________________________

Client or Parent/Guardian Signature Date

Privacy Practices

I have been provided with the Notice of Privacy Practices and take responsibility to review it and seek clarification from Developmental Enhancement, PLC, regarding unclear information.

____ __________________________

Client or Parent/Guardian Signature Date

Confidentiality

If seeking payment or reimbursement from a third-party payer (e.g., health insurance, flexible spending account), such payers might request disclosure of pertinent information during the course of treatment.

Do you authorize release of necessary information to third-party payers **required to bill insurance?**

☐Yes ☐No

____ __________________________

Client or Parent/Guardian Signature Date

If staff at Developmental Enhancement needs to reach you by telephone, may they leave a message on your answering machine?

☐Yes ☐No

____ __________________________

Client or Parent/Guardian Signature Date

If staff at Developmental Enhancement needs to reach you, may they contact you by secure email?

☐Yes ☐No

Email address: ____

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Release of Information - Primary Care Physician - REQUIRED

I, ____, (_______________) hereby authorize Developmental
Client Name DOB
Enhancement, PLC, to ☐ **disclose** and/or ☐ **receive** the following psychiatric and/or medical information to/from:

Name & Organization: ____ Relationship: ______________________

Address: ____

Phone Number: __________________________________Fax number: __________________________________

Covering the dates of _________________________ through ___________________________

This release includes professional communications, both verbal and written, and/or reports produced during treatment, with the exception of: ____

This authorization shall be in force and effect until______________ (1-year maximum), or event or purpose at which time this authorization to use or disclose this protected health information expires (Ex. termination of treatment with clinician).

I understand that:

- A revocation is not effective to the extent Developmental Enhancement, PLC, has relied on the use or disclosure of the protected health information. The Notice of Privacy Practices outlines privacy issues including revocation of authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Developmental Enhancement, PLC will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Revoke this authorization, in writing, at any time by sending such written notification to Developmental Enhancement at the above address.
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a copy of this authorization containing my signature.

I have been made aware of Developmental Enhancement, PLC's Privacy Practices. The statements included in this authorization are binding on Developmental Enhancement, PLC's service.

____ ______________________

Client/Parent/Guardian Signature Date

____ ____

Client/Parent/Guardian Printed Name Witness/Date

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Release of Information

I, ____, (_______________) hereby authorize Developmental
Client Name DOB
Enhancement, PLC, to ☐ **disclose** and/or ☐ **receive** the following psychiatric and/or medical information to/from:

Name & Organization: ____ Relationship: __________________

Address: ____

Phone Number: __________________________________Fax number: __________________________________

Covering the dates of _________________________ through ___________________________

This release includes professional communications, both verbal and written, and/or reports produced during treatment, with the exception of: ____

This authorization shall be in force and effect until______________ (1-year maximum), or event or purpose at which time this authorization to use or disclose this protected health information expires (Ex. termination of treatment with clinician).

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Developmental Enhancement, PLC will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

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- Revoke this authorization, in writing, at any time by sending such written notification to Developmental Enhancement at the above address.
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a copy of this authorization containing my signature.

I have been made aware of Developmental Enhancement, PLC's Privacy Practices. The statements included in this authorization are binding on Developmental Enhancement, PLC's service.

____ ______________________
Client/Parent/Guardian Signature Date

____ ____
Client/Parent/Guardian Printed Name Witness/Date

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Emergency Information

Please list any individuals who are directly involved in caring for the client.

Name: ____ DOB: __________________

Relationship: __________________________

Type of Custody: (☐Legal ☐Physical ☐Sole ☐Joint Legal ☐Joint Physical ☐None)

Phone Number: ______________________ Address:_____________________________

Emergency Contact: ☐Yes ☐No ____________________________________

____

Name: ____ DOB: __________________

Relationship: __________________________

Type of Custody: (☐Legal ☐Physical ☐Sole ☐Joint Legal ☐Joint Physical ☐None)

Phone Number: ______________________ Address:_____________________________

Emergency Contact: ☐Yes ☐No ____________________________________

____

Name: ____ DOB: __________________

Relationship: __________________________

Type of Custody: (☐Legal ☐Physical ☐Sole ☐Joint Legal ☐Joint Physical ☐None)

Phone Number: ______________________ Address:_____________________________

Emergency Contact: ☐Yes ☐No ____________________________________

____

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Release and Waiver

Acknowledging participation in the activities at Developmental Enhancement, the undersigned, on his or her own behalf, and on behalf of any executors, heirs, successors and assigns, hereby acknowledges and agrees as follows:

1. The undersigned knowingly and fully assumes all risks, known and unknown, associated with participation in activities at Developmental, and waives all claims for damage to personal property or injury to person arising from such participation. This release and waiver covers risks of death, serious injury, and property loss whether arising from (a) negligence or carelessness on the part of the persons or entities being released and other participants, or (b) dangerous or defective equipment.

2. The undersigned certifies that the client may participate in the activities available, and has not been advised to the contrary by a qualified medical professional;

3. The undersigned on his or her behalf and on behalf of any executors, heirs, successors and assigns, hereby releases, discharges, and holds harmless Developmental Enhancement, including its officers, agents, employees, representatives, and all affiliates, from any and all claims, damages, or liability arising from death, disability, personal injury, property damage, or theft, or any kind of action;

4. The undersigned acknowledges that this release and waiver of liability form will be used and relied upon by Developmental Enhancement and that it will govern the undersigned's actions and rights.

____ _________________________

Parent/Guardian Signature Date

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Confidentiality Agreement for Shared Treatment Spaces

During the assessment and treatment at Developmental Enhancement, PLC clients frequently come in contact with other clients of Developmental Enhancement, PLC..

Confidentiality—trusting that communication and information will be kept private—is important to Developmental Enhancement, PLC. While employees at Developmental Enhancement, PLC follow strict confidentiality rules, we also want to ensure that clients also respect confidentiality.

While in any area utilized by Developmental Enhancement, PLC, both clients and family members of clients agree not to divulge any confidential information which comes to them in relation to any other client or family member of another client at Developmental Enhancement. This shall include:

- Not discussing any information pertaining to any other client or family member of a client with anyone including but not limited to, my own family, friends, or relatives.
- Not discussing any information pertaining to any client or family member of a client in any place where it can be overheard by others.
- Not contacting any individual or agency outside of Developmental Enhancement, PLC to get personal information about any client or family member of a client
- Not releasing any information, in writing or orally, regarding any client or family member of a client to any person(s) or agencies.
- I understand that violation of these confidentiality principals could potentially result in my termination at Developmental Enhancement, PLC. Further, breaching of confidentiality may subject me to civil or criminal liability.

By my signature below, I indicate that I have read carefully and understand this agreement and that I agree to its terms and conditions.

____ ____________________
Client/Parent/Guardian Signature Date

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Adult Intake Questionnaire

Please fill out this form completely. The information you provide is confidential and protected by law.

Client Name: ____ DOB: _____________________

Gender: ☐Male ☐Female ☐Other

Name of person filling out this form: ________________________Relationship to Client: _______________________

Who referred you to Developmental Enhancement, PLC?:____

Reason for coming to our office:

Behavior Problems:

- ☐ Aggression
- ☐ Alcohol use
- ☐ Compulsiveness
- ☐ Crying spells
- ☐ Dishonesty
- ☐ Disorganization
- ☐ Disrespectfulness
- ☐ Distractibility
- ☐ Drug use
- ☐ Fire setting
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Over-activity
- ☐ Poor attention
- ☐ Seizures
- ☐ Self-harm
- ☐ Sexual behavior
- ☐ Stealing
- ☐ Suicide attempt
- ☐ Temper tantrums
- ☐ Tics
- ☐ Verbal aggression
- ☐ Withdrawal

Emotional Distress:

- ☐ Anger
- ☐ Excessive guilt
- ☐ Hopeless, helpless
- ☐ Irritability
- ☐ Lack of enjoyment
- ☐ Loneliness
- ☐ Moodiness
- ☐ Nervousness
- ☐ Obsessions
- ☐ Panic attacks
- ☐ Sadness
- ☐ Suicidal thoughts
- ☐ Thoughts of harming others
- ☐ Perfectionism
- ☐ Sensitive to criticism
- ☐ Rapid mood changes

Functional Problems:

- ☐ Appetite problem
- ☐ Cognitive problems
- ☐ Inadequate energy
- ☐ Irresponsible
- ☐ Learning problems
- ☐ Memory problems
- ☐ Money management
- ☐ Physical pain/injury
- ☐ Poor hygiene
- ☐ Problems with mobility
- ☐ Problems with speech
- ☐ Recognition of danger
- ☐ Sleep problems
- ☐ Social relationships
- ☐ Toileting problems
- ☐ Apathy

Other Issues/concerns:

____

____

How do these affect your life?

____

____

How long have these issues been present?

____

____

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Race/Ethnicity (Optional)

Please check the box that best represents your race/ethnic background:

☐American Indian or Alaska native ☐Asian ☐Black of African American ☐Caucasian

☐Hispanic ☐Native Hawaiian or Other Pacific Islander ☐Two or more races

Sexual Orientation (Optional)

☐Heterosexual ☐Gay/Lesbian ☐Transgender ☐Bisexual ☐Other

In the past, have you been treated by a mental health professional? ☐No ☐Yes
Please list the doctor(s) name and date range of treatment

Psychologist(s):____

Psychiatrist(s):____

Neurologist(s):____

Other:____

Are you currently in treatment with a mental health professional? ☐No ☐Yes
Please list the doctor(s) name and date range of treatment

Psychologist(s):____

Psychiatrist(s):____

Neurologist(s):____

Other:____

Have you ever been admitted to a psychiatric hospital? ☐No ☐Yes

If yes, when? ______________________ Where? ____

Why? ____

____

Significant Trauma *(Include age at time of incident, nature of trauma, and any legal details)*

☐Physical injury by accident ____

☐Physical abuse (client was the ☐victim ☐perpetrator):____

☐Sexual assault/abuse (client was the ☐victim ☐perpetrator):______________________________________

☐Emotional abuse (client was the ☐victim ☐perpetrator):____

☐Neglect ____

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Psychiatric and Medical History- *Family and Personal*

Paternal (Biological Father's) Family History

☐ADHD, ADD, attention/concentration/activity level problems ☐Depression

☐Alcohol/drug abuse ☐Genetic problems ☐Anxiety, panic attacks ☐Learning Disorder, problems

☐Autistic Spectrum Disorders ☐Major mental illness ☐Bipolar Disorder ("Manic"-depression)

☐Neurological ☐Cardiopulmonary difficulties (e.g., high blood pressure, heart disease, etc.)

☐Other: ____

Maternal (Biological Mother's) Family History

☐ADHD, ADD, attention/concentration/activity level problems ☐Depression

☐Alcohol/drug abuse ☐Genetic problems ☐Anxiety, panic attacks ☐Learning Disorder, problems

☐Autistic Spectrum Disorders ☐Major mental illness ☐Bipolar Disorder ("Manic"-depression)

☐Neurological ☐Cardiopulmonary difficulties (e.g., high blood pressure, heart disease, etc.)

☐Other: ____

Medical History

Have you ever experienced the following? *If yes, please elaborate.*

☐High fever requiring hospitalization or treatment: ______________________________

☐Unexplained fever or spike in temperature: ______________________________

☐Head injury: ______________________________

☐Concussion: ______________________________

☐Loss of consciousness: ______________________________

☐Seizures Type: ☐Petit Mal ☐Grand Mal Beginning at what age________ Frequency______________

☐Tics – Please describe: ______________________________

☐Thyroid or endocrine problems ______________________________

☐Chronic ear infections/sinus infections *Were tubes required?*: ☐No ☐Yes: At what age(s)________________

☐Chronic allergies ☐Diabetes/blood sugar problems ☐Meningitis, encephalitis ☐Bronchitis, pneumonia

☐Upper respiratory problems/asthma ☐Hearing problems ☐Vision problems

☐Congenital Conditions:______________________________

Current/Chronic illnesses:______________________________

____

Hearing: ☐No problem ☐Conductive Impairment ☐Sensori-neural Impairment

Vision: ☐No problem ☐Nearsighted ☐Farsighted ☐Blind ☐Other:____________________________

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Are you currently taking any medication?
Please list medication, including dose, frequency and prescribing physician

____
____
____
____

Past medications that have produced a negative reaction or ineffective medications?
Please list medication and reason for discontinuation

____
____
____
____

Have you had any major surgeries?
Please list procedure, age, outcome and any complications

____
____
____

Appetite:

☐No problems ☐Obsessed with food – since____

☐Increased/decreased appetite – since____

☐Weight gain/loss of more than 5 pounds (at ________________ height)

☐Consistent Weight?: ________ Since: ___________

Substance Use

Do you drink alcohol?	☐ Daily use	☐ Occasional Use	☐ None
Do you use tobacco?	☐ Daily use	☐ Occasional Use	☐ None
Do you use drugs?	☐ Daily use	☐ Occasional Use	☐ None

Has alcohol/drug use interfered with family, work, health, or interpersonal life? ☐ Yes ☐ No

If yes, please explain: ____

Have others viewed your use as a problem? ☐ Yes ☐ No

Have you ever tried to cut down on your alcohol or drug use or quit using? ☐ Yes ☐ No

If yes, please explain: ____

Have you had any prior substance abuse treatment? ☐ Yes ☐ No

When? *Where?*

_________________________________ _________________________________

_________________________________ _________________________________

DEVELOPMENTAL ENHANCEMENT BEHAVIORAL HEALTH

W// debh.org

1428 44th Street SW	854 Washington Ave Suite 600	185 44th Street SW
Wyoming, MI 49509	Holland, MI 49423	Grandville, MI 49418
P// 616.604.8492	P// 616.499.2218	P// 616.244.2246
F// 616.604.8493	F// 616.499.2219	F// 616.244.2247

Developmental History

As a child did you have any developmental issues? ☐Yes ☐No

*If yes, please explain:*____

Were developmental milestones generally on time? ☐Yes ☐No

If no, please explain: ____

Educational Information

Highest level of education achieved: ____

Degrees: ____

Did you in the past or do you currently have any learning issues? ☐Yes ☐No

*If yes, please explain:*____

Occupational Information

Do you currently work? ☐Full time ☐Part time ☐No

Occupation: _________________________________ Current Employer: _________________________________

Are you currently having problems at work? ☐ Yes ☐ No

If yes, please explain: ____

Military History

Are you currently serving or have you served in the military? ☐ Yes ☐ No

If yes, please explain: ____

Persons living in the home:

Name	*Age*	*Relationship to Patient*	*Quality of Relationship*
___________________________	___	________________________________	☐Good ☐Fair ☐Poor
___________________________	___	________________________________	☐Good ☐Fair ☐Poor
___________________________	___	________________________________	☐Good ☐Fair ☐Poor
___________________________	___	________________________________	☐Good ☐Fair ☐Poor
___________________________	___	________________________________	☐Good ☐Fair ☐Poor

Other important persons in patient's life:

Name	*Age*	*Relationship to Patient*	*Quality of Relationship*
___________________________	___	________________________________	☐Good ☐Fair ☐Poor
___________________________	___	________________________________	☐Good ☐Fair ☐Poor
___________________________	___	________________________________	☐Good ☐Fair ☐Poor

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Legal

Please detail any contacts you have had with the courts:____

____

____

Please detail any contacts you have had with the police: ____

____

____

Personal Information

What are your greatest strengths?

____

____

____

What are your most likeable attributes?

____

____

____

Hobbies/Interests *(Please list any changes in interest)*

____ ☐No change ☐Decreased ☐Increased

____ ☐No change ☐Decreased ☐Increased

____ ☐No change ☐Decreased ☐Increased

____ ____________________

Form Completed By Date