THE EXCEL CENTER PATIENT FACE SHEET

Patient Name: ______________________ (First / Middle / Last) **D.O.B.** ___ / ___ / ___ **Age:** _____ **Biological Sex:** _____ **Race:** _____

Address: ______________________ **SS #:** ______ -- ______ -- ______

City: ______________ **State:** ______ **Zip Code:** ________ **Patient Lives With:** ____________

Cell (____)_____ -______ **Home** (____)_____ -______ **Work** (____)_____ -______ **Marital Status:** ________

E-mail address if patient is an adult: ______________________ □N/A

Guardian/Support Person # 1 □N/A
Name: ______________________
Relation: __________ Cell #(______) ______ -______
Home (____)_____ -______ Work (____)_____ -______

Guardian/Support Person # 1 □N/A
Name: ______________________
Relation: __________ Cell #(______) ______ -______
Home (____)_____ -______ Work (____)_____ -______

Alternate Emergency Contact:
Name: Phone#: ( ) -- Relationship:

Guarantor □ Same as Patient
Name: ______________ D.O.B. ___ / ___ / ___ SS #: ______- ______- ______ Race: _____
Address: ______________ City: ______________ State: _____ Zip Code: ________
Cell (____)_____ -______ Home (____)_____ -______ Work (____)_____ -______
E-mail address of guardian if patient is a minor: ______________________ □N/A

Primary Insurance Name: ______________ Policy ID: ______________ Group #: ________
Insured First Name: __________ Middle: __________ Last: __________ D.O.B ___/___/___
SS #: ______-______-______ Relation to patient: __________ Sex: ______ Insurance # (____)_____ -______
Employer name: ______________________ Employer phone #: (____)_____ -______
Employer address: ______________ City: ________ State: ______ Zip: ______

Secondary Insurance Name: ______________ Policy ID: ______________ Group #: ________
Insured First Name: __________ Middle: __________ Last: __________ D.O.B ___/___/___
SS #: ______-______-______ Relation to patient: __________ Sex: ______ Insurance # (____)_____ -______
Employer name: ______________________ Employer phone #: (____)_____ -______
Employer address: ______________ City: ________ State: ______ Zip: ______ □N/A

Primary Doctor: ______________________
Phone(____)_____ -______ Fax (____)_____ -______

Preferred Pharmacy: ______________________
□ Permission To Contact? Initials______
Phone#: ( ) --

Involved Therapist
Name: ______________________
Phone #( ) - Fax #( ) -

Involved Psychiatrist
Name: ______________________
Phone #( ) - Fax #( ) -

School: ______________ **Grade:** ______ **Phone#**(____) ______ - ______ **Fax#** (____) ______- ______
CPS Case Worker Name: ______________________ **Phone#** (______) ______ - ______
Foster Care Agency: ______________________ **Phone#** (______) ______ - ______

*** FOR STAFF USE ONLY ***

Group T: **Ins. #1**: □ABH □Aetna □Amerigroup □BCBS □BCBS Anthem □Beacon □Cigna □Cigna Health Springs □Magellan □Superior □UBH □UMR □Tricare □Other: ______________

Family T: **Ins. #2**: ______________________ **Admit Date:** / /

Physician: □ Ali □ Allawala □ Bennett □ Bhatia □ Costello □ Day **Program:** □PHP □IOP □OPS □PHP-Virtual □IOP-Virtual

Program: □PHP □IOP □OPS □PHP-Virtual □IOP-Virtual

Group: □Elem □Interm □PreAd □Adol □DBT □MH □CD □2nd Chances □OPS □MH Adult MWF

Diagnosis: □ ADHD Hyper. □ ADHD Comb. □ DMDD □ MDD S/S w/o Ψ features □ MDD R/S w/o Ψ fxs □ MDD R/S w/ Ψ fxs □ GAD □ PTSD □ Unspecified disruptive, impulse-control, and conduct d/o □ Bipolar I specify: ______________ □ Schizophrenia □ Schizoaffective specify: ____________ □ Other: ______________
Other: ______________ □ Other: ______________ □ Other: ______________

THE EXCEL CENTER PATIENT FACESHEET

PATIENT LABEL

THE EXCEL CENTERS ASSESSMENT SERVICE DISCLOSURE STATEMENT AND CONSENT TO ASSESS
DECLARACIO DE DIVULGAVION DEL SERVICIO DE EVALUACION Y CONSENTIMIENTO A LA EVALUACION DE LOS CENTROS DE EXCEL

The Excel Center lawfully and ethically operates an assessment service at no cost, which provides assessment by licensed mental health professionals. The clinician may refer appropriate patients for outpatient treatment or to a physician for further evaluation or recommend admission to the facility. *El Centro Excel opera legal y éticamente un servicio de evaluación sin costo alguno, lo que proporciona una evaluación por profesionales de salud mental con licencia. El clínico puede remitir a pacientes apropiados para tratamiento ambulatorio o a un médico para una evaluación posterior o recomendar la admisión a la instalación.*

Before referring and/or assessing a person, the following disclosures must be made to each person seeking treatment or assessment: *Antes de referirse y / o evaluar a una persona, se deben hacer las siguientes revelaciones a cada persona que solicite tratamiento o evaluación:*

- **The Excel Center is not obligated to provide an assessment by a physician unless deemed necessary by the assessment clinician. Physician assessments are billable services.** *El Centro Excel no está obligado a proporcionar una evaluación por un médico a menos que el clínico evaluador lo considere necesario. Las evaluaciones médicas son servicios facturables.*
- **This assessment is voluntary and the client is free to choose whether they want to pursue further treatment.** *Esta evaluación es voluntaria y el cliente es libre de elegir si desea continuar con el tratamiento.*
- **The assessment clinician is an employee of Millwood Hospital/Excel Center.** *El clínico de evaluación es un empleado de Millwood Hospital / Excel Center.*
- **The assessment is confidential unless the client gives permission in writing to release information.** *La evaluación es confidencial a menos que el cliente dé permiso por escrito para divulgar información.*
- **Specific mental health professionals the client may be referred to are licensed and meet clinical and ethical standards of the Excel Center.** *Los profesionales de salud mental específicos a los que el cliente puede ser referido tienen licencia y cumplen con los estándares clínicos y éticos del Centro Excel.*
- **Financial reimbursements are never given or received by the Excel Center based on referrals.** *Los reembolsos financieros nunca son entregados o recibidos por el Centro Excel basado en referencias.*

I certify that I have read and fully understand the above consent for assessment. I agree to absolve Millwood Hospital/Excel Center and its staff rending the treatment(s) from any liability. *Certifico que he leído y entiendo completamente el consentimiento anterior para la evaluación. Estoy de acuerdo en absolver Millwood Hospital / Excel Center y su personal desvinculando el tratamiento (s) de cualquier responsabilidad.*

I certify that I am/*Certifico que soy:*

______ **Patient of legal age, 18 & older and can consent to own treatment**/*Paciente de edad legal y puede dar concentimiento*
______ **Biological parent with authority to consent for treatment**/*Padre biologico con autoridad de dar concentimiento*
______ **Adoptive Parent**/*Padre adoptivo* ______ **Foster Parent**/*Padres de crianza* ____ **Guardian**/ *Guardian*

☐ **I Consent to Assessment**/*Consiento la evaluación* ☐ **I Refuse Assessment**/*No consiento la evaluación*

IN CASES INVOLVING DIVORCE/ADOPTION OR FOSTER PARENT ARRANGEMENTS PAPERS MUST BE PRESENTED PRIOR TO CONSENTING FOR ASSESSMENT. YOUR APPOINTMENT MAY BE RESCHEDULED IF DOCUMENTS ARE NOT PRESENT. EN CASOS DE DIVORCIO / *ADOPCIÓN O FOMENTO DE LOS ARREGLOS DE LOS PADRES DEBERÁN PRESENTARSE ANTES DE CONSENTIR PARA LA EVALUACIÓN. SU CITA PUEDE SER CANCELADA SI LOS DOCUMENTOS NO ESTÁN PRESENTES.*

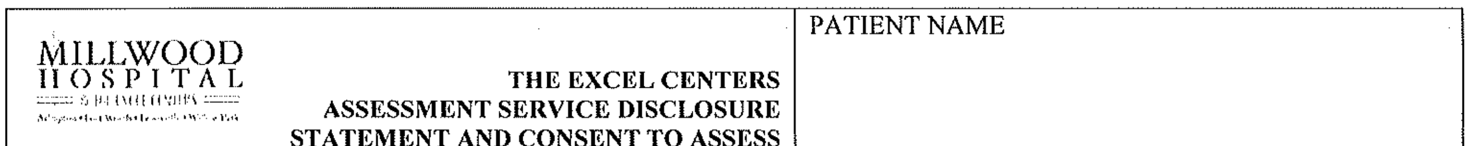
☐ **I attest that there is no formal custody arrangements/divorce decree applicable to my child and that I can make decision regarding their care.**/ *Yo certifico que no existe ningún acuerdo formal de custodia/decreto de divorcio aplicable a mi hijo(a) y que yo puedo tomar decisión con respecto a su cuidado.*

☐ **N/A patient of legal age, 18 & older and can consent to own treatment**/ *Paciente de edad legal y puede dar concentimiento*

____ ___/___/______ ____:____
*Name of Individual Consenting or Refusing Assessment/Medical Screening — Date/ *Fecha* — Time/*Hora*
Nombre del individual consintiendo o rechazando la evaluación/examen médico

____ ___/___/______ ____:____
*Patient/Guardian Signature /*Firma de paciente/tutor:* — Date/ *Fecha* — Time/*Hora*

____ ___/___/______ ____:____
Witness Signature /*Firma Del Testigo:* — Date/Fecha — Time/Hora



THE EXCEL CENTERS LIMITATIONS OF CONFIDENTIALITY AND RECEIPT OF NOTICE OF PRIVACY PRACTICE
LIMITACIONES DE CONFIDENCIALIDAD Y RECIBO DE AVISO DE PRÁCTICAS DE PRIVACIDAD DE LOS CENTROS DE EXCEL

Confidentiality is of the upmost importance where the patient-hospital relationship is concerned. We believe that it is important that the patient be able to assume that their private communications with the staff be kept private. However, there are certain exceptions, which supersede the confidentiality of the patient-hospital relationship. It is our ethical obligation to inform you of the exceptions. *En la relación entre el paciente y el hospital, su confidencialidad es lo más importante. Creemos que es importante que su comunicación con nuestro personal sea privada y va quedarse privada. Sin embargo, hay excepciones en que sustituyen la confidencialidad ente paciente y hospital. Es muestra obligación a informales de estas excepciones.*

Exceptions to Confidentiality/*Excepciones al Confidencialidad:*

1. **The staff makes assessment of an impending suicide risk.** (Chapter 611, Family Code)
   El personal hace una evaluación de un riesgo inminente de suicidio.
2. **A patient reports past or present instances of the abuse or neglect of a child, elderly person, or mentally challenged person.** (Chapter 261, Family Code)
   El paciente reporte abuso o descuidado, presente o pasado, de un niño, de persona de edad avanzada, o de persona mentalmente desafiada.
3. **A patient acknowledges committing abuse or neglect of a child, elderly person or mentally challenged person either in present or the past.** (Chapter 261, Family Code)
   El paciente reconoce cometiendo abuso o descuidado, presente o pasado, de un niño, de persona de edad avanzada, o de persona mentalmente desafiada.
4. **There is a probability of imminent harm to the patient or others.** (Chapter 611, Sec 004(a)(2) Health and Safety Code)
   Hay una probabilidad de daño inminente al paciente o a otros.
5. **Counseling records may be release when they are subpoenaed by a court of law.**
   Registros de consejeria pueden ser soltados cuando somos notificados por un tribunal.
6. **Commanders of active duty soldiers must be informed of any information pertaining to treatment recommendations and treatment prognosis.**
   Los comandantes de soldados de servicio militar deben ser informados de cualquier información que pertenece a recomendaciones de tratamiento y pronóstico de tratamiento.
7. **For active duty soldiers, if you have been involved in any activities prohibited by military regulation.**
   Para soldados de servicio militar, si ha participado en cualquier actividad prohibida por regulación militar.

I have read the preceding statement and understand that under the above stated circumstances Millwood Hospital/The Excel Center is bound to inform the proper authorities.
He leído la declaración anterior y comprendo las circunstancias indicadas cuando Millwood Hospital/Excel Center tiene que informar la autoridad apropiada.

Printed Patient Name/*Impresión del nombre del Paciente*: ______________________________

Patient Signature/*Firma del Paciente* (**over age 12**/*mayor de 12 años*): ______________________________

Guardian Signature, if applicable: ______________________ **Date:** ___/___/___ **Time:** ___:___
Firma de/tutor si es aplicable *Fecha* *Hora*

☐ **I acknowledge that I have reviewed the Hospital's Notice of Privacy Practices and would like a paper copy.**
Reconozco que he revisado la Notificación de Prácticas de Privacidad del Hospital y deseo recibir una copia en papel.

☐ **I acknowledge that I have reviewed the Hospital's Notice of Privacy Practices and decline a paper copy.**
Reconozco que he revisado la Notificación de Prácticas de Privacidad del Hospital y deseo renuncio una copia en papel.

______________________ ☐ **Patient is a minor and unable to sign**/*Paciente es menor de edad, no puede firmar*
***Patient's Name**/*Nombre del paciente*

______________________ ___/___/___ ___:___
***Patient Signature**/*Firma del Paciente* (**over age 18**/*mayor de 18 años*): **Date**/ *Fecha* **Time**/ *hora*

______________________ ___/___/___ ___:___
***Guardian Signature (if patient is a minor)**/*Firma de tutor(Si el paciente es menor de edad)*: **Date**/*Fecha* **Time**/ *hora*

Witness Signature/*Firma de testigo*: ______________________ Date/*Fecha*: ___/___/___ Time: ___:___

MILLWOOD HOSPITAL & THE EXCEL CENTERS Arlington • Fort Worth • Lewisville • Willow Park THE EXCEL CENTERS LIMITATIONS OF CONFIDENTIALITY AND RECEIPT OFNOTICE OF PRIVACY PRACTICE	PATIENT NAME

Respecting Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect the privacy of your health information. We call it "Protected Health Information" (PHI).

Staff members, employees and volunteers of this hospital/facility must follow legal regulations with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

Your Authorization May Be Required

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a workers compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communication from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with the facility or the Secretary.

- To file a complaint with us, please contact the hospital's Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.

- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C.20201 or call **1-877-696-6775**.

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our privacy practices. This document is our notice. We will abide by the privacy practices set forth in this notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law.

If we change our notice of privacy practices, we will provide our revised notice to you when you next seek treatment from us.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

EFFECTIVE DATE: This notice takes effect on April 14, 2003. Version #10808EB

THE EXCEL CENTER PHYSICAL HEALTH SCREENING

DRUG ALLERGIES: ☐ Yes ☐ No If yes, Describe: ______________________________

FOOD ALLERGIES: ☐ Yes ☐ No If yes, Describe: ______________________________

Does the patient require emergency room treatment for food allergies? ☐ Yes ☐ No

Does the patient currently prescribed an EpiPen? ☐ Yes ☐ No

IMMUNIZATION STATUS: Are immunizations current with all required and on file at school (if a minor) or PCP: ☐ Yes ☐ No

If patient is a minor, does parent object to immunizations given or current: ☐ Yes ☐ No ☐ N/A – patient is an adult

CURRENT MEDICATIONS

MEDICATION NAME	STRENGTH	TIMES TAKEN	DATE BEGAN TAKING	REASON

PHYSICAL HEALTH AND HISTORY --- Check current and past problems the child has had with the following areas:

AREA OF PHYSICAL HEALTH	NO	PAST	CURRENT	IF CURRENT OR PAST, DESCRIBE
Vision (eyes sight, glasses, contacts)				
Hearing (hearing impairment, aid, tubes in ears, tonsillectomy)				
Cardiac history: heart structural problems, heart murmur, passing out episodes, seen by cardiologist				
Nervous system (seizure, numbness, tingling)				
Muscles/Bones (breaks, sprains, etc.)				
Digestive (frequent diarrhea, constipation, overeating, restricting food history, self-induced vomiting, soiling self)				
Urinary (kidneys, bladder, hx of bedwetting)				
Reproductive (STD, pregnancy, Chlamydia)				
Respiratory (excessive URI, asthma, exercise induced asthma) Is inhaler ordered for child				
Hepatic (jaundice at birth, hepatitis A, B, & C)				
Lymphatic (swollen glands)				
Integument (hair, skin, rash, lesions, eczema)				
Pancreas – Pre diabetic, diabetes, use of insulin or medication				
Infectious agent (Staph, Mono, blood-borne)				

LIST HOSPITALIZATIONS AND SURGERIES

Date	Where	Reason

Screening Health Evaluation – Statement of Purpose: I understand that a limited evaluation of the patient's general health will be performed by a physician. I also understand that this evaluation in no way is intended to provide a comprehensive review for the purpose of establishing previously undiagnosed disease. Specifically, the purpose of the evaluation is to determine the propriety and adequacy of my fitness for participation on the treatment program. I will then neither now, nor in the future, hold the physician responsible or The Excel Center for the diagnosis or disease on the basis of this limited health evaluation.

______________________________ ____/____/____ ____:____

*Patient/Legal Guardian Signature Date Time

STAFF USE ONLY

Physician/R.N. Review: A physician and/or R.N. will review this Health History and sign in the space provided below. Any specific recommendations, observations, or requirements, other than the requirement for a physical decision below, will be written by the physician in the Progress Notes.

☐ No evidence of current infectious disease noted from report of physical health status.

☐ Evidence of potential infectious disease and parent instructed to report to PCP for clearance for admission.

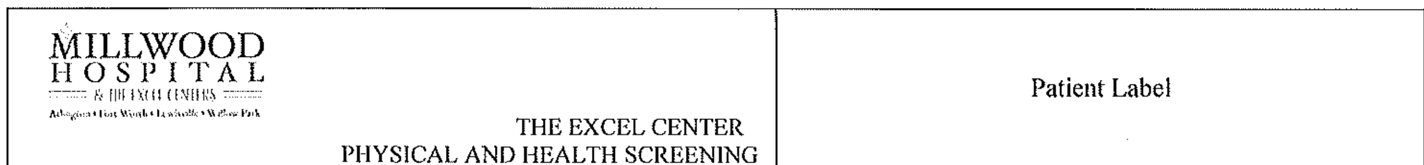
☐ A physical examination to be completed by contract physician.

______________________________ __________ __________

RN Signature Date Time

______________________________ __________ __________

Physician Signature Date Time



Reasons causing you to seek help at The Excel Center:

How long has this been a problem?

Who does the patient live with?

Symptom Checklist

Depressive Symptoms	Yes	No	Comments/Additional Thougths
Depressed or irritable mood most of the day			
Excessive crying spells daily			
Severe decreased interest in pleasurable activities			
Trouble falling asleep, staying asleep, or increased sleep			
Changes in appetite: weight gain or weight loss			
Expressing Feelings of worthlessness or low self esteem			
Hopeless, helpless or expresses excessive guilt			
Decreased concentration or increased indecisiveness daily			
Cutting on self or other self harm behaviors			
Thoughts of dying or hurting self			
Previous suicide attempt?			
Mood Disorder Symptoms	**Yes**	**No**	**Comments/Additional Thoughts**
Struggling with a lot of ideas at one time			
Periods of excessive, rapid speech			
Rapid, abrupt mood swings			
Irritable mood states			
Excessively silly, giddy mood states			
Explosive temper tantrums or rages			
Intentional destruction of property			
Cursing viciously in anger			
Physically assaulted another person			
ADHD Symptoms	**Yes**	**No**	**Comments/Additional thoughs**
Easily distracted			
Makes careless mistakes			
Struggles to sit still, "on the go"			
Impulsivity			
Difficulty following verbal instruction/completing tasks			
Interrupts often or has difficulty waiting			
Anxiety Symptoms	**Yes**	**No**	**Comments /Additional thoughts**
Fear of strangers or new situations			
Persistent nightmares or flashbacks			
Excessive fears about being alone			
Panic attacks			
Other Issues	**Yes**	**No**	**Comments/ Additional thoughts**
Bedwetting, soiling self			
Developmentally inappropriate sexual or hypersexualized behaviors			
Gender identity issues – questioning biological sex			
Hearing or seeing objects/shadows/voices etc			
Excessive internet/gaming/cell phone use			
Seeking out pornography			
Binging/Purging/Restricting food			
Have you ever been or are you currently in the military?			
Family military history			