Dear Parent/Guardian,

Thank you for selecting me as your child's psychologist. As a bilingual - English/Spanish, Ph.D., Level Clinical Psychologist with over 20 years of experience in psychological diagnostics, I treat a variety of patients, ranging in age from infancy to adulthood.

Below you will find an overview of what you and your child are to expect. Please read and initial each point.

_____ Your child will be scheduled for three appointments. **Please note, the first two appointments have the potential to last anywhere from two (2) to four (4) hours.**

_____ **First Appointment:**
Initial Consultation and Assessment, Diagnosis and Treatment Plan
***NOTE: Patients who completed their paperwork first, will be seen first.**

_____ **Second Appointment:**
Psychological Testing
Testing consists of the following: Intelligence, Achievement and Emotional State and Reality Testing. These tests assist in determining the differential diagnosis; such as ADHD, Clinical Depression and Academic Placement. A Screening Test may also be administered to rule out emotional factors that may be contributing to negative behavior.

_____ **Third Appointment:**
Results of the Psychological Testing and the Screening Test
You will receive a full detailed Psychological Report at this time. Verbal results are only available for the Screening Test. Additionally, referrals will be given based on the child's diagnosis.

_____ **Phone/Electronic Device Policy: Out of respect for our patients, we have a no cell phone policy. If you need to use your phone, please step into the hallway. If you wish to listen to music/watch videos on your electronic device, a headset is required. For patient privacy, no photos are to be taken in our office. Thank you for respecting all our patients.**

_____ **Once again, your wait can be anywhere between two (2) to four (4) hours for any given appointment. During your visit, no food is allowed in our waiting area. We appreciate your patience and respecting our no food policy.**

My staff and I look forward to assisting your child and family.

Sincerely,

Dr. Charles E. Gutierrez, Ph.D.

Dr. Charles E. Gutierrez, Ph.D.

Informed Consent

Patient's Name _____

To better serve our patients, we have implemented important office policies and procedures regarding your treatment with Dr. Charles E. Gutierrez. **Please read them carefully and initial.** If you have any questions, please raise them with your doctor or our office staff.

_____ **Appointments:** Patients are seen by appointment only. Punctuality is important! If you are more than 15-minutes late, Dr. Gutierrez WILL NOT see you and your appointment will be rescheduled. You will need to present your insurance/Medicaid card at each appointment. **Patients who have submitted their completed paperwork, prior to their appointment, will be seen first. The first two appointments have the potential to last anywhere between two (2) to four (4) hours.** A detailed Scheduling Policies and Procedures can be found in your New Patient Packet.

_____ **Payment of Fees:** Payment is appreciated at each visit. We will assist in completing your health insurance claim; however, the CLIENT, NOT THE INSURANCE is responsible for payment of the bill. If another arrangement is needed, please consult with our staff. All efforts will be made to work out an acceptable method of payment. If the client fails to comply with attempts to negotiate payment, Dr. Gutierrez's office will utilize an outside collection agency for delinquent accounts.

_____ **Cancellation Policy:** If you need to cancel an appointment, please notify our office as soon as possible. ***A missed appointment without 24-hour notice will be charged as a session and you will be charged a $25.00 "no show" fee.***

_____ **No Show Policy:** As a courtesy to our patients and office, it is important you keep your scheduled appointments. A no show means a loss to us and another patient to receive treatment. Therefore, after three (3) consecutive no shows, we will refer you elsewhere for your mental health needs.

_____ **Emergency Call Services:** In case of an emergency, please go to the nearest hospital or dial 911, as Dr. Gutierrez does not provide 24-hour service.

By signing below, I agree to the Informed Consent, set forth by Dr. Gutierrez's office.

PRINTED _____ _____

Patient/Personal Representative's First and Last Name — Relationship to Patient

SIGNATURE _____ DATE _____

Patient/Personal Representative's First and Last Name

ELECTRONIC SIGNATURE (IF APPLICABLE)

☐ I understand that checking this box constitutes a legal signature confirming I acknowledge and agree to the above information.

Dr. Charles E. Gutierrez, Ph.D.

Scheduling Policies and Procedures

1. On the business day before your appointment, we will call to confirm your appointment.
***This will be done Monday - Thursday between the hours of 9:00 a.m. and 11:30 a.m. and Friday 9:00 a.m. and 12:00 p.m.**

2. If we call and receive no answer, we will leave a voice mail explaining:
If we do not receive a confirmation for your appointment by 2:00 p.m., that same afternoon, we will cancel your appointment.

3. If we left you a voice mail on our 1st attempt to confirm your appointment and have not heard back from you, we will call a 2nd time, between 2:00 p.m. and 3:00 p.m.

4. If we cannot directly reach you on the 2nd attempt, we will leave a voice mail advising you to call our office to reschedule your appointment, since your original appointment has been canceled.

If your contact number has changed or your phone service has been interrupted, it is your responsibility to contact our office and furnish us with a new contact number.

DUE TO THE LARGE NUMBER OF PATIENTS SCHEDULED AT THIS OFFICE, THESE POLICIES WILL BE ENFORCED AND NO EXCEPTIONS WILL BE MADE.

By signing below, I agree to the scheduling policies and procedures, set forth by Dr. Gutierrez's office.

PRINTED _____ _____

Patient/Personal Representative's First and Last Name | Relationship to Patient

SIGNATURE _____ DATE _____

Patient/Personal Representative's First and Last Name

ELECTRONIC SIGNATURE (IF APPLICABLE)

☐ I understand that checking this box constitutes a legal signature confirming I acknowledge and agree to the above information.

HIPAA PRIVACY AUTHORIZATION FORM

** Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. AUTHORIZATION

I authorize ***Dr. Charles E. Gutierrez, Ph.D.*** (healthcare provider) to use and disclose the protected mental health information described below to:

Individual(s) seeking the information
(Doctors, School, Attorneys, Family Members, etc.) _____

_____

_____

_____

2. EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from:

a. ☐ Date _____ to Date _____

OR

b. ☐ all past, present and future periods (for one year only)

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes I may direct.

4. This authorization shall be in and effective for one (1) year from today's date _____, at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest the claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

SIGNATURE _____ PRINTED NAME _____

PATIENT/PERSONAL REPRESENTATIVE PATIENT/PERSONAL REPRESENTATIVE

TODAY'S DATE _____ RELATIONSHIP TO PATIENT _____

ELECTRONIC SIGNATURE (IF APPLICABLE)

☐ I understand that checking this box constitutes a legal signature confirming I acknowledge and agree to the above information.

Dr. Charles E. Gutierrez, Ph.D.

Child/Adolescent - Patient/Insurance Information

PATIENT'S INFORMATION:

FIRST NAME | MIDDLE | LAST NAME

SSN | DATE OF BIRTH | AGE | SEX

ADDRESS | CITY | STATE | ZIP CODE

STUDENT STATUS | CURRENT SCHOOL

SCHOOL COUNSELOR | TEACHER

PRIMARY CARE PHYSICIAN | PHYSICIAN PHONE

PHYSICIAN ADDRESS

CITY | STATE | ZIP CODE

MAY WE CONTACT YOUR PHYSICIAN SO THAT THIS PROVIDER MAY BE FULLY INFORMED AND WE MAY COORDINATE YOUR TREATMENT? ☐ YES ☐ NO

REFERRED BY

PARENT/GUARDIAN (RESPONSIBLE PARTY) INFORMATION:

FIRST NAME | MIDDLE | LAST NAME

SSN | DATE OF BIRTH | AGE | MARITAL STATUS

DRIVER'S LICENSE # | STATE | RELATIONSHIP TO PATIENT

EMPLOYMENT STATUS | EMPLOYER | JOB TITLE

HOME PHONE | CELL PHONE | WORK PHONE

PERSONAL EMAIL | WORK EMAIL

PRIMARY INSURANCE INFORMATION:

POLICY HOLDER | EMPLOYER

SSN | RELATIONSHIP TO PATIENT | INSURANCE NAME

INSURANCE PHONE # | I.D. # | GROUP #

SECONDARY INSURANCE INFORMATION:

POLICY HOLDER | EMPLOYER

SSN | RELATIONSHIP TO PATIENT | INSURANCE NAME

INSURANCE PHONE # | I.D. # | GROUP #

HOW DID YOU HEAR ABOUT US?

☐ DOCTOR REFERRAL ☐ INSURANCE COMPANY ☐ MAGAZINE/NEWS ARTICLE ☐ YELLOW PAGES

☐ FRIEND/RELATIVE ☐ INTERNET/WEBSITE ☐ TELEVISION ☐ OTHER

I hereby give Dr. Charles Gutierrez, Ph.D., authorization to release any information necessary to process medical insurance claims to authorize payments of benefits to him for services rendered.

SIGNATURE _____ PRINTED NAME _____

PATIENT/PERSONAL REPRESENTATIVE PATIENT/PERSONAL REPRESENTATIVE

Today's Date _____ RELATIONSHIP TO PATIENT _____

ELECTRONIC SIGNATURE (IF APPLICABLE)

☐ I understand that checking this box constitutes a legal signature confirming I acknowledge and agree to the above information.

Dr. Charles E. Gutierrez, Ph.D.

Child/Adolescent Questionnaire

DIRECTIONS: To be completed by parent/guardian. Please complete this form with reference to the child/teen for whom you are seeking help.

TODAY'S DATE

PATIENT'S NAME

DATE OF BIRTH IS THE CHILD/TEEN ADOPTED? ○ YES ○ NO ARE YOU THE BIOLOGICAL PARENT? ○ YES ○ NO

(IF THE CHILD/TEEN IS ADOPTED, ADOPTION PAPERS ARE REQUIRED AT THE APPOINTMENT)

ADDRESS

CITY STATE ZIP CODE

PARENT/GUARDIAN EMAIL

LANGUAGES SPOKEN AT HOME

PARENT/GUARDIAN (Relationship to Patient)	FIRST/LAST NAME	MARITAL STATUS	CELL PHONE

IF OTHER, SPECIFY

(WHERE PATIENT RESIDES) SIBLINGS/OTHER HOUSEHOLD MEMBERS' NAME	AGE	RELATIONSHIP TO PATIENT

IF YOU ARE DIVORCED/SEPARATED, IS THERE A CUSTODY ORDER?

(IF YOU ANSWERED YES, AND ONLY ONE PARENT IS PRESENT FOR THE INTAKE, YOU WILL BE ASKED TO PRODUCE A COPY OF THE CUSTODY ORDER PRIOR TO ANY SUBSEQUENT APPOINTMENTS)

IF SEPARATED/DIVORCED, WHO HAS LEGAL CUSTODY OF THE CHILD?

DOES THE CHILD VISIT WITH NON-CUSTODIAL PARENT?

WHO HAS BEEN THE PRIMARY CAREGIVER OF THE CHILD

ANY SIGNFICANT SEPARATIONS DURING THE FIRST THREE YEARS

FAMILY HISTORY

CHECK ALL THAT APPLY - (FAMILY MEDICAL HISTORY)

- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ BONES
- ☐ CANCER
- ☐ CARDIAC
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ LIVER FUNCTION
- ☐ RENAL
- ☐ SURGERY
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ NONE LISTED

OTHER

CHECK ALL THAT APPLY - (FAMILY PSYCHIATRIC HISTORY)

- ☐ ADHD
- ☐ ADDICTION DISORDER
- ☐ ANXIETY
- ☐ AUTISM
- ☐ BI-POLAR
- ☐ DEPRESSION
- ☐ EATING DISORDER
- ☐ IMPULSE CONTROL DISORDER
- ☐ LEARNING DISABILITY
- ☐ OBSESSIVE-COMPULSIVE DISORDER (OCD)
- ☐ PERSONALITY DISORDER
- ☐ POST-TRAUMATIC STRESS DISORDER (PTSD)
- ☐ SCHIZOPHRENIA

OTHER

LIST ANY PSYCHIATRIC HOSPITAL STAYS

PATIENT HISTORY

WHY ARE YOU SEEKING TREATMENT FOR YOUR CHILD/CHIEF COMPLAINT

HOW WOULD YOU RATE THE SEVERITY OF THE PROBLEM RIGHT NOW? (0 - MILD ...10 - SEVERE)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

AGE AND ONSET OF SYMPTOMS, PROBLEMS & PROGRESSION OF PROBLEMS

PATIENT DEVELOPMENTAL HISTORY

WAS THE PREGNANCY PLANNED? DURING PREGNANCY, DID THE MOTHER SMOKE? DID THE MOTHER DRINK?

DID THE MOTHER DO ILLEGAL DRUGS? LENGTH OF PREGNANCY TYPE OF DELIVERY

ANY COMPLICATIONS WITH PREGNANCY/DELIVERY

BIRTH WEIGHT LENGTH OF TIME IN HOSPITAL AFTER DELIVERY

BEGAN TO WALK (MONTHS) BEGAN TO TALK (MONTHS) TOILET TRAINED BY (MONTHS)

AS AN INFANT, DID THE CHILD HAVE REGULAR SLEEPING AND EATING HABITS?

ANYTHING UNUSUAL ABOUT SPEECH DEVELOPMENT

ANY SIGNFICANT ILLNESSES/INJURIES DURING FIRST YEAR OF LIFE

LIST ANY REGRESSION IN DEVELOPMENT IN THE FIRST THREE (3) YEARS OF LIFE

PATIENT MEDICAL HISTORY

PRIMARY CARE PHYSICIAN PSYCHIATRIST

CHECK ALL THAT APPLY

☐ ALLERGIES	☐ BONES	☐ DIABETES	☐ RENAL	☐ TUMORS
☐ ANEMIA	☐ CANCER	☐ EPILEPSY	☐ SURGERY	☐ NONE LISTED
☐ ASTHMA	☐ CARDIAC	☐ LIVER FUNCTION	☐ TUBERCULOSIS	

OTHER

LIST ANY MEDICAL CONDITIIONS AND/OR ILLNESSES THEY ARE CURRENTLY BEING TREATED FOR AND/OR HAVE BEEN TREATED FOR IN THE PAST AND GIVE DATES OF TREATMENT

LIST ANY PAST SURGERIES/HOSPITALIZATIONS

PATIENT PSYCHIATRIC HISTORY

CHECK ALL THAT APPLY - (PATIENT PSYCHIATRIC HISTORY)

- ☐ ADHD
- ☐ ADDICTION DISORDER
- ☐ ANXIETY
- ☐ AUTISM
- ☐ BI-POLAR
- ☐ DEPRESSION
- ☐ EATING DISORDER
- ☐ IMPULSE CONTROL DISORDER
- ☐ LEARNING DISABILITY
- ☐ OBSESSIVE-COMPULSIVE DISORDER (OCD)
- ☐ PERSONALITY DISORDER
- ☐ POST-TRAUMATIC STRESS DISORDER (PTSD)
- ☐ SCHIZOPHRENIA

OTHER

HAS YOUR CHILD SEEN A PSYCHIATRIST/THERAPIST BEFORE TODAY? ○ YES ○ NO

IF SO, WHEN WAS THE TREATMENT?

FOR HOW LONG?

HAS YOUR CHILD BEEN ADMITTED TO A PSYCHIATRIC HOSPITAL? ○ YES ○ NO

IF SO WHEN AND FOR HOW LONG?

WERE ANY MEDICATIONS EVER PRESCRIBED TO THE PATIENT BY A PSYCHIATRIST/OTHER PROVIDER (PCP, NURSE PRACTITIONER) FOR ANY PSYCHIATRIC ILLNESS OR OTHER MEDICAL ISSUES? ○ YES ○ NO

IF YES, WHAT MEDICATIONS/DOSES WERE PRESCRIBED?

DATES (FROM/TO)	MEDICATION/DOSES	PATIENT'S RESPONSE

WHY DID YOUR CHILD STOP TAKING THE MEDICATION, IF THEY DID?

DOES YOUR CHILD TAKE ANY OVER THE COUNTER MEDICATIONS/VITAMINS/SUPPLEMENTS (INCLUDE DOSE AND HOW OFTEN)

HOW DOES THE CHILD GET ALONG WITH (MARK THE SCALE FROM 1 - 10 AND EXPLAIN WHY)

MOTHER: GETS ALONG VERY POORLY GETS ALONG VERY WELL

☐ N/A ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

DETAILS

FATHER: GETS ALONG VERY POORLY GETS ALONG VERY WELL

☐ N/A ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

DETAILS

STEPMOTHER: GETS ALONG VERY POORLY GETS ALONG VERY WELL

☐ N/A ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

DETAILS

STEPFATHER: GETS ALONG VERY POORLY GETS ALONG VERY WELL

☐ N/A ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

DETAILS

SIBLINGS: GETS ALONG VERY POORLY GETS ALONG VERY WELL

☐ N/A ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

DETAILS

OTHER: GETS ALONG VERY POORLY GETS ALONG VERY WELL

☐ N/A ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

DETAILS

HAS VIOLENCE BEEN A PART OF THE MARRIAGE OR ANY OTHER IMPORTANT RELATIONSHIP IN YOUR CHILD'S LIFE?

IF YES, DESCRIBE

IS THERE CURRENTLY ANY PHYSICAL OR VERBAL ABUSE IN YOUR HOME?

HAS YOUR CHILD BEEN THE VICTIM OF SEXUAL, PHYSICAL, EMOTIONAL OR VERBAL ABUSE?

SIGNFICANT EVENTS IN THE CHILD'S LIFE

1. DEATH OF A PARENT	○ YES	○ NO	8. PREGNANCY	○ YES	○ NO
2. PARENTS' DIVORCE	○ YES	○ NO	9. SEXUAL PROBLEMS	○ YES	○ NO
3. PARENTS' SEPARATION	○ YES	○ NO	10. DEATH OF A CLOSE FRIEND	○ YES	○ NO
4. DEATH OF A CLOSE FAMILY MEMBER	○ YES	○ NO	11. SERIOUS RELATIONSHIP PROBLEMS	○ YES	○ NO
5. MAJOR PERSONAL INJURY/ILLNESS	○ YES	○ NO	12. SIBLING LEAVING HOME	○ YES	○ NO
6. ILLNESS OF FAMILY MEMBER	○ YES	○ NO	13. FREQUENT CHANGE OF RESIDENCE	○ YES	○ NO
7. CHANGE OF SCHOOL	○ YES	○ NO	14. ANY PARENT INCARCERATED	○ YES	○ NO

PLEASE GIVE THE # OF ANY **YES** ITEMS AND EXPLAIN

SCHOOL HISTORY

CURRENT SCHOOL

TEACHER GRADE

SCHOOL COUNSELOR

SELECT YES OR NO TO ALL RESPONSES REGARDING YOUR CHILD'S SCHOOL EXPERIENCES

NO SIGNFICANT PROBLEMS	○ YES	○ NO
LEARNING DISABILITIES	○ YES	○ NO
ACADEMIC ACHIEVEMENT PROBLEMS	○ YES	○ NO
SCHOOL AVOIDANCE/PHOBIA	○ YES	○ NO
TRUANCY	○ YES	○ NO
BEHAVIOR PROBLEMS	○ YES	○ NO
PEER PROBLEMS	○ YES	○ NO
IEP	○ YES	○ NO
504 PLAN	○ YES	○ NO

OTHER

HAS YOUR CHILD BEEN ACHIEVING ABOUT AS WELL AS YOU FEEL HE/SHE SHOULD? ○ YES ○ NO

WHAT BEST DESCRIBES THE GRADES HE/SHE USUALLY GETS?

○ WELL ABOVE AVERAGE
○ SOMEWHAT ABOVE AVERAGE
○ AVERAGE
○ SOMEWHAT BELOW AVERAGE
○ WELL BELOW AVERAGE

WHAT TYPE OF GRADES DO YOU FEEL YOUR CHILD IS CAPABLE OF GETTING?

ON AVERAGE, HOW MUCH TIME DOES YOUR CHILD SPEND ON HOMEWORK NIGHTLY?

DOES YOUR CHILD PARTICIPATE IN EXTRACURRICULAR ACTIVITIES? IF YES, WHAT ACTIVITIES?

ON AVERAGE, HOW MUCH TIME DOES YOUR CHILD SPEND ON ELECTRONIC DEVICES DAILY?

HAS YOUR CHILD EVER BEEN EVALUATED FOR ADHD/OTHER LEARNING PROBLEMS? IF SO, WHEN, WHERE AND BY WHOM? WHY WAS THE EVALUATION DONE?

DRUG/ALCOHOL HISTORY

PAST OR PRESENT HISTORY OF DRUG/ALCOHOL ABUSE

IF YES, PLEASE DESCRIBE

HAS YOUR CHILD HAD ANY POLICE/LEGAL INVOLVEMENT?

IF YES, PLEASE DESCRIBE

Dr. Charles E. Gutierrez, Ph.D.

Child/Adolescent Questionnaire

PROBLEM CHECKLIST

PLEASE INDICATE WHICH OF THE PROBLEMS ARE BOTHERING THE CHILD AT THIS TIME
0 - NONE.....1 - MILD.....2 - MODERATE.....3 - SERIOUS.....4 - SEVERE

SUICIDAL THOUGHTS/BEHAVIORS.....	○0	○1	○2	○3	○4	HEARS VOICES.....	○0	○1	○2	○3	○4
SELF HARM.....	○0	○1	○2	○3	○4	SEES THINGS NOT THERE.....	○0	○1	○2	○3	○4
FEELS HOPELESS.....	○0	○1	○2	○3	○4	FITS OF RAGE.....	○0	○1	○2	○3	○4
FEELS WORTHLESS.....	○0	○1	○2	○3	○4	OVERLY SUSPICIOUS.....	○0	○1	○2	○3	○4
IRRITABLE.....	○0	○1	○2	○3	○4	FEW FRIENDS.....	○0	○1	○2	○3	○4
SAD/TEARFUL.....	○0	○1	○2	○3	○4	EXCESSIVELY SHY.....	○0	○1	○2	○3	○4
MOODY.....	○0	○1	○2	○3	○4	BOSSY.....	○0	○1	○2	○3	○4
BULLY.....	○0	○1	○2	○3	○4	OVERLY SENSITIVE.....	○0	○1	○2	○3	○4
POOR SLEEP.....	○0	○1	○2	○3	○4	TEASES OTHERS.....	○0	○1	○2	○3	○4
TOO MUCH SLEEP.....	○0	○1	○2	○3	○4	TEASED BY OTHERS.....	○0	○1	○2	○3	○4
NIGHTMARES.....	○0	○1	○2	○3	○4	CRUEL TO OTHERS/ANIMALS.....	○0	○1	○2	○3	○4
POOR CONCENTRATION.....	○0	○1	○2	○3	○4	LYING.....	○0	○1	○2	○3	○4
EXCESSIVE WORRY/FEARS.....	○0	○1	○2	○3	○4	STEALING.....	○0	○1	○2	○3	○4
PANIC.....	○0	○1	○2	○3	○4	FIRE SETTING.....	○0	○1	○2	○3	○4
IRREGULAR EATING HABITS.....	○0	○1	○2	○3	○4	RUNS AWAY.....	○0	○1	○2	○3	○4
WEIGHT PREOCCUPATION.....	○0	○1	○2	○3	○4	AGGRESSION.....	○0	○1	○2	○3	○4
NAIL BITING.....	○0	○1	○2	○3	○4	TRUANCY.....	○0	○1	○2	○3	○4
REPETITIVE BEHAVIORS.....	○0	○1	○2	○3	○4	SEXUAL ACTING OUT.....	○0	○1	○2	○3	○4
THUMB SUCKING.....	○0	○1	○2	○3	○4	LEGAL PROBLEMS.....	○0	○1	○2	○3	○4
SOILING IN PANTS.....	○0	○1	○2	○3	○4	AUTHORITY CONFLICTS.....	○0	○1	○2	○3	○4
BED WETTING.....	○0	○1	○2	○3	○4	TICS.....	○0	○1	○2	○3	○4
ATTENTION SEEKING.....	○0	○1	○2	○3	○4	ACCIDENT PRONE.....	○0	○1	○2	○3	○4
STUTTERING.....	○0	○1	○2	○3	○4	EXCESSIVE PHYSICAL COMPLAINTS....	○0	○1	○2	○3	○4