Great Life Counseling Center
14673 Midway Rd., Ste. 230
Addison, TX 75001
Blair Kenney, Psy.D./646-653-4522/ GREATLIFECONSULTS.COM

~ Welcome ~

Please read and complete the forms of this packet. Please note any questions you have and discuss them with your psychologist prior to or during the first session.

Child & Adolescent Intake Packet Contents:

1. **Demographic/Financial Responsibility Forms**
2. **Private Fee Schedule Form**
3. **Credit Card Authorization Form**
   (*please complete this form, even if you plan to pay by cash or check)*
4. **Office Policies and Consent to Treatment Form**
5. **Child/Adolescent Intake Questionnaire**
   (*for family therapy, please complete questionnaire regarding child of most concern or you may complete one questionnaire per child*)

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DEMOGRAPHIC INFORMATION

Today's Date____/___/_____

Name of Child/Adolescent: _____ Date of Birth: ____/___/_____

School: _____ Grade: _____

Name of Custodian Filling Out This Form: _____

Custodian Status (Joint, Sole, or Primary): _____

Relationship to the child: _____

I authorize text messages to my cell phone and messages to my contact numbers and email YES NO

(If applicable) Other Custodian Name & Status: _____

If your adolescent is old enough to drive himself/herself to therapy appointments, please provide your adolescent's email address and cell phone number so that he/she can receive appointment reminders.
.

Cell phone: (_____)_____

Email Address: _____

Child's Primary Residence: _____ City: _____ Zip: _____

Caregiver (s) at this address: _____

If applicable:

Child's Secondary Residence _____ City: _____ Zip: _____

Caregiver (s) at this address: _____

Family Relations

Parents Status: Married Divorced Separated Never Married Widowed
Parental Rights Terminated Joint Legal Custody Sole Legal Custody

Other (Explain)_____

If divorced, what is the custody agreement (please attach copy of agreement)? _____
_____

Mother: _____ Father: _____

Biological □ Adoptive □ Biological □ Adoptive □

Date of Birth: _____ Date of Birth: _____

Ethnicity: _____ Ethnicity: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Home phone: (_____) _____ Home phone: (_____)_____

Cell phone: (_____) _____ Cell phone: (_____)_____

Email Address: _____ Email Address: _____

Emergency Contact: _____ Address_____

Relationship to child: _____ Best contact number: _____

Other Caregivers (If applicable to treatment)

Please check relationship:

Stepfather	Foster Father	Legal Custodian	Grandparent
Stepmother	Foster Mother	Babysitter	Other:_____

Name: _____ Name: _____

Date of Birth: _____ Date of Birth: _____

Ethnicity: _____ Ethnicity: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Home phone: (_____) _____ Home phone: (_____)_____

Cell phone: (_____) _____ Cell phone: (_____)_____

Email Address: _____ Email Address: _____

Siblings	**Age**	**Relationship** full half sib paternal step sib paternal step sib maternal half sib maternal adoptive sib
		full half sib paternal step sib paternal step sib maternal half sib maternal adoptive sib
		full half sib paternal step sib paternal step sib maternal half sib maternal adoptive sib
		full half sib paternal step sib paternal step sib maternal half sib maternal adoptive sib
		full half sib paternal step sib paternal step sib maternal half sib maternal adoptive sib

Please list any other people living in the home: _____

Other Health Care Providers

Pediatrician:

Name: _____ Phone: _____

Psychiatrist (if applicable):

Name: _____ Phone: _____

Who referred you to Great Life Counseling Center? (Please circle one):

Internet Search Insurance Co. Friend Physician Other:_____

If referred by an individual, do you give permission to acknowledge the referral? YES NO

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INSURANCE INFORMATION AND

CONSENT TO FINANCIAL RESPONSIBILITY

Insurance information

Name of Insured (Policy holder):_____ Date of Birth of Insured: _____/_____/_____

Insurance Carrier: _____ Insurance Phone#: _____ Co-pay $_____

Deductible: _____ Deductible Met: _____ Pays at: _____

Policy/ ID#: _____ Group#: _____ Employer: _____

FINANCIAL RESPONSIBILITY

- Great Life Counseling Center clinicians are currently out-of-network providers for all insurance companies, except Blue Cross Blue Shield PPO.
- If you would like to pay through BCBS, please contact your representative to verify coverage details & inform your psychologist prior to your initial appointment. Great Life Counseling Center will bill your insurance company directly for services provided minus your copayment. Great Life Counseling Center may be required to release the required information about your care to your insurance provider including, but is not limited to, diagnosis codes, dates of service, treatment plans, and treatment progress.
- Private payment of services, copays, and administration fees are due at the time of each appointment. Walkout statements can be downloaded through your profile with our electronic health records system-TherapyAppointment.com.
- If your insurance company should deny payment or reimbursement, you remain ultimately responsible for any outstanding financial debt associated with services provided, including no show/late cancellation fees. Great Life Counseling Center reserves the right to charge a client's credit card, email or mail client an invoice, and/or utilize a collection agency in efforts to address outstanding balances.

Please Acknowledge the Above Statements with Initials _____ _____

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PAYMENT OF FEES:

- Payment is due at the time services are rendered in the form of **cash, check, or charge**. All checks should be made out to **Great Life Counseling Center.** MasterCard, Visa, American Express, & Discover are accepted but cash & check payments are preferred.
- For insurance reimbursements or more detailed receipts, clients may request a walkout statement to be given in paper form or sent to an email address.
- Clients will be given the option to add no show or late cancellation charges to the cost of the next session as long as the next session is scheduled to occur within 10 days of the cancellation. Clients are also welcome to mail a check but are advised to mail it at least 4 days prior to the 10 day deadline. Please note: no show/late cancellation fees are not usually reimbursed by insurance companies.

SUMMARY OF FEES

Direct Contact Fees (may be covered by insurance):

Child/Family Therapy Sessions (with client present)……**Intake sessions (per 75 minutes) = $160**
……**Follow-up sessions (per 55 minutes) = $160**
……**Play/Art Therapy surcharge (per 55 minutes) = $25**
……**Weekend session surcharge (per 55 minutes) = $25**
……**Additional time pro-rated by 15 minute increments**

Guardian or Family Member Consultation (without client)……**more than 15 min. - $125/hour (pro-rated)**

Group Psychotherapy Sessions……**All sessions (per 55 minutes) = $30**

Phone & E-Consultation fees ……**15 min. or less - FREE; 15+ min. - $125/hour (pro-rated)**

Consultation with Other Professionals (with written consent)……**more than 15 min. - $125/hour (pro-rated)**
(i.e., teachers, school psychologist, psychiatrist, doctor, etc.)

Short Psych. Evaluation (Clinical Interview and MMPI-II)……**$500 for test administration & written report**
Full Psych. Evaluation (Short Eval + 3 additional measures)……**$1250 for test administrations & written report**
……**Up to $250 per additional measure**

Indirect contact/Administration fees (not covered by insurance)

Other services (i.e. write letters, fill out forms, report writing)……**$125/hour (pro-rated)**
Legal (i.e., attorney calls, reports, testimony preparation & court appearances)……**$250/hour (pro-rated)**
Preparation of Record Summary Letters.……**$125.00/hour (pro-rated)**
Returned/Invalid Check Fee……**$50.00**
Late Cancellation Fees (less than 24 hours of notice)……**50% of session fee**
No show Fees (notice not provided prior to scheduled appointment time)……**100% of session fee**

- If a Great Life clinician has authorized a session rate modification/discount/coupon, please note on line below & confirm agreement during initial appointment.

GLCC clinician initial_____

With my signature below, I acknowledge the statements above and accept financial responsibility for services rendered. I authorize Great Life Counseling Center to bill me directly for services provided, not covered by insurance, or any administration fees not covered by insurance.

Client Signature: _____ Date: _____

A copy of this completed & signed docment will be provided at your request.

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Credit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file. You may pay by cash or check, but a card must still be kept on file.****
This policy exists both for your convenience as well as a way to insure that outstanding balances are paid in a timely manner. You will be notified via phone/voicemail, text, and/or email prior to any charges being applied to your card.

With my signature, I authorize Great Life Counseling Center to charge my credit/debit card & imitate my signature for the e-sign authorization for the following outstanding charges:

- **All visits for which payment was not made at time of visit (this includes fees for service, deductibles, and co-pays).**
- **50% of the session fee for each late cancellation (less than 24 hours of notice)**
- **100% of the session fee for each no show**

_____ _____
Client/Card Holder Signature **Date**

Name _____
Print Last *First* *Middle Initial*

Name on Card (if different)

Type of Card: □ Visa □ MasterCard □ Discover □ American Express

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____ 3-digit number on **back of** card or 4-digit number on **front** of AE card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements:

_____
Street Address Apt./Ste./Room #

_____
City *State* *Zip*

Card Holder Signature _____, Date ____ /_____ /____

Email address and/or phone number for receipts_____

A copy of this completed & signed document will be provided at your request.

Office Policies and Informed Consent For Child & Family Therapy Treatment

Office Policies and Informed Consent
Welcome and thank you for entrusting Great Life Counseling Center (GLCC) with your care! This document contains important information about our professional services, business practices, and it will serve as a therapeutic contract. Please read it carefully and jot down any questions you would like to discuss.

Philosophy/Approach
Individual Child Therapy Sessions (sessions with a minor)

- Most young children do not respond well to talk therapy. Play & art therapy are often utilized to build, develop, & maintain rapport as well as examine your child's worldview. The number of sessions needed to establish rapport & understand your child well enough to make significant interventions may vary from 1 to 3 sessions or more, depending on the child's openness & comfort with the therapy process as well as their overall ability to share their experience. However, you can be assured that your clinician will work hard to put your child at ease.

Child Therapy = Parent/Child or Family Therapy

- An important part of child therapy includes regular meetings with parents or parents & children together. Both parent and family meetings are an essential part of your child's growth in therapy as well as an important factor for increasing the likelihood of gains being further developed & maintained beyond treatment.
- At the onset of treatment, all legal guardians and other primary caretakers are strongly encouraged to be involved and attend at least one of the first 3 sessions. This is not always feasible but strongly preferred.
- Consistent weekly attendance to sessions and follow through on recommendations are vital factors for successful treatment outcomes.

Family Therapy (at least 1 legal guardian & 1 minor)

- All family members affected by or contributing to the issues of concern will be encouraged to provide input at some point, if not regularly.
- Family sessions give the parents and child an opportunity to work on new skills or ways of relating with the psychologist's support & guidance.

About the Therapy Process

- Child & family counseling has some inherent risks and many potential benefits.

Risks

- Possible risks for therapy include the possibility of disagreement between parents or between parents & psychologist regarding conceptualization of the problem, determining what needs to change, or how change needs to be achieved. Other risks include the treatment being ineffective, changes not meeting your expectations, and relapse & regression. If any of these negative results or issues occurs, your psychologist will make every effort to listen, understand, and respond to your concerns.

Benefits

- Although there are no guarantees about the outcomes of therapy, the benefits of therapy for children & their families often include the reduction of concerning behaviors, the enhancement of their ability to articulate their feelings, improved relationships (with parents,

other family members, teachers, & peers), better coping strategies, and an increase in emotional well-being.

- Trust between clients and their psychologist is vital to the therapy process, especially for young children. Child therapy is most effective when the child views it as a sanctuary in which they are completely free to express themselves. In order to create & maintain this safe environment for the child, the specific details of what your child discloses in individual sessions will not be shared with you (the legal guardian) or anyone else without the child's verbal consent, unless there is a concern for the child's safety or the safety of others. However, your psychologist will inform your child that general themes, treatment plans, & progress updates are shared with guardians. The child will be strongly encouraged to share their experience of the session with you but interrogating the child for specific detail is discouraged.
- ***In the process of child therapy treatment, conflicts between parents & differences in parenting styles or philosophies become relevant to the child & family's treatment. However, it is important that the focus of these discussions maintain a strict focus on discovering a resolution that will best benefit your child (or children). This means that both guardians agree not to utilize the child's treatment or psychologist's session comments to gain an advantage in any legal proceedings. You also agree that you will avoid involving your psychologist in any legal processes that would require the psychologist to take sides with one of the child's guardians or share details about your child's sessions. You must also agree to instruct your attorneys to not subpoena records or refer to anything your psychologist has said in any court filing without your psychologist's consent.***
- Marriage & couples therapy are not considered the same as family therapy. Couples therapy issues are treated separately and require completion of a separate intake packet. If parents are in need of this treatment, separate treatment for these issues can be arranged with a separate GLCC clinician or a referral to other experienced & qualified clinicians in the area.

Custody/Guardianship

- Consent for services can only be authorized by a current legal guardian.
- For divorced parents, consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required.
  - Please Note: A copy of the divorce decree must be included in the client file indicating the custodial arrangement.
- Permission from both parents, regardless of the custodial arrangement is the preferred practice of this office.

TERMINATION OF THERAPY PROCESS

Ideally, the therapy sessions will end when psychologist & client/family mutually agree treatment goals have been adequately met. However, there are times when therapy sessions need to be discontinued for a time or spaced out due to financial reasons, conflicts in schedule, physical illness, or relocation. The psychologist may also decide that client would be better served by another clinician and refer client to a colleague.

Regardless of reasons for termination, continuity of care is vital to effective treatment and clarity regarding the status of the therapeutic relationship is a necessity for accurate record keeping. Thus, it is preferred that clients and/or guardians inform their psychologist of their intention to terminate sessions at least one session in advance. When this is not feasible, clients are asked to at least inform their psychologist of plans to discontinue or take a break from sessions as soon possible.

Unless a date & time has been established for the next session, termination of the therapy relationship will be assumed after 2 weeks of no correspondence or booking of the next appointment. At such time, clients

may be sent an email informing them of this default termination & requesting that all outstanding balances are paid within 1 week of their last session. Clients/Families that have terminated therapy are always welcome to return to treatment as long as outstanding balances have been resolved.

OUTSIDE-OF-SESSION COMMUNICATION & EMERGENCY PROCEDURES/POLICIES:

- Telephone, text, & email consultations between office visits are welcome. However, any contact outside of session will be kept brief. Clients and their legal guardians are encouraged to consider scheduling additional sessions or waiting until their next session to discuss matters that will take more than 15 minutes to explore. If out-of-session correspondence requires more than 15 minutes of the psychologist's time, charges for each 15 minute increment will incur (including the first 15 minutes). Payment for such consultations is due at the start of the next session or within 10 business days (whichever occurs first).

- **Clients & their legal guardians are welcome to leave voicemail or text messages at 646-653-4522 or send emails to BKenney@GreatLifeConsults.com.** On weekends and holidays, messages are checked less frequently. Calls, texts, & emails will generally be responded to within 24 hours or the end of the next business day.

- **Great Life Counseling Center's contact number is *not* an emergency number. In the event of a mental health or medical crisis, please call 911 or one of the following crisis lines, which are available 24/7:**
  - Suicide & Crisis Center of North Dallas – **214-828-1000**
  - National Suicide Prevention Lifeline – **1-800-273-TALK**
  - National Domestic Violence Hotline – **1-800-799-SAFE**
  - National Sexual Assault Hotline – **1-800-656-HOPE**
  - If your crisis is due to a medical issue or medication, contact your physician or psychiatrist.
- Vacation: Clients & their guardians are informed in advance whenever their psychologist plans to be unavailable for more than 2 days. In these events, arrangements may be made for coverage, if the psychologist determines it is necessary or it is requested by the client or client's guardian. Otherwise, clients & their guardians are encouraged to utilize one of the crisis lines listed above for assistance in the absence of their GLCC clinician.

CONFIDENTIALITY:

In most cases (see "Exceptions to Confidentiality" below) communications between client and psychologist will be held in strict confidence - unless client provides psychologist with written permission to release information about treatment. In the case of couples or family therapy, the psychologist will not disclose confidential information about treatment to a third party (other than to a third-party payer) unless all adult participants or legal guardians provide written authorization to release such information.

Protecting client privacy is a high priority for Great Life Counseling Center & its associates. Intake paperwork, therapy notes, consultation notes, & reports are all electronically archived. Each item is password protected whenever possible and the files are eventually archived on an accredited web-based electronic health records system called Practice Fusion. Scheduling & file information on Practice Fusion is protected with bank-level security, which includes the highest levels of data infrastructure, virus prevention, spam filtering, and encryption measures. Prior to being archived, encrypted records are kept on a secured flash drive so they are not saved on any computer. For additional information about your privacy rights & HIPPA, visit the HIPPA website:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

EXCEPTIONS TO CONFIDENTIALITY & PRIVACY RISKS

Safety Concerns

Psychologists & other mental health professionals are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Psychologists are also may break client confidentiality as they attempt to prevent clients from harming themselves or others.

Professional Consultation

In accordance with recommended best practices, your psychologist may consult with other professionals regarding better ways to help you reach your treatment goals. However, client names & other identifying information are never shared and remain protected.

Electronic Communication, Videoconferencing, or Phone

Great Life Counseling Center is nearly a paperless business and relies on different information technologies such as emails, text messages, phone calls, video conferences, fax, & an electronic medical record system to communicate, record, and store client information as well as transmit business transactions. Use of these technologies allows Great Life Counseling Center to serve your needs more efficiently and effectively. Great Life Counseling Center & its associates take reasonable steps to protect the privacy of its clients & minimize risk of any breach or errors in transmission. However, clients are required to acknowledge and accept the inherent risks of such technologies and electronic mechanisms (e.g., risk of information being erased or destroyed due to a malfunction or act of God; information intercepted and/or hacked by unauthorized parties; or information being erroneously transmitted to the wrong email, fax number, or phone number).

ACKNOWLEDGEMENT OF POLICIES & CONSENT TO TREATMENT:

- With my signature below, I acknowledge that I have had ample opportunity to read the information in this policies & consent to treatment document. My signature also indicates that I understand & accept the stated policies, expectations for participation, fees, and risks noted herein.
- My signature also confirms that I am the legal guardian of (list full legal names of all minors who may attend sessions)_____

  _____

  and I consent to the treatment and participation of each child listed.
- Finally, my signature indicates my willingness to abide by all the terms of this agreement, my personal consent to fully participate in the treatment process, and my commitment to paying for all services rendered in a timely fashion.

_____Date_____

Parent/Guardian signature

_____Date_____

Parent/Guardian signature

A copy of this completed & signed document will be provided at your request.

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INTAKE QUESTIONNAIRE

(to be completed by parent/guardian)

CLIENT NAME: _____

PARENT/GUARDIAN COMPLETING FORM: _____

PRIMARY COMPLAINTS: What caused you to bring your child/adolescent in for therapy today?

_____

_____

_____

EXPECTATIONS: What do you hope to change or accomplish as a result of therapy treatment?

_____

_____

_____

HISTORY OF TREATMENT: Has your child/adolescent been in therapy before? Yes No
If yes, please note the when, name of clinician/agency, and primary issues addressed:

_____

_____

Reflecting on the last 6 months, please circle all that apply regarding your child's struggles:

Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	Mood Swings
Irritable and/or short temper	Decreased need for sleep (only need 3-4 hrs)
Significant change in weight	Seems more talkative than usual
Low energy level/fatigue	Excessive spending/shopping
Feeling excessive guilt or shame	Abuse of alcohol or illicit substances
Unable to relax	Easily distracted by unimportant things
Lack of appetite/increased appetite	Takes too many risks
Loss of interest in activities/hobbies	Troubling thoughts about the past
Feeling hopeless	Nightmares
Feeling worthless	Exaggerated startle response
Difficulty motivating	Too neat and orderly
Withdrawn/isolating self	Repeating certain behaviors over and over
Cry easily/often	Easily upset or angered
Difficulty making a decision	Feeling different from most people
Difficulty finishing tasks	Shy around others
Thoughts to hurt self	Increasingly forgetful
Attempts to harm self	Strong fears
Thoughts to hurt others	Difficulty with work or school
Threats to hurt others	Use of painkillers and analgesics
Feeling ill/sick	Stomach aches/vomiting

SUPPORT SYSTEMS **Please describe or elaborate**

Does your child have one or two close friends?	Yes No	
Do you and/or your child have a religion or spiritual practice?	Yes No	
Does your child belong to any social groups or participate in hobbies they enjoy?	Yes No	
Does your child have a close relationship with each parent or primary caregiver?	Yes No	
Does your child have hopes or dreams for their future? Are they inspired by any particular role models?	Yes No	

FAMILY HISTORY

Have <u>you</u> or <u>anyone in your family</u>, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on.

Has anyone experienced:	**Family Member(s)**
Anxiety	
Depression	
Bipolar disorder	
Learning disorders (ADHD, dyslexia, etc.)	
Illicit drug use	
Alcohol abuse	
Schizophrenia	
Anger	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or completed suicide	

Medical History
Check if client has or had, any symptoms in the following areas to a significant degree and briefly explain.

Chest/Heart	Seizures	**Any Recent Changes In:**
Back	Head/Neck injury	Weight Energy Level
Intestinal	Ear/Nose/Throat	Ability to Sleep Mood
Bladder	Headaches	Other Pain/Discomfort:
Bowel	Skin	
Circulation	Lungs	

Childhood illnesses: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio
Immunizations: Tetanus Pneumonia Hepatitis Chickenpox *Influenza

Has your child ever been hospitalized for any emotional/ mental health condition? Yes No
If Yes, please provide dates/details:

Has your child ever been hospitalized for any surgeries/hospitalizations? Yes No
If Yes, please provide dates/details:

Is your child currently being treated for any medical problems? Yes No
Is your child currently taking any prescribed medications? Yes No
List medications:

Medication	Dosage	Purpose (i.e. depression)	Prescribed by

Is your child currently taking over the counter medications, herbs or supplements? Yes No
Would you consider your child to presently be in general good physical health? Yes No
If No, please explain_____
Does your child engage in regular physical activity? Yes No
If yes, what activities? _____ How often?_____

Has your child ever experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc.) Yes No Does your child have a history of being violent or destructive? Yes No Has your child been verbally, emotionally or physically abused? Yes No Has your child been a victim of sexual abuse or sexual assault? Yes No Has your child been a victim of sexual abuse or sexual assault? Yes No If you answered 'Yes' to any of the questions in this box, please provide the general details below (including date/duration of events)
_____ _____ _____ _____

Does your child have history of any legal issues: (custody litigation, CPS involvement, drug or alcohol or Juvenile Justice System)? Yes No Does your child have a history of psychotherapy? Yes No Does your child have a history of Speech Therapy? Yes No Does your child have a history of Occupational? Yes No Does your child have a history of psychological testing/Educational Testing? Yes No If you answered 'Yes' to any of the questions in this box, please provide the general details below (including date/duration of events)
_____ _____ _____ _____

Has your child even been diagnosed with a Learning Disability)? Yes No Has your child ever received Special Education services? (If so, what type?) Yes No
_____ _____ _____

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Prenatal & Early Developmental History

The client is the mother's 1st born 2nd born 3rd born 4th born Other:____

1. Does mother have history of previous: Miscarriage Abortion Stillbirth

2. During the pregnancy, were there any complications, unusual symptoms, high emotional stress, or physical injuries? _____

3. Any use of and/or exposure to Tobacco Coffee/Caffeine Alcohol Heroin Marijuana Methamphetamine Cocaine Other _____
   Also, list any medication used during pregnancy:

4. Was the pregnancy full-term (40 weeks)? Yes No, born premature at ___ weeks.

5. During delivery were there any complications, unusual symptoms, or problems that occurred?

6. Delivery was: C-Section Vaginal Head First Feet First Breech Vacuum
   Birth weight: _____pounds _____ounces

Developmental Milestones

	Age		Age
Hold Head Up	_____	Stood Independently	_____
Rolled Over	_____	Walked Independently	_____
Sat Up	_____	First Word	_____
		Combined Words	_____
		Toilet Trained	_____

Any additional information of significance regarding early development.

_____
_____
_____

Please note any other areas/issues of concern:

_____
_____
_____
_____
_____

Thank you ~