Thank you for your referral for the Ellis Human Development Institute.

To make a Montgomery County Department of Jobs and Family Services- Children Services Division referral, please complete the attached MCDJFS Intake Packet and send to:

Ellis Human Development Institute
9 N. Edwin C. Moses Blvd.
Dayton, OH 45402

Or Fax to 937-775-4311

Referrals to the Ellis Institute must contain the following information in order to meet regulatory requirements and initiate a diagnostic assessment. If you have any questions about the enclosed information, please call 937-775-4300 and our clinical staff will be happy to assist with the referral process.

After we have the completed information, we will contact the foster parent, prospective adoptive parent, or the caseworker to schedule an intake appointment. Please identify who we should contact:

- Foster Parent
- Prospective Adoptive Parent
- MCDJFS Caseworker
- Other:__________

**Intake Packet Checklist**—Please complete all of the following forms in their entirety and send them to the address listed above:

- A copy of the **current Custody Order or a statement on agency letterhead** stating that your agency currently has custody of the child. The Custody Order **must be received** before the appointment can be scheduled.

- A **release of information** for the foster parent(s) and/or prospective adoptive parent unless it is requested that they not be a part of the assessment or treatment process.

- Any additional releases for other persons, agencies, or schools should be included. **Note**: A release of information is not necessary between Ellis Human Development Institute and your organization if you have custody of the child. Release forms can be copied.

- MCDJFS-CSD Intake Referral Information Form

- Parent Background Form: please complete all 9 pages

- Health History Questionnaire: please complete all 4 pages through the top of page 4 (signature of person completing this questionnaire)

- Previous evaluations which are currently available (e.g., school ETR/IEP, Diagnostic Assessment from counselor or psychiatrist, evaluations conducted by MCDJFS, Child Study Inventory)

- Childhood Trust Survey: to be completed by an adult who is aware of the child’s trauma history

- A signed copy of the Consent for Treatment and Client Orientation Checklist, giving permission to Ellis to provide services. Please initial and sign as indicated on the form.

- Disclosure Statement: Please enter the child’s name at the top and sign the form at the bottom. Once the case is assigned to a clinician, we will fax you a copy of the form with the clinician’s name and supervisor’s name for your records.

**Note**: A copy of the Ellis Humans Development Institute’s Note of Privacy Practices is also included with this packet for your review. There is also a link to our Notice of Privacy Practices on our website.
Referral Date: _______ Person Completing form: ______________________ Phone: _________

Caseworker Name: __________________________________________ Caseworker Phone: _________

May we leave a message?  ☐ Yes  ☐ N

Child’s Name: (Last, First, MI): ____________________________________________

DOB: _______ Gender: ___________ Preferred spoken language: _______________________

Social Security #: ___________________ CareSource #: _____________________________

Caretaker Name: ____________________________ Caretaker Phone: _________

Caretaker Address: ____________________________________________________________

Current Medications: __________________________________________________________

Lethality/Safety Issues: ________________________________________________________

School/Grade/Special Education Placement: ______________________________________

Counseling History: ___________________________________________________________

Previous Assessments: _________________________________________________________

Relevant Social History Including Placement History, Number of Disruptions, and Family History:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Recommendations/Request/Reasons for Referral: __________________________________

____________________________________________________________________________
**Client Orientation to Services Checklist & Consent to Treat—MCDJFS-CSD**

I acknowledge that I have received and understand the Ellis Human Development Institute (EHDI) orientation information that consists of:

<table>
<thead>
<tr>
<th>Client Initials</th>
<th>Orientation Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to Treat</td>
<td>I agree and hereby give consent for the Ellis Institute to provide services to me and/or my child under the conditions identified in the paragraphs below. In addition, I acknowledge that any psychological tests used will not be released to me, that test data and personal data may be collected and processed through the publisher’s electronic scoring system, and that the publisher of psychological testing materials may gain access to the test data scored and my electronic protected health information.</td>
</tr>
<tr>
<td><strong>Client/Guardian Signature:</strong> ______________________________________</td>
<td></td>
</tr>
<tr>
<td>Video Taping</td>
<td>I understand that most assessment services provided as part of the contract between the Ellis Human Development Institute and the Montgomery County Department of Job and Family Services will not be audio or video recorded. However, if the evaluation includes the Marschak Interaction Method (MIM), a structured observation of the parent-child relationship, the MIM will be video-recorded for supervision and scoring purposes. The MIM video recording is not part of the client’s record and, as such, will not be released to the client/guardian. Please sign below:</td>
</tr>
<tr>
<td>* I consent to video/audio recording for the MIM: ____________________________</td>
<td></td>
</tr>
<tr>
<td>* I decline video/audio recording for the MIM: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Video Taping</td>
<td>Support Staff Initials</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Here</th>
<th>Training Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand that Ellis Institute is a training, service and research center and services are provided by doctoral level students who are under the supervision of licensed psychologists.</td>
<td></td>
</tr>
<tr>
<td>• If you are asked to participate in a research project, you will also be asked to sign a separate consent. Participation in research is always voluntary. Not participating in a research project does not affect your services.</td>
<td></td>
</tr>
<tr>
<td><strong>Support Staff Initials</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Here</th>
<th>Receipt of HIPAA Privacy Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>I acknowledge that I have received the Ellis Institute’s HIPAA Privacy Policy, which was attached to this packet, entitled: <em>Notice of Privacy Practices</em> or available for download from the website.</td>
<td></td>
</tr>
<tr>
<td><strong>Support Staff Initials</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Here</th>
<th>Client Services Handbook</th>
</tr>
</thead>
<tbody>
<tr>
<td>I acknowledge that I have access to a copy of the Ellis Institute’s Client Service Pamphlet, which includes the following information:</td>
<td></td>
</tr>
<tr>
<td>• Client Rights &amp; Responsibilities, Information on Advanced Directives</td>
<td></td>
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<tr>
<td>• Grievance Procedures</td>
<td></td>
</tr>
<tr>
<td>• Therapy and Treatment Planning Processes (Includes transition/discharge planning, Satisfaction Surveys, quality of care &amp; outcome achievement)</td>
<td></td>
</tr>
<tr>
<td>• Assessment of Needs</td>
<td></td>
</tr>
<tr>
<td>• Risks &amp; Benefits of Treatment</td>
<td></td>
</tr>
<tr>
<td>• Client Code of Ethics</td>
<td></td>
</tr>
<tr>
<td>• Attendance &amp; Cancellation Guidelines.</td>
<td></td>
</tr>
<tr>
<td>• Program Rules (Includes Involuntary Termination)</td>
<td></td>
</tr>
<tr>
<td>• No use of Seclusion and Restraint, no smoking, illicit or licit drugs or weapons brought into the facility.</td>
<td></td>
</tr>
<tr>
<td>• Confidentiality and Exceptions to Confidentiality</td>
<td></td>
</tr>
<tr>
<td>• Motivational incentives when appropriate (food, gift cards)</td>
<td></td>
</tr>
<tr>
<td>• Guidelines for prescription and over-the-counter medications while on Ellis property.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fire Exit Locations and Evacuations</th>
<th>Support Staff Initials</th>
</tr>
</thead>
</table>

**Legal Rule with Minors**

- Disclosed to minor that parent and/or guardian has a right to access minor’s records.

I was given the opportunity to ask questions. I understand I can have these booklets read to me if I am unable to read them.

<table>
<thead>
<tr>
<th>Client Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Signature</td>
<td>Date</td>
</tr>
<tr>
<td>EHDI Provider Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

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DISCLOSURE STATEMENT

Client Name: ________________________________ Client ID#_____________________

The staff of Duke E. Ellis Human Development Institute includes licensed psychologists, psychology fellows, psychology interns, and psychology trainees with a range of training and experience. Services provided by the Psychology staff include individual, family, couples, and group psychotherapy, psychological testing and assessment, psychoeducation, and consultation services. If your mental health provider is a psychology trainee, a psychology intern, or a psychology fellow, he or she will be supervised by a licensed psychologist. The supervisor has ultimate professional responsibility for your care and, as such, all supervisees are required to discuss your treatment, including the content of your sessions, your progress, and psychological testing results, with the supervisor. You have the right to know the status of the provider working with you, to know the identity of his or her supervisor, and to meet with that supervisor if you so desire.

Supervisee assigned to your case is: ___________________________ Phone: (937) 775-4300

His/her supervisor is: ___________________________ Phone: (937) 775-4300

Supervisor's Ohio License Number is: ___________________________

As you enter treatment, a client record or file is opened which includes information about your history, service plan, medications, progress, and any testing results or correspondence which may be generated. This information is shared only with those involved in your treatment or with other staff within Duke E. Ellis Human Development Institute who may be consulted about your case. You must provide written consent before this information is shared with anyone outside of Duke E. Ellis Human Development Institute; however, Duke E. Ellis Human Development Institute may release information without your consent if the law requires that we do so. This might occur if (a) a court order is received; (b) there is an emergency or a situation which threatens your life or the life of another; or (c) it is suspected that child or elder abuse and/or neglect has occurred, or there is abuse of a developmentally disabled "vulnerable" adult. Knowledge/belief of domestic violence/abuse will be noted in the client records. (Other information regarding disclosure of information is outlined in the Client Services Handbook.)

The frequency of appointments will be determined by the mental health provider with input from the client. Appointments will be scheduled by the mental health provider or office staff, unless other arrangements are made. If illness or an emergency prevents you from keeping a scheduled appointment, please contact Duke E. Ellis Human Development Institute as soon as possible. Cost of services and billing will be consistent with Duke E. Ellis Human Development Institute's policies.

Supervisors do not typically provide back-up coverage for supervisees (i.e., psychology fellows, psychology interns, and psychology trainees). In the event that a supervisee is temporarily or permanently unable to speak to or meet with clients on their caseload, backup coverage will be arranged in accordance with the policy in place at Duke E. Ellis Human Development Institute.

Mental health services are generally provided at:

Duke E. Ellis Human Development Institute
Wright State University
9 N. Edwin C. Moses Boulevard
Dayton, OH 45402

At times, services may be delivered in another location.

For emergency services at a time when Duke E. Ellis Human Development Institute is closed, you may contact Crisis Care (937-224-4646) or go to the nearest emergency room.

I understand and agree to the above conditions. I understand that my signature indicates my consent to treatment by a supervisee at Duke E. Ellis Human Development Institute.

Client or Parent/Guardian ___________________________ Date ________________

Supervisee ___________________________ Date ________________

Supervisor ___________________________ Date ________________
**HEALTH HISTORY QUESTIONNAIRE**

This form should be completed as fully as possible by client but reviewed by medical or clinical staff. Clients should notify staff if they need any assistance in completing this form.

<table>
<thead>
<tr>
<th>Client Name (First, Mi, Last)</th>
<th>Client No.</th>
<th>Age</th>
</tr>
</thead>
</table>

Has the client had any of the following health problems?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure (high or low)</td>
<td></td>
</tr>
<tr>
<td>Bone/Joint Problems</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Cirrhosis/Liver Disease</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td></td>
</tr>
<tr>
<td>Eye Disease/Blindness</td>
<td></td>
</tr>
<tr>
<td>Fibromyalgia/Muscle Pain</td>
<td></td>
</tr>
<tr>
<td>Glaucoma</td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
</tr>
<tr>
<td>Head Injury/Brain Tumor</td>
<td></td>
</tr>
<tr>
<td>Hearing Problems/Deafness</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
</tr>
<tr>
<td>Hepatitis/Jaundice</td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
</tr>
<tr>
<td>Lung Disease</td>
<td></td>
</tr>
<tr>
<td>Menstrual Pain</td>
<td></td>
</tr>
<tr>
<td>Oral Health/Dental</td>
<td></td>
</tr>
<tr>
<td>Stomach/Bowel Problems</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Disease</td>
<td></td>
</tr>
<tr>
<td>Learning Problems</td>
<td></td>
</tr>
<tr>
<td>Speech Problems</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
</tr>
<tr>
<td>Hyperactivity / ADD</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Sexual Problems</td>
<td></td>
</tr>
<tr>
<td>Sleep Disorder</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Please note family history of any of the above conditions and client's relationship to that family member.
Has client had medical hospitalizations/surgical procedures in the last 3 years?

- Yes
- No

If yes, complete information below.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>City</th>
<th>Date</th>
<th>Reason</th>
</tr>
</thead>
</table>

Allergies/Drug Sensitivities

- None
- Food (specify):
- Medicine (specify):
- Other (specify):

Pregnancy History (if applicable)

- Not Applicable

Currently pregnant?
- Yes
- No

Receiving pre-natal healthcare?
- Yes
- No

Last Menstrual Period Date

Any significant pregnancy history?
- Yes
- No

Last Physical Examination

<table>
<thead>
<tr>
<th>By Whom</th>
<th>Date</th>
<th>Phone No. (if known)</th>
</tr>
</thead>
</table>

Has client had any of the following symptoms in the past 60 days? Please check.

- Ankle Swelling
- Bed-wetting
- Blood in Stool
- Breathing Difficulty
- Chest Pain
- Confusion
- Consciousness Loss
- Constipation
- Coughing
- Cramps
- Diarrhea
- Dizziness
- Falling
- Gait Unsteadiness
- Hair Change
- Hearing Loss
- Lightheadedness
- Memory Problems
- Mole/Wart Changes
- Muscle Weakness
- Nervousness
- Nosebleeds
- Numbness
- Panic Attacks
- Penile Discharge
- Pulse Irregularity
- Seizures
- Shakiness
- Sleep Problems
- Sweats (night)
- Tingling in Arms & Legs
- Vomiting
- Other: __________

Immunizations

- Chicken Pox
- Diphtheria
- German Measles
- Hepatitis B
- Mumps
- Measles
- Polio
- Small Pox
- Tetanus
- Other: __________

Immunizations Within the Past Year

Height/Weight

<table>
<thead>
<tr>
<th>Height</th>
<th>If reporting for a child, has height changed in the past year?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight</th>
<th>Has client’s weight changed in the past year?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
**Client Name** (First, M.I., Last)  

**Nutritional Screening** (please check)

<table>
<thead>
<tr>
<th>Eating</th>
<th>Drinking</th>
<th>Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Problem</td>
<td>No Problem</td>
<td>No Problem</td>
</tr>
<tr>
<td>More</td>
<td>More</td>
<td>Increased</td>
</tr>
<tr>
<td>Less</td>
<td>Less</td>
<td>Decreased</td>
</tr>
<tr>
<td>Not Eating</td>
<td>Takes Liquids Only</td>
<td></td>
</tr>
</tbody>
</table>

- Nausea
- Vomiting
- Trouble Chewing or Swallowing

**Special Diet**  

**Other**

**Pain Screening**

**Does pain currently interfere with your activities?**  
- No
- Yes

If yes, how much does it interfere with these activities (please check)

- Not at All
- Mildly
- Moderately
- Severely
- Extremely

**Please indicate the source of the pain.**

**Substance Use History/Current Use** (please check appropriate columns)

<table>
<thead>
<tr>
<th>Substance</th>
<th>No Use</th>
<th>Past Use</th>
<th>Current Use</th>
<th>Substance</th>
<th>No Use</th>
<th>Past Use</th>
<th>Current Use</th>
<th>Substance</th>
<th>No Use</th>
<th>Past Use</th>
<th>Current Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Beer/Wine</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
<td>Sleep Medication</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
<td>Cocaine/Crack</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
</tr>
<tr>
<td>Marijuana</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
<td>Tranquilizers</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
<td>Heroin</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
</tr>
<tr>
<td>Hashish</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
<td>Hallucinogens</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
<td>Pain Medication</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
</tr>
<tr>
<td>Stimulants</td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
<td>Inhalants</td>
<td>Yes</td>
<td>Current Use</td>
<td>No</td>
<td></td>
<td>No</td>
<td>Past Use</td>
<td>Current Use</td>
</tr>
</tbody>
</table>

**Caffeine use?**  
- No
- Yes

If yes, form (coffee, tea, pop, etc.)

**How much per week** (cups, bottles)?

**Tobacco use?**  
- No
- Yes

If yes, form (cigarettes, cigars, smokeless, etc.)

**How much per week** (packs, etc.)?

**Was there any prenatal exposure to alcohol, tobacco, or other drugs?**  
- Yes
- No
- I don’t know

If yes, please describe:

**Are you currently prescribed medications?**  
- Yes
- No

If yes, complete information below.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Prescribing Physician</th>
<th>Is Medication Effective (yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

**Please describe your use of complementary health approaches (i.e. massage, chiropractic, homeopathic remedies, acupuncture, herbs, probiotics, etc.):**
**Client Name** (First, MI, Last)  

<table>
<thead>
<tr>
<th>How would you rate your current level of functioning in the following areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognition (Thinking, Memory, Problem-Solving, Judgment):  &amp; Poor &amp; Fair &amp; Good</td>
</tr>
<tr>
<td>Emotional (How you feel, i.e., happy, sad, depressed, angry):  &amp; Poor &amp; Fair &amp; Good</td>
</tr>
<tr>
<td>Behavioral (Daily activities, impulse control, work/school):  &amp; Poor &amp; Fair &amp; Good</td>
</tr>
</tbody>
</table>

Please list any co-occurring disabilities/disorders that we should know about:

How would you rate your adjustment to any disabilities/disorders that you might have?  

Poor  Fair  Good

<table>
<thead>
<tr>
<th>Referrals Needed</th>
<th>□ No Referral Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check Referral(s) Needed and Specify Action(s)</td>
<td></td>
</tr>
<tr>
<td>□ Primary Care Physician:</td>
<td></td>
</tr>
<tr>
<td>□ Healthcare Agency:</td>
<td></td>
</tr>
<tr>
<td>□ Specialty Care:</td>
<td></td>
</tr>
<tr>
<td>□ Other (specify):</td>
<td></td>
</tr>
</tbody>
</table>

Recommendations shared with client?  □ Yes  □ No

If no, how will recommendations be shared with client?

Print Name of Person Completing this Questionnaire  

Signature of Person Completing this Questionnaire  

Provider Signature/Credentials  

Supervisor Signature/Credentials  

SQ-04-020  

Page 4 of 4
Authorization for Release of Protected Health Information

Client Name: ___________________________ Client #: ___________________ Birth Date: __________

Social Security #: _____________________ Name of Provider: ___________________________

I hereby grant my permission for release, review, and exchange of the following information relating to my care between the parties named here. This release is intended to cover all services provided by the Ellis Human Development Institute.

I am aware that once this information is released to another party, it may no longer be protected. I understand that I may further limit the type of exchange between the listed parties. List limitations, if any: __________________________________________

Ellis Human Development Institute
9 N. Edwin C. Moses Blvd.
Dayton, OH 45402
Phone: (937) 775-4300 FAX: (937) 775-4311

Purpose of this request: [check all that may apply during the timeframe of this release]
- Continuity of Care/Treatment
- Legal
- Insurance Claim
- Patient Request
- Other, specify: __________________________

Ways information may be shared: [check all that may apply during timeframe of this release]
- Mail
- Fax
- Phone
- In Person
- Picked Up

The following information pertaining to the patient named above:
Dates of Treatment: __________________________

I specify that this release/exchange to include (choose all that apply):

| Drug/Alcohol Abuse Assessment | Pathology / Laboratory Reports | Final Discharge |
| Drug/Alcohol Treatment | Physical Orders |
| Mental Health Assessment | Operative Reports | Discharge Summary |
| Psychological Assessment | Consultation |
| Mental Health Treatment | Emergency Room Treatment |
| Other Specified → → → |

- I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.
- I understand that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter to Ellis Human Development Institute at the address listed on this authorization form. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
- Unless otherwise revoked, I understand that this authorization will expire one hundred and eighty (180) days from the date of this form or on the following date or event: __________________________
- I understand that I may refuse to sign this authorization and that Ellis Human Development Institute may not condition treatment on the completion of this authorization except as indicated in HIPAA Regulations at 45 CFR §164-508(b)(4).
- I certify that I have read and received a copy of the authorization. This authorization supersedes any and all previous authorizations.

A copy or facsimile of this document will be considered as an original

Signature ___________________________ Date __________ Witness ___________________________ Date __________

I hereby consent to the above for a minor or person unable to assume personal responsibility.

Signature ___________________________ Date __________ Relationship to Client ___________________________

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

FOR OFFICE USE ONLY

Date signed by client/guardian __________ Authorization Expiration Date (180 days) __________

If REVOKED, Date of Revocation __________

Rev. 8/24/17
The Childhood Trust Events Survey
Children and Adolescents: Caregiver Form
Version 2.0; 10/10/2006

It is important for us to understand what may have happened to your child. The questions below describe some kinds of upsetting experiences. Since we give these questions to everyone, we list a lot of possible events that may have happened at any time in your child’s life. If one or more of these experiences has happened at some time in your child’s life, please circle Y for Yes. If not, circle N for No. If you are unsure, circle DK for Don’t Know. Thank you for completing this survey.

1. Was your child ever in a really bad accident, such as a serious car accident? Y N DK
2. Was your child ever in a disaster such as a tornado, hurricane, fire, big earthquake, or flood? Y N DK
3. Was your child ever so badly hurt or sick that he/she had to have painful or frightening medical treatment? Y N DK
4. Has your child ever been threatened or harassed by a bully (someone outside of his/her family)? Y N DK
5. Has your child ever repeatedly had a parent swear at him/her, insult him/her, or had hurtful things said to him/her such as “You are no good,” “You will be sent away because you are bad,” or “I wish you were never born”? Y N DK
6. Was your child ever completely separated from his/her parent(s) for a long time, such as going to a foster home, the parent living far apart from him/her, or never seeing the parent again? Y N DK
7. Has your child ever had a family member who was put in jail or prison or taken away by the police? Y N DK
8. Has your child ever had a time in his/her life when he/she did not have the right care, such as not having enough to eat, being left in charge of younger brothers or sisters for long periods of time, or being left with an adult who used drugs? Y N DK
9. Has your child ever had a time in his/her life when he/she was living in a car, living in a homeless shelter, living in a battered women’s shelter, or living on the street? Y N DK
10. Has your child ever had someone living in his/her home who abused alcohol or used street drugs? Y N DK
11. Has your child ever seen someone in the home try to hurt or kill himself/herself, such as cutting himself/herself or taking too many pills or drugs? Y N DK

Page 1 subtotals ___ ___ ___
12. Has your child ever had a family member who was depressed or mentally ill for a long time?  
   Y N DK

13. Has your child ever had a family member or someone else very close to him/her die unexpectedly?  
   Y N DK

14. Has someone in your child’s home ever been physically violent toward him/her, such as whipping, kicking, or hitting hard enough to leave marks?  
   Y N DK

15. Has an adult ever said they were going to hurt your child really badly or kill him/her, or acted like they were going to hurt your child very badly or kill him/her, even if this person didn’t actually do it?  
   Y N DK

16. Has your child ever seen or heard family members act like they were going to kill or hurt each other badly, even if they didn’t actually do it?  
   Y N DK

17. Has your child ever seen or heard a family member being hit, punched, kicked very hard, or killed?  
   Y N DK

18. Has your child ever seen someone in his/her neighborhood be beaten up, shot at or killed?  
   Y N DK

19. Has someone ever robbed or tried to rob (jump) your child or your child’s family with a weapon?  
   Y N DK

20. Has someone ever kidnapped your child or has someone close to your child ever been kidnapped?  
   Y N DK

21. Has your child ever been badly hurt by an animal, such as attacked by a dog?  
   Y N DK

22. Has your child ever had a pet or animal that was hurt or killed on purpose by someone he/she knew?  
   Y N DK

23. Has your child ever seen a friend killed?  
   Y N DK

24. Has someone ever touched your child’s private sexual body parts when he/she did not want them to?  
   Y N DK

25. Has someone ever made your child touch another person’s private sexual body parts?  
   Y N DK

26. Has an adult ever tied your child up, gagged him/her, blindfolded him/her, or locked him/her in a closet or a dark scary place?  
   Y N DK

<table>
<thead>
<tr>
<th>Subtotals</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 2</td>
<td></td>
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<tr>
<td>Page 1</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If more than one event happened AND still seems to bother your child, put a star next to the one that you believe bothers him/her the most.

---

Trauma Treatment Training Center  
The Childhood Trust & The Mayerson Center for Safe and Healthy Children  
Cincinnati Children’s Hospital Medical Center  
3333 Burnet Ave, MLC 3008 Cincinnati, Ohio 45229-3039

This survey is a public domain document and may be freely reproduced and distributed without copyright restrictions. Please do not alter the item wording or content or the response format and then distribute the modified version under the original name. If you feel you must make any modifications of this survey, please rename it so that others will not be confused. For more information about this scale, please contact Erica Pearl, Psy D. Email: erica.pearl@cchmc.org.
Please answer all of the following questions as honestly as possible with a BLUE or BLACK INK PEN.

CLIENT NAME: __________________ NUMBER: ___________ DATE: _______

DATE OF BIRTH: _______________ SEX: M__F____

FORM COMPLETED BY: ________________________________________________

RELATIONSHIP TO CHILD: ____________________________________________
(Please indicate if child is adopted)

Why are you referring your child for services at this time: ____________________________________________________________________

Who referred you to us: ____________________________________________________________________

MEDICAL HISTORY

1. The child’s present state of health is: __Good __Fair __Poor

2. Does she/he currently have any medical problem(s)? __No __Yes
If you answered “yes,” please indicate the nature of the problem(s): ________________________________________________________________

3. When was she/he last treated by a physician? Date: _______________
Please indicate where: __Private __Physician __Clinic
Name of Physician or Clinic: _________________________________________
Address: __________________________________________________________

4. When did she/he receive his/her last physical? Date: _______________
Name of Physician or Clinic: _________________________________________
Address: __________________________________________________________

5. Do you have a family physician: __No __Yes
Name of Physician: __________________________________________________
Address: __________________________________________________________

6. Please check any of the following which have been a problem for your child:
   __ ___ Sleep problems __ ___ Problems w/ motor coordination
<table>
<thead>
<tr>
<th>High or prolonged fever</th>
<th>Shortness of breath</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convulsions</td>
<td>Low blood pressure</td>
</tr>
<tr>
<td>Unconsciousness</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Allergies</td>
<td>Underweight</td>
</tr>
<tr>
<td>Asthma</td>
<td>Overweight</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Vision Problems</td>
<td>Menstrual problems</td>
</tr>
<tr>
<td>Stomach trouble</td>
<td>Hernia</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Chronic Cough</td>
</tr>
<tr>
<td>Constipation</td>
<td>Bladder infections</td>
</tr>
<tr>
<td>Vaginal infections</td>
<td>Problems w/ motor coordination</td>
</tr>
<tr>
<td>Low blood pressure</td>
<td>Shortness of breath</td>
</tr>
</tbody>
</table>

**7.** Does this child have any allergies? **__No**  **__Yes**  
If "yes," please name the drug(s), food(s), or other substance(s) to which she/he is allergic:

---

**EARLY DEVELOPMENT**

1. Did the mother have any difficulties with the pregnancy, labor, or delivery of this child? **__No**  **__Don’t Know**  **__Yes**
   If ‘Yes’, please specify:

   ---

2. What was the child’s weight at birth:  ____ lbs.  ____ oz.

3. Did the child have any problems at birth? **__No**  **__Don’t Know**  **__Yes**
   If ‘Yes’, please specify:

   ---

4. Was this child’s rate of development normal during the first 18 months?  **__No**  **__Don’t Know**  **__Yes**
   If ‘Yes’, please specify:

   ---

5. Please check the appropriate age at which your child performed the following:

<table>
<thead>
<tr>
<th>Crawled</th>
<th>Walked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 6 Months</td>
<td>Between 6 &amp; 1 Year</td>
</tr>
<tr>
<td>Between 1 &amp; 1½ Years</td>
<td>Over 1½ Years</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

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Revised: 09.25.08/ms  Page 2 of 9
5. Check any of the following which describe how you felt about having this child:
   ___ Happy  ___ Unprepared  ___ Unhappy
   ___ Nervous  ___ Life disrupted  ___ Financially burdened
   ___ Excited  ___ Fulfilled
   ___ Other, please specify: ____________________________________________

6. Which of the following best describes this child as an infant?
   ___ Fun  ___ Sickly  ___ Fussy
   ___ Overactive  ___ Quiet  ___ Irritating

Summary
(please do not write in this space)

________________________________________
________________________________________
________________________________________

SOCIAL AND FAMILY HISTORY

1. What grade is this child in now? ________________________________

2. How many different schools has this child attended? ________________

3. What kind of grades does she/he make in school? ________________
   ___ Excellent  ___ Good  ___ Fair  ___ Poor  ___ Failing

4. Has this child ever repeated a grade? ___ No  ___ Yes
   If 'Yes', please specify: ________________________________________

5. Has this child ever had specialized testing at school?
   ___ No  ___ Yes
   If 'Yes', please specify: ________________________________________

6. How would you describe the child’s school attendance? ___ Good  ___ Fair  ___ Poor

7. Does this child have problems in school? ___ No  ___ Yes
   If 'Yes', please specify: ________________________________________
8. How well does this child get along with other children?
   ___ Very well    ___ Not very well
   ___ Satisfactory ___ Very poorly

9. Does this child participate in school activities?  ___ No    ___ Yes, some    ___ Yes, many

10. Choose those characteristics which describe your child’s attitude toward authority figures (teachers, parents, etc.)
    ___ Assertive       ___ Cooperative
    ___ Defiant         ___ Excessive demands for attention
    ___ Fearful         ___ Overly anxious to please
    ___ Respectful      ___ Shy
    ___ Submissive      ___ Uncooperative

11. Are most of this child’s close friends: ___ Same age    ___ Older    ___ Younger

12. Are most the child’s close friends: ___ Same age    ___ Opposite sex    ___ Both sexes

13. What does this child do well?

14. Does this child have interests or hobbies she/he enjoys?  ___ No    ___ Yes
    If ‘Yes’, please specify:

15. Does this child have a strong fear about any of the following?
    ___ Being left alone    ___ Being in crowds
    ___ The dark            ___ Strangers
    ___ Any animals or insects ___ Bodily harm
    ___ Thunder or lightning ___ Death
    ___ Closed in places    ___ Riding in a car
    ___ High places        ___ No known fears
    ___ Other, please specify:

16. Check any of the following which apply to your child:
    ___ Lonely          ___ Obedient    ___ Clumsy
    ___ Dependable      ___ Destructive of property    ___ Energetic
    ___ Fire setting    ___ Sleep-walking     ___ Shy
    ___ Friendly        ___ Acts young     ___ Artistic for age
    ___ Cruel to animals ___ Acts old for age    ___ Overactive
<table>
<thead>
<tr>
<th></th>
<th>Rigid/compulsive</th>
<th>Feelings easily hurt</th>
<th>Impulsive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intelligent</td>
<td>Easily influenced</td>
<td>Clinging</td>
</tr>
<tr>
<td></td>
<td>Daydreaming</td>
<td>Sleep problem</td>
<td>Stubborn</td>
</tr>
<tr>
<td></td>
<td>Messy</td>
<td>Sense of humor</td>
<td>Lazy</td>
</tr>
<tr>
<td></td>
<td>Bed wetting</td>
<td>Nail-biting</td>
<td>Tells lies</td>
</tr>
<tr>
<td></td>
<td>Irresponsible</td>
<td>Self-confident</td>
<td>Considerate</td>
</tr>
<tr>
<td></td>
<td>Cries easily</td>
<td>Fights constantly</td>
<td>Steals</td>
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<tr>
<td></td>
<td>Loving</td>
<td>Likes to be alone</td>
<td>Jealous</td>
</tr>
<tr>
<td></td>
<td>Often sad</td>
<td>Unsure of self</td>
<td>Nightmares</td>
</tr>
<tr>
<td></td>
<td>Nervous</td>
<td>Temper tantrums</td>
<td>Short attention span</td>
</tr>
<tr>
<td></td>
<td>Independent</td>
<td>Many physical complaints</td>
<td></td>
</tr>
</tbody>
</table>

17. Has your child ever had previous treatment for any of the above?  __No  __Yes

Whom did she/he see? ____________________________________________________________

Address: ____________________________________________________________________

18. Did anything happen that affected the family shortly before your child’s behavior problem occurred?

  ___Death – Specify: ____________________________________________________________________

  ___Job change – Specify: ____________________________________________________________________

  ___Divorce/Separation – Specify: ____________________________________________________________________

  ___Birth/Adoption – Specify: ____________________________________________________________________

  ___Other – Specify: ____________________________________________________________________

  ___No

21. Check all persons with whom this child has lived most of her/his life and indicate how well s/he gets along with these people.

<table>
<thead>
<tr>
<th></th>
<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural Mother</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Natural Father</td>
<td></td>
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<td></td>
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<tr>
<td>Stepmother</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Stepfather</td>
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<td></td>
<td></td>
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<tr>
<td>Adoptive parents</td>
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<td><strong>Foster parents</strong></td>
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<tr>
<td><strong>Brothers (list)</strong></td>
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<tr>
<td><strong>Sisters (list)</strong></td>
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<tr>
<td><strong>Other relative(s)</strong> (who?)</td>
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<tr>
<td><strong>Institution</strong> (where?)</td>
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</tr>
</tbody>
</table>

22. Whom does child live with now? ____________________________________________

23. In your family, who likes your child best? __________________________________

24. In your family, who likes her/him least? ____________________________________

25. Does your child remind you of anyone else (yourself, spouse, a relative)?
   - No   - Yes
   If ‘Yes’, please specify: ______________________________________________________
   __________________________________________________
   __________________________________________________

26. Does another child in this family have a serious medical or emotional problem?
   - No   - Yes
   If ‘Yes’, please specify child and condition: ____________________________________
   __________________________________________________
27. Does your family regularly engage in family activities? __No  __Yes
Please describe: _______________________________________________________
_________________________________________________________________
_________________________________________________________________

28. Have you had trouble with the police? __No  __Yes
If ‘Yes’, please specify: _______________________________________________
_________________________________________________________________
_________________________________________________________________

29. Has your child had trouble with the police? __No  __Yes
If ‘Yes’, please specify: _______________________________________________
_________________________________________________________________
_________________________________________________________________

30. Please complete the following:

<table>
<thead>
<tr>
<th></th>
<th>Child’s Mother</th>
<th>Child’s Father</th>
<th>Step-Parent, if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (present)</td>
<td>_______________</td>
<td>_______________</td>
<td>_________________________</td>
</tr>
<tr>
<td>Age when first married to</td>
<td>_______________</td>
<td>_______________</td>
<td>_________________________</td>
</tr>
<tr>
<td>First spouse</td>
<td>_______________</td>
<td>_______________</td>
<td>_________________________</td>
</tr>
<tr>
<td>Total number of marriages</td>
<td>_______________</td>
<td>_______________</td>
<td>_________________________</td>
</tr>
<tr>
<td>Number of children by previous Marriage</td>
<td></td>
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<tr>
<td>_________________________</td>
<td>_______________</td>
<td>_______________</td>
<td>_________________________</td>
</tr>
<tr>
<td>Years of schooling</td>
<td>_______________</td>
<td>_______________</td>
<td>_________________________</td>
</tr>
<tr>
<td>Occupation</td>
<td>_______________</td>
<td>_______________</td>
<td>_________________________</td>
</tr>
</tbody>
</table>

31. How often do you attend religious services? _________________________

32. Check any of the following which describe your relationship with your current spouse:

_____ Stormy   _____ Indifferent   _____ Unrewarding
_____ Disappointing   _____ Harmonious   _____ Impossible
_____ Happy   _____ Mistake   _____ Understanding
_____ Devoted   _____ Wholesome   _____ Hopeless
_____ Insecure   _____ Average   _____ Secure
33. I In general, would you say life in your present family is:
   ______Excellent   ______Good   ______Fair   ______Poor   ______Bad

34. How do you get along with your other child(ren)?
   ______Very well   ______Fairly well   ______Not very well   ______Very poorly

35. How well does your spouse or partner get along with your other child(ren)?
   ______Very well   ______Fairly well   ______Not very well   ______Very poorly

36. How do you usually punish your child(ren)?
   ______Spanking   ______Assigning work duties
   ______Withholding privileges   ______Spanking and withholding
   ______Privileges   ______Other, specify

37. How does your spouse/partner usually punish your child(ren)?
   ______Spanking   ______Assigning work duties
   ______Withholding privileges   ______Spanking and withholding
   ______Privileges   ______Other, specify

38. Is getting away from your child(ren) - (having time for yourself) a problem for you?
   ______No   ______Yes

39. Do you feel your life is being disrupted by this child? ______No ______Yes

40. Do you or others feel you or your spouse/partner have a problem with use of drugs or alcohol?
   ______No

   ______Yes, I do with ____________________________________________

   ______Yes, my spouse does with ______________________________________

41. Do you and your spouse disagree frequently about this child?
   ______No   ______Yes

42. Was your home life a happy one? ______No ______Yes

43. Were you raised by your natural parents? ______Yes ______No
   ______Specify by whom: ____________________________________________

44. How were you usually punished as a child?
   ______Spanking   ______Assigning work duties
   ______Withholding privileges   ______Spanking and withholding
   ______Privileges   ______Other, specify
45. Carefully read the following list, then check up to five (5) traits that were stressed in your home during your childhood.

- Personal appearance
- Warmth and affection
- Power and position
- Aggressiveness
- Social obligations
- Cleanliness
- Independence
- Generosity
- Quietness
- Fun
- Religion
- Initiative
- Manners
- Thrift
- Honesty
- Ambition
- Education
- Morality
- Pride
- Work
- Survival
- Obedience
- Security
- Other, specify
- Health

46. Please state here any additional information you feel may be important (include how you think this child could be helped, i.e., counseling with parents and/or teacher, psychological testing, medication, individual therapy, etc.): ________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________