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 Human 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 □ No

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><strong>Consent to Treat</strong></td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td><strong>Client/Guardian Signature:</strong></td>
<td></td>
</tr>
</tbody>
</table>

| **Video Taping** |
| I understand that most 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: |
| * I consent to video/audio recording for the MIM: ____________________________ |
| * I decline video/audio recording for the MIM: ____________________________ |

| **Initial Here** |
| Training Clinic |
| 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. |
| • 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. |

| **Initial Here** |
| Receipt of HIPAA Privacy Policy |
| I acknowledge that I have received the Ellis Institute’s HIPAA Privacy Policy, which was attached to this packet, entitled: Notice of Privacy Practices or available for download from the website. |

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

| Fire Exit Locations and Evacuations |

| 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. |

| Client Signature | Date |
| Parent/Guardian Signature | Date |
| EHDI Provider Signature | Date |

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>Now</th>
<th>Past</th>
<th>Never</th>
<th>Treatment Received and Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td></td>
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<tr>
<td>Arthritis</td>
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<tr>
<td>Asthma</td>
<td></td>
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<tr>
<td>Bleeding Disorder</td>
<td></td>
<td></td>
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<tr>
<td>Blood Pressure (high or low)</td>
<td></td>
<td></td>
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<tr>
<td>Bone/Joint Problems</td>
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</tr>
<tr>
<td>Cancer</td>
<td></td>
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<tr>
<td>Cirrhosis/Liver Disease</td>
<td></td>
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</tr>
<tr>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Epilepsy/Seizures</td>
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<tr>
<td>Eye Disease/Blindness</td>
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<tr>
<td>Fibromyalgia/Muscle Pain</td>
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<tr>
<td>Glaucoma</td>
<td></td>
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<tr>
<td>Headaches</td>
<td></td>
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<tr>
<td>Head Injury/Brain Tumor</td>
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<tr>
<td>Hearing Problems/Deafness</td>
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<tr>
<td>Heart Disease</td>
<td></td>
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<tr>
<td>Hepatitis/Jaundice</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Lung Disease</td>
<td></td>
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<tr>
<td>Menstrual Pain</td>
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<tr>
<td>Oral Health/Dental</td>
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<tr>
<td>Stomach/Bowel Problems</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Thyroid</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>AIDS/HIV</td>
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<tr>
<td>Sexual Transmitted Disease</td>
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<tr>
<td>Learning Problems</td>
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<tr>
<td>Speech Problems</td>
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<tr>
<td>Anxiety</td>
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<tr>
<td>Bipolar Disorder</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Eating Disorder</td>
<td></td>
<td></td>
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<tr>
<td>Hyperactivity/ADD</td>
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<tr>
<td>Schizophrenia</td>
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<tr>
<td>Sexual Problems</td>
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<tr>
<td>Sleep Disorder</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Other:</td>
<td></td>
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</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?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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)

<table>
<thead>
<tr>
<th>Currently pregnant?</th>
<th>Receiving pre-natal healthcare?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Last Menstrual Period Date

<table>
<thead>
<tr>
<th>Any significant pregnancy history?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

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
- Tremor
- Vomiting
- Other: __________

Immunizations

- Chicken Pox
- Diphtheria
- German Measles
- Hepatitis B
- Measles
- Mumps
- 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>No</td>
<td>Yes</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>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Heath History Questionnaire
**Nutritional Screening** (please check)

- [ ] No Problem
- Eating: [ ] More [ ] Less [ ] Not Eating
- Drinking: [ ] More [ ] Less [ ] Takes Liquids Only
- Appetite: [ ] Increased [ ] Decreased
- Nausea [ ] Vomiting [ ] Trouble Chewing or Swallowing

**Special Diet**

**Other**

**Pain Screening**

**Does pain currently interfere with your activities?**
- [ ] No
- [ ] Yes
- Not at All [ ] Mildly [ ] Moderately [ ] Severely [ ] Extremely

Please indicate the source of the pain.

| Substance Use History/Current Use (please check appropriate columns) |
|---|---|---|---|---|---|---|---|---|---|
| Substance | No Use | Past Use | Current Use | Substance | No Use | Past Use | Current Use | Substance | No Use | Past Use | Current Use |
| Alcohol/Beer/Wine | Sleep Medication | Cocaine/Crack |
| Marijuana | Tranquilizers | Heroin |
| Hashish | Hallucinogens | Pain Medication |
| Stimulants | Inhalants | Other: |

**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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please describe your use of complementary health approaches (*i.e.* massage, chiropractic, homeopathic remedies, acupuncture, herbs, probiotics, etc.):
**Safety Screening**

Our goal at the Ellis Institute is that all clients are safe. Please respond to the following questions. Your clinician will discuss these questions with you during your intake.

### FOR ADULT CLIENTS:
1. In the past two weeks, have you thought about harming yourself?  □ Yes  □ No
2. In the past two weeks, have you thought about killing yourself?  □ Yes  □ No
3. Have you ever made a suicide attempt?  □ Yes  □ No
   - If Yes, when? Please state the month & year  

### FOR CHILD/adolescent CLIENTS. PARENT/GUARDIAN, PLEASE COMPLETE THESE ITEMS:
1. In the past two weeks, has your child thought about harming himself/herself/themselves?  □ Yes  □ No  □ I don't know
2. In the past two weeks, has your child thought about killing himself/herself/themselves?  □ Yes  □ No  □ I don't know
3. Has your child ever made a suicide attempt?  □ Yes  □ No  □ I don't know
   - If Yes, when? Please state the month & year  

---

### Safety Screening

Our goal at the Ellis Institute is that everyone is safe. Please respond to the following questions. Your clinician will discuss these questions with you during your intake.

### FOR ADULT CLIENTS:
1. In the past two weeks, have you thought about harming other people  □ Yes  □ No

### FOR CHILD/adolescent CLIENTS. PARENT/GUARDIAN, PLEASE COMPLETE THIS ITEM:
1. In the past two weeks, has your child thought about harming others?  □ Yes  □ No  □ I don't know

---

**Print Name of Person Completing this Questionnaire** | **Signature of Person Completing this Questionnaire** | **Date**
---|---|---

**Clinician Reviewer Comments, if any**

- Medical Review Recommended

**Provider Signature/Credentials** | **Date**
---|---

**Referrals Needed**  □ No Referral Needed

**Check Referral(s) Needed and Specify Action(s)**

- Primary Care Physician:  
- Healthcare Agency:  
- Specialty Care:  
- Other (specify):  

**Recommendations shared with client?**  □ Yes  □ No

**If no, how will recommendations be shared with client?**

**Provider Signature/Credentials** | **Date**
---|---

**Supervisor Signature/Credentials** | **Date**
---|---

---

**SQ-04-020**  **HEALTH HISTORY QUESTIONNAIRE**  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 is to include (choose all that apply):

<table>
<thead>
<tr>
<th>Drug/Alcohol Abuse Assessment</th>
<th>Medications Prescribed</th>
<th>Final Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Assessment</td>
<td>Pathology / Laboratory Reports</td>
<td>Discharge Summary</td>
</tr>
<tr>
<td>Psychological Assessment</td>
<td>Operative Reports</td>
<td>Physical Exam</td>
</tr>
<tr>
<td>Drug/Alcohol Treatment</td>
<td>Emergency Room Treatment</td>
<td>Consultation</td>
</tr>
<tr>
<td>Mental Health Treatment</td>
<td>Physical Orders</td>
<td></td>
</tr>
<tr>
<td>Other Specified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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 HIPPA 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>Subtotal</th>
<th>Page 2 subtotal</th>
<th>Page 1 subtotal</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
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</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.

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>
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<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>

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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: ________________________________

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

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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
    ____ Dependent  ____ Destructive of property  ____ Energetic
    ____ Fire setting  ____ Sleep-walking  ____ Shy
    ____ Friendly  ____ Acts young  ____ Artistic for age
    ____ Cruel to animals  ____ Acts old for age  ____ Overactive

Revised: 09.25.08
<table>
<thead>
<tr>
<th>Rigid/compulsive</th>
<th>Feelings easily hurt</th>
<th>Impulsive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligent</td>
<td>Easily influenced</td>
<td>Clinging</td>
</tr>
<tr>
<td>Daydreaming</td>
<td>Sleep problem</td>
<td>Stubborn</td>
</tr>
<tr>
<td>Messy</td>
<td>Sense of humor</td>
<td>Lazy</td>
</tr>
<tr>
<td>Bed wetting</td>
<td>Nail-biting</td>
<td>Tells lies</td>
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<tr>
<td>Irresponsible</td>
<td>Self-confident</td>
<td>Considerate</td>
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<tr>
<td>Cries easily</td>
<td>Fights constantly</td>
<td>Steals</td>
</tr>
<tr>
<td>Loving</td>
<td>Likes to be alone</td>
<td>Jealous</td>
</tr>
<tr>
<td>Often sad</td>
<td>Unsure of self</td>
<td>Nightmares</td>
</tr>
<tr>
<td>Nervous</td>
<td>Temper tantrums</td>
<td>Short attention span</td>
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<tr>
<td>Independent</td>
<td>Many physical complaints</td>
<td></td>
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</tbody>
</table>

17. Has your child ever had previous treatment for any of the above?  ___ No  ___ Yes
Whom did she/he see? ______________________________________________________

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>
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</thead>
<tbody>
<tr>
<td>Natural Mother</td>
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<tr>
<td>Natural Father</td>
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<td>Stepmother</td>
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<tr>
<td>Stepfather</td>
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<td>Adoptive parents</td>
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<td>Foster parents</td>
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<tr>
<td>Brothets (list)</td>
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<td>Sisters (list)</td>
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<tr>
<td>Other relative(s) (who?)</td>
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<tr>
<td>Institution (where?)</td>
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</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:  Child’s  Child’s  Step-Parent,    
                                   Mother    Father    if applicable

   Age (present)  _______  _______    _______

   Age when first married to
   First spouse  _______  _______    _______

   Total number of marriages
   _______  _______    _______

   Number of children by previous
   Marriage  _______  _______    _______

   Years of schooling  _______  _______    _______

   Occupation  _______  _______    _______

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. 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
- Health

- Morality
- Pride
- Work
- Survival
- Obedience
- Security
- Other, specify

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.): ________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________