



## ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING OF SYNTERO POLICIES AND CONSENT FOR TREATMENT

- ❖ I hereby certify that Syntero has provided me with copies of:
  - Orientation to Rules, Expectations, and Risks/Benefits of Treatment
  - Financial Policies
  - Client & Family Rights
  - Grievance Procedure
  - Privacy Notice including a summary of 42 CFR Part 2 Laws and Regulations
  - Information regarding exposure and transmission of infectious diseases
  - Agency maps
  - ADAMH Board of Franklin Notice of Privacy Practice
  
- ❖ If I self pay for appointments or are uninsured, I certify that I have received a Good Faith Estimate for the total expected cost of services. I understand that it may be updated as needed or at a minimum, on an annual basis.
  
- ❖ Syntero makes an effort to communicate with clients through different mediums to gather input on our services, provide updates regarding our services, send appointment reminders, obtain outcome information, and send personalized links to telehealth sessions. Please initial if you provide consent:
  - \_\_\_\_ I consent to receive phone calls/voicemails
  - \_\_\_\_ I consent to receive text messages
  - \_\_\_\_ I consent to receive emails
  
- ❖ For parent/guardian of minor child:
  - \_\_\_\_ I hereby give Syntero my permission to send my child service related emails
  - \_\_\_\_ I hereby give Syntero my permission to send my child service related text messages
  
- ❖ Further, I certify I have read and understand the aforementioned documents
  
- ❖ Consent for Treatment  
I hereby give Syntero my permission to provide services including, but not limited to, counseling, psychotherapy, alcohol and other drug treatment and case management to:

\_\_\_\_\_  
**Please Print Client's Name**

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Legal Guardian Name**

\_\_\_\_\_  
**Signature of Parent/ Legal Guardian**

\_\_\_\_\_  
**Date**

**For a Minor Seeking Treatment without Parental Consent:**

As a minor 14 years of age or older, I understand I am entitled to receive counseling services for no more than six sessions or thirty days, whichever comes first, without the consent of my parent/guardian and without that parent/guardian being informed. If services extend beyond that point, I will work with my therapist to involve my parent/guardian in treatment.

\_\_\_\_\_  
**Minor without Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**



Client Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Please Print)

Responsible Party Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

**2023 Standard Rates**

*\*Subject to change-updates are posted in our agency lobbies*

Service Type:	Rates:
Diagnostic assessment	\$200 per clinical hour
Individual psychotherapy	\$160 per clinical hour
Psychiatric assessment	\$267 per clinical hour
Group psychotherapy	\$55 per clinical hour
Intensive outpatient for substance use (IOP)	\$218 per group

*\*\*Please be aware that your services at Syntero begin with an assessment, completing your assessment may take multiple appointments and if your provider is not in network with your insurance, you will be responsible for the full charge\*\**

- I understand that failure to provide insurance or supplemental coverage information in a timely manner will result in my being responsible for full payment for my services.
- I understand that I am responsible for providing up-to-date and accurate insurance information and that a change in my insurance plan could result in a full fee charge/change in payment or change in provider.
- I understand that Syntero will bill my insurance carrier as a courtesy, but that I am responsible for understanding my own benefits and ensuring Syntero receives payment.
- I understand that, if my insurance is considered Out of Network with Syntero and if the cost of services is higher than what my insurance will cover, my explanation of benefits (EOB) can state a zero-dollar amount Client Responsibility. However, I will still be responsible for paying the remaining balance that my insurance does not cover.
- I understand that at each visit I am expected to make a payment as a deposit toward my patient financial responsibility but that it may not be the total amount that I will be responsible for, as the total amount due is based on my insurance plan.
- I understand that if I have a high balance, services may be discontinued until a payment plan is arranged.
- I assign to Syntero any third-party benefits due from any and all insurance benefits in an amount not to exceed Syntero's regular and customary charges for services.
- I assume responsibility for determining in advance whether the services provided and the provider are covered by my insurance or other third-party payer.
- I authorize Syntero to disclose medical information as required by any third-party payers to process a claim for service.
- I understand that I am expected to keep my appointments and, if I must cancel or reschedule an appointment, I will provide as much notice as possible. **I understand that, should I have to cancel my appointment, and I am not able to give a full business day notice, I may be charged a \$25 cancellation fee.**



\_\_\_\_\_  
**Client/Parent/Guarantor/Responsible Party Signature**

\_\_\_\_\_  
**Date**



## INFORMED CONSENT ADDENDUM FOR TELEBEHAVIORAL HEALTH SERVICES

Syntero continues to monitor the latest preventative measures recommended by the Centers for Disease Control and the State of Ohio to curb the spread of the COVID-19 virus. Effective immediately, we are providing telebehavioral health services rather than face to face services at our offices.

### What is Telebehavioral Health?

Telebehavioral health includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making through the use of internet-based videoconferencing or phone calls. Services may include counseling, case management and psychiatry including the prescribing of medications.

1. Benefits include greater flexibility by geographical location, reduction of travel to a physical office and participation from your own home environment.
2. Risks include the potential breakdown in the technology including poor connection, loss of sound or loss of connection. A second factor that may impact the communication is that nonverbal cues are less readily available to both the clinician and the client.
3. All existing laws regarding privacy, confidentiality, access to mental health information, and client rights and grievance procedures apply the same as face-to-face sessions.
4. Nobody will record the session without the permission from the other person(s).
5. It is important to be in a quiet, private space that is free of distractions (including computers, additional phones, or other devices) during the session.
6. Only agreed upon participants will be present in the room of the clinician and the client during the telebehavioral health session.
7. The clinician will verify the physical address of the client's location at the start of each session. This is to ensure we are "meeting" at a place that will protect your confidentiality (e.g. No coffee shops or public places). Sessions will not occur while any of the participants are driving.
8. It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the clinician in advance by phone.
9. We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
10. We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
11. If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telebehavioral health sessions.
12. Your clinician may determine that due to certain circumstances, telebehavioral health is no longer appropriate and that we should consider alternative resources for your treatment.

Client Name	Client Signature	Date
<i>If minor: Parent/Guardian Printed Name</i>	Client or Guardian Signature	Date

\* Pursuant to Ohio Revised Code 5122.04, a minor 14 years of age or older is entitled to receive counseling services for no more than six sessions or thirty days, whichever comes first, without the consent of a parent/guardian and without that parent/guardian being informed. Pursuant to Ohio Revised Code 3719.012, individuals of any age can request and consent to substance use prevention/treatment services with no specified time limit for such services, without the consent of a parent/guardian and without that parent/guardian being informed.



**CLIENT CONTACT INFORMATION:** This form is to be completed by the client (or parent/guardian/foster if client is under 18)

Legal Name (First, M, Last)		Preferred Name:		Age:
DOB:	SSN:	Preferred Pronouns:		Gender:
Physical Address		City	State	Zip
Mailing Address		City	State	Zip
Home Phone	Cell Phone	Receive reminders at the following number		
Email				
Primary Language	Does client need interpreting services? <input type="checkbox"/> Yes, please specify: _____ <input type="checkbox"/> No			
Syntero provides training to future counselors and social workers. Is client comfortable with an intern sitting in on your sessions? <input type="checkbox"/> Yes <input type="checkbox"/> No				

**DEMOGRAPHIC INFORMATION:** The information collected used for internal reports and state reporting.

<b>Race:</b>				
<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Black/African-American	<input type="checkbox"/> Two or More Races		
<input type="checkbox"/> American Indian	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Unknown		
<input type="checkbox"/> Asian	<input type="checkbox"/> Other Single Race	<input type="checkbox"/> White		
<b>Ethnicity:</b>				
<input type="checkbox"/> Cuban	<input type="checkbox"/> Mexican	<input type="checkbox"/> Other Hispanic	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Hispanic Not Specified	<input type="checkbox"/> Not of Hispanic/Latino Origin	<input type="checkbox"/> Puerto Rican		
<b>Client's Living Arrangements:</b>				
<input type="checkbox"/> Community Residence	<input type="checkbox"/> Foster Care	<input type="checkbox"/> Other	<input type="checkbox"/> Residential Care	
<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Homeless	<input type="checkbox"/> Permanent Housing	<input type="checkbox"/> Temporary Housing	
<input type="checkbox"/> DD/Operated Facility	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Private Residence	<input type="checkbox"/> Unknown	
<b>Client's marital status:</b>				
<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed		
<input type="checkbox"/> Married (Or living Together)	<input type="checkbox"/> Single (Never Married)	<input type="checkbox"/> Unknown		
<b>Military Status:</b> <input type="checkbox"/> Active <input type="checkbox"/> Disabled Veteran <input type="checkbox"/> Discharged <input type="checkbox"/> None				
<b>Military Service:</b> <input type="checkbox"/> Overseas <input type="checkbox"/> Reserve				
<b>Tobacco Use?</b> <input type="checkbox"/> User <input type="checkbox"/> Non-User				
<b>Smoking Status:</b> <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoked				
<b>Current or highest level of education</b>				
<input type="checkbox"/> <1 <sup>st</sup> Grade	<input type="checkbox"/> 4 <sup>th</sup> Grade	<input type="checkbox"/> 8 <sup>th</sup> Grade	<input type="checkbox"/> High School/GED	<input type="checkbox"/> 4yr College Degree
<input type="checkbox"/> 1 <sup>st</sup> Grade	<input type="checkbox"/> 5 <sup>th</sup> Grade	<input type="checkbox"/> 9 <sup>th</sup> Grade	<input type="checkbox"/> Tech School	<input type="checkbox"/> Graduate Degree
<input type="checkbox"/> 2 <sup>nd</sup> Grade	<input type="checkbox"/> 6 <sup>th</sup> Grade	<input type="checkbox"/> 10 <sup>th</sup> Grade	<input type="checkbox"/> Some College	<input type="checkbox"/> Unknown
<input type="checkbox"/> 3 <sup>rd</sup> Grade	<input type="checkbox"/> 7 <sup>th</sup> Grade	<input type="checkbox"/> 11 <sup>th</sup> Grade	<input type="checkbox"/> 2yr College Degree	

**HOUSEHOLD MEMBERS:** Please include anyone also living in the house. Additional space provided in the ADDITIONAL INFORMATION.

Name	Relationship	Birthdate	Age

**EMERGENCY CONTACT INFORMATION:** In case of emergency, Syntero has my permission to notify

Name:	Relationship:
Address:	Phone Number:

**HEALTH HISTORY QUESTIONNAIRE:** This form is to be completed by client and/or parent/guardian/foster parent (if client is under 18) and reviewed by medical or clinical staff.

Has the client had any of the following health problems? (If never, leave blank)	Now	Past	If you received treatment add the type and date(s)
1. AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	
2. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
3. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
4. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
5. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
6. Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
7. Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
8. Blood Pressure (high or low)	<input type="checkbox"/>	<input type="checkbox"/>	
9. Bone/Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	
10. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
11. Cirrhosis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
12. Depression	<input type="checkbox"/>	<input type="checkbox"/>	
13. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
14. Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
15. Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
16. Eye Disease/Blindness	<input type="checkbox"/>	<input type="checkbox"/>	
17. Fibromyalgia/Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	
18. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
19. Head Injury/Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	
20. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
21. Hearing Issues/Deafness	<input type="checkbox"/>	<input type="checkbox"/>	
22. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
23. Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	
24. Hyperactivity/ADD	<input type="checkbox"/>	<input type="checkbox"/>	
25. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
26. Learning Problems	<input type="checkbox"/>	<input type="checkbox"/>	
27. Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
28. Menstrual Pain	<input type="checkbox"/>	<input type="checkbox"/>	
29. Oral Health/Dental	<input type="checkbox"/>	<input type="checkbox"/>	
30. Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	
31. Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>	
32. STD	<input type="checkbox"/>	<input type="checkbox"/>	
33. Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
34. Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>	
35. Stomach/Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	
36. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
37. Suicide Attempts Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	
38. Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
39. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
40. Other	<input type="checkbox"/>	<input type="checkbox"/>	

Please note family history of any of the above conditions and client's relationship to that family member.

Do you have a healthcare advanced directive?  Yes  No  
If Yes, please provide a copy.

**NUTRITIONAL SCREENING:** Please check box if there have been any recent changes

Height: _____ft _____in	Height changed within past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Yes, how much?
Weight: _____lbs.	Weight changed within past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Yes, how much?
Has your thirst:	<input type="checkbox"/> Decreased <input type="checkbox"/> Increased	<input type="checkbox"/> No change
Has your appetite:	<input type="checkbox"/> Decreased <input type="checkbox"/> Increased	<input type="checkbox"/> No change
Do any apply?	<input type="checkbox"/> Nausea <input type="checkbox"/> Special diet? Please Specify: _____	<input type="checkbox"/> Vomiting
	<input type="checkbox"/> Picky Eater <input type="checkbox"/> Trouble chewing or swallowing	

**PAIN SCREENING**

Does pain currently interfere with your activities? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the source of the pain and the treatment regimen?
If yes, how much does it interfere with your activities?
<input type="checkbox"/> Extremely <input type="checkbox"/> Mildly <input type="checkbox"/> Moderately <input type="checkbox"/> Severely <input type="checkbox"/> Not at all

**PREGNANCY AND MENSTRUAL HISTORY** ( does not apply)

Currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, expected delivery date:
Currently breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any significant pregnancy history?
Age at first menstrual period?	
Last menstrual period:	

**ALLERGIES OR DRUG SENSITIVITIES** If you have any of the following please check and specify as best you can: ( None)

<input type="checkbox"/> Food:
<input type="checkbox"/> Medication:
<input type="checkbox"/> Other:

**IMMUNIZATIONS:** Only required for children or individuals with developmental delays.

<input type="checkbox"/> 1. Chicken Pox	<input type="checkbox"/> 3. German Measles	<input type="checkbox"/> 5. Measles	<input type="checkbox"/> 7. Polio	<input type="checkbox"/> 9. Tetanus
<input type="checkbox"/> 2. Diphtheria	<input type="checkbox"/> 4. Hepatitis B	<input type="checkbox"/> 6. Mumps	<input type="checkbox"/> 8. Small Pox	<input type="checkbox"/> 10. Other:

**LAST PHYSICAL EXAMINATION:** (Client does not have a Primary Care Physician )

Primary Care Doctor	Phone number
Address/Location	Date of last visit
Has the client had any of the following symptoms in the past 60 days?	
<input type="checkbox"/> 1. Ankle Swelling	<input type="checkbox"/> 14. Hair Change
<input type="checkbox"/> 2. Bed-wetting	<input type="checkbox"/> 15. Hearing Loss
<input type="checkbox"/> 3. Blood in stool	<input type="checkbox"/> 16. Lightheadedness
<input type="checkbox"/> 4. Breathing Difficulty	<input type="checkbox"/> 17. Memory Problems
<input type="checkbox"/> 5. Chest Pain	<input type="checkbox"/> 18. Mole/Wart Changes
<input type="checkbox"/> 6. Confusion	<input type="checkbox"/> 19. Muscle Weakness
<input type="checkbox"/> 7. Loss of Consciousness	<input type="checkbox"/> 20. Nervousness
<input type="checkbox"/> 8. Constipation	<input type="checkbox"/> 21. Nosebleeds
<input type="checkbox"/> 9. Coughing	<input type="checkbox"/> 22. Numbness
<input type="checkbox"/> 10. Cramps	<input type="checkbox"/> 23. Panic Attacks
<input type="checkbox"/> 11. Diarrhea	<input type="checkbox"/> 24. Penile Discharge
<input type="checkbox"/> 12. Falling	<input type="checkbox"/> 25. Pulse Irregularity
<input type="checkbox"/> 13. Gait Unsteadiness	<input type="checkbox"/> 26. Seizures
	<input type="checkbox"/> 27. Shakiness
	<input type="checkbox"/> 28. Sleep Problems
	<input type="checkbox"/> 29. Night Sweats
	<input type="checkbox"/> 30. Swelling
	<input type="checkbox"/> 31. Tingling in limbs
	<input type="checkbox"/> 32. Tremor
	<input type="checkbox"/> 33. Urination Difficulty
	<input type="checkbox"/> 34. Vaginal Discharge
	<input type="checkbox"/> 35. Vision Changes
	<input type="checkbox"/> 36. Vomiting
	<input type="checkbox"/> 37. Other:
	<input type="checkbox"/> 38. Other

**HOSPITALIZATIONS:** Has the client had medical hospitalizations/surgical procedures in the last 3 years? Additional space provided in the **ADDITIONAL INFORMATION** page

Hospital	City	Date	Reason

**SUBSTANCE USE HISTORY/CURRENT USE:** Please check all that apply

Substance	No Use	Past Use	Current Use	Substance	No Use	Past Use	Current Use
1. Alcohol, Beer, Wine				7. Inhalants			
2. Anxiety Medication				8. Marijuana			
3. Cocaine, Crack				9. Pain Medication			
4. Hallucinogens				10. Sleep Medications			
5. Hashish				11. Stimulants			
6. Heroin				12. Other			
Caffeine use:		<b>If yes, from where</b>		<b>How much a week?</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		(i.e. coffee, tea, pop, etc.):		(i.e. cups, cans, bottles, etc.):			
Tobacco use:		<b>If yes, from:</b>		<b>How much a week?</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		(i.e. packs, cartridges, etc.)		(i.e. cigarettes, smokeless, etc.)			

**LIST OF CURRENT MEDICATIONS:** List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (i.e. Viagra, Albuterol, Nitroglycerin, etc.)

Medication	Dose	Frequency	Reason	Start date	Prescriber

**ADDITIONAL INFORMATION:** Include here additional information you wish your clinician to know.

**If the document was completed by a Parent/Guardian/Custodian:**

Name	Address
Signature	Phone number

**FOR STAFF USE ONLY:**

Clinical Reviewer Comment (if any):	
Clinical Signature and Credentials	Date

**CLIENT QUESTIONNAIRE:** Please complete the following questions. Your responses will be very helpful in understanding why you have chosen to be involved in treatment at this time and what you would like to achieve in the process.

1. Please describe the issue(s) that brings you and/or your child here. Be as specific as you can. Try to include such details as the duration of the problem, how often it occurs, and under what circumstances

2. How does this interfere with your or your child's life? Who else is being affected?

3. If treatment is successful, how will life be different for you and/or your child? (What are your goals for treatment?)

4. Please tell us about your family's culture, beliefs, practices, and traditions.

5. Are there any special needs or preferences you have?

6. How did you hear about Syntero?





**PATIENT HEALTH QUESTIONNAIRE 9**

Only for clients over the age of 11

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's date: \_\_\_\_\_

Never or Almost Never    Rarely    Sometimes    Frequently    Almost Always or Always

**PURPOSE:** The Y-OQ® 30.2 is designed to describe a wide range of situations, behaviors, and moods that are common to children and adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank but mark the “Never or almost never” category. When you begin to complete the Y-OQ® 30.2 you will see that you can easily make your child look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

**DIRECTIONS:**

- Read each statement carefully.
- Decide how true this statement is during the **past 7 days**.
- Completely fill the circle that most accurately describes the past week.
- Fill in only one answer for each statement and erase unwanted marks clearly.

Please mark your answers like this:



Not like this:



- |   |                       |                       |                       |                       |                       |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. My child has headaches or feels dizzy.   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. My child doesn't participate in activities that used to be fun.....                                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. My child argues or speaks rudely to others.  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. My child has a hard time finishing assignments or does..... them carelessly.                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. My child's emotions are strong and change quickly.   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. My child has physical fights (hitting, kicking, biting, scratching) with family or others his/her age. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. My child worries and can't get thoughts out of his/her mind.   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. My child steals or lies.....   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. My child is has a hard time sitting still (or has too much energy).                                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. My child uses alcohol or drugs.....   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. My child seems tense and easily startled (jumpy).   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. My child is sad or unhappy.....   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. My child has a hard time trusting friends, family members, or other adults.                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14. My child thinks that others are trying to hurt him/her even ..... when they're not.                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15. My child has threatened to, or has run away from home.  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. My child physically fights with adults.....   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17. My child's stomach hurts or feels sick more than others his/her age.                                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18. My child doesn't have friends or doesn't keep friends very long...                                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19. My child thinks about suicide or feels s/he would be better off dead.                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20. My child has nightmares, trouble getting to sleep, oversleeping, or waking up too early.              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 21. My child complains or questions rules, expectations, or responsibilities.                             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22. My child breaks rules, laws, or doesn't meet others expectations on purpose                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23. My child feels irritated  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24. My child gets angry enough to threaten others.....  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25. My child gets into trouble when he/she is bored.  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. My child destroys property on purpose.....  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27. My child has a hard time concentrating, thinking clearly, or sticking to tasks.                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28. My child withdraws from family and friends.....   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29. My child acts without thinking & doesn't worry about what will happen                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30. My child feels like s/he doesn't have any friends and that no one likes them                          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Developed by:  
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