SYNTERO, INC SERVICE AGREEMENT

Client Name: _____ Date of Birth: _____
(Please Print)

Guarantor/Responsible Party Name: _____ Date of Birth: _____
(Please Print)

2021 Standard Rates

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

Service Type:	Rates:
Diagnostic assessment	$153 per clinical hour
Individual psychotherapy	$132 per clinical hour
Psychiatric assessment	$249 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 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 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 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.**

Sign _____ _____
Guarantor/Responsible Party Signature **Date**

SYNTERO, INC
SERVICE AGREEMENT
SUBSIDY/REDUCED FEE

Client Name: _____ **Date of Birth:** _____ **SSN:** _____
(Please print)

Guarantor/Responsible Party: _____ **Date of Birth:** _____
(Please print)

2021 Standard Rates
**subject to change-updates are posted in our agency lobbies*

Service Type:	Rates:
Diagnostic assessment	$153 per clinical hour
Individual psychotherapy	$132 per clinical hour
Psychiatric assessment	$249 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

Please complete this form to apply for a subsidized or reduced fee. We are required to gather proof of income and proof of residence to establish eligibility for the subsidy. **We must have documented proof of income and residency within 30 days of your first appointment**, if we do not have this documentation after 30 days you will be billed the full fee for services provided.

Required for Subsidy: What county do you reside in (please circle)? Franklin, Delaware, Morrow County, Other: _____

Number of dependents, including yourself:		_____
Monthly gross income:		_____
Spouse's monthly gross income:		_____
Other income:	Social Security/SSI/SSDI	_____
	Workers' Compensation	_____
	Unemployment	_____
	Pension	_____
	Alimony	_____
	Other taxable income	_____
TOTAL MONTLY INCOME:		_____

I, the undersigned client or responsible party for the person receiving services, do hereby declare that this information is true and includes income received from all sources. I will notify Syntero if my financial circumstances change and I understand the fee quoted is an estimate and could change.

_____
Signature

_____
Date

_____ INITIALS

You are expected to make payment at the time of each visit to assure the balance of your account does not become a financial burden. If you have a high balance, we may discontinue services until a payment plan has been arranged. Any insurance checks that you may receive must be submitted to the billing department. Any time the combination of your payment plus insurance collections exceed the cost of providing services, a refund or credit will be made to you. ***If you have to cancel your appointment, you must give 24 hours' notice to avoid being charged $25.00 for the session. Please note that insurance companies will not cover the cost of canceled appointments***

_____ INITIALS

I understand that County Subsidies are a payer of last resort. If I have insurance coverage and choose not to use that coverage, I do not have access to any INITIALS subsidy and will be required to pay the full costs of services at each appointment. I understand that I have an obligation to notify Syntero should my address, employment, and/or insurance coverage change and if I do not provide documentation of income and residency within 30 days that I will be required to pay the full cost of services.

_____ INITIALS

I understand that each visit I am making a payment as a deposit toward my patient financial responsibility and it may not be the total amount I will be responsible for. The total patient responsibility is based on benefit information from the County Board received at the time of remittance from that payer.

_____ INITIALS

I understand that If it has been determined that I am eligible for a subsidy and I have insurance I will be responsible for my co-pay/co-insurance/deductible unless my assessed subsidized fee is less than my co-pay/co-insurance/deductible. The subsidy will only be used if my assessed fee and the insurance payments do not cover the full cost of service.

Sign

_____
Client/Parent/Guardian Signature

_____
Date

_____
Syntero Employee Initials

ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING OF SYNTERO POLICIES AND CONSENT FOR TREAMENT

- ❖ I hereby certify that Syntero has provided me with copies of:
  - Client & Family Rights
  - Financial Policies
  - Privacy Notice including a summary of 42 CFR Part 2 Laws and Regulations
  - Orientation to Rules, Expectations, and Risks/Benefits of Treatment
  - Agency maps
  - Information regarding exposure and transmission of infectious diseases
- ❖ 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**

_____ _____
Signature of Parent/ Legal Guardian **Date**

<u>For a Minor Seeking Treatment without Parental Consent:</u>

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

Syntero
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. The benefits of telebehavioral health include greater flexibility by geographical location, reduction of travel to a physical office and participation from your own home environment.

2. The risks of telebehavioral health 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** _____

If minor: Parent/Guardian Printed Name _____ If minor: 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 parent if client is under 18)

Legal Name (First, M, Last)		**Preferred Name**		**Age**
Date of Birth (MM/DD/YYYY)	**Social Security Number**	**Preferred Gender Pronouns**		**Gender**
Physical Address		**City**	**State**	**Zip**
Mailing Address		**City**	**State**	**Zip**
Home Phone	**Cellphone**	**Client would like to receive appointment reminders at the following number:**		

Check if OK to leave detailed voicemails otherwise leave blank ☐ **Home Phone** ☐ **Cellphone**

Syntero sends surveys to gather input on our services and updates regarding our services.
Please indicate if OK to email survey links ☐ **No** ☐ **Yes**
Indicate if OK to send emails regarding Syntero updates ☐ **No** ☐ **Yes**

Email

Military Status:
☐ None ☐ Active ☐ Reserve ☐ National Guard ☐ Veteran ☐ Disabled

Primary language	**Does client need interpreting services?** ☐ No ☐ Yes, please specify:

Syntero provides training to future counselors and social workers.
Is client comfortable with an intern sitting in on your sessions? ☐ No ☐ Yes

DEMOGRAPHIC INFORMATION

Client's marital status:
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Other_____

Race:
☐ Alaskan Native ☐ Multiple Race ☐ Unknown
☐ Asian ☐ Native American ☐ White
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____

Ethnicity:
☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Not Hispanic/Latino ☐ Other Hispanic

HOUSEHOLD MEMBERS

Please include anyone living in the house. Additional space provided in the ADDITIONAL INFORMATION page.

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	☐	☐	
2. Anemia	☐	☐	
3. Anxiety	☐	☐	
4. Arthritis	☐	☐	
5. Asthma	☐	☐	
6. Bipolar Disorder	☐	☐	
7. Bleeding Disorder	☐	☐	
8. Blood Pressure (high or low)	☐	☐	
9. Bone/Joint Problems	☐	☐	
10. Cancer	☐	☐	
11. Cirrhosis/Liver Disease	☐	☐	
12. Depression	☐	☐	
13. Diabetes	☐	☐	
14. Eating Disorder	☐	☐	
15. Epilepsy/Seizures	☐	☐	
16. Eye Disease/Blindness	☐	☐	
17. Fibromyalgia/Muscle Pain	☐	☐	
18. Glaucoma	☐	☐	
19. Head Injury/Brain Tumor	☐	☐	
20. Headaches	☐	☐	
21. Hearing Problems/Deafness	☐	☐	
22. Heart Disease	☐	☐	
23. Hepatitis/Jaundice	☐	☐	
24. Hyperactivity/ADD	☐	☐	
25. Kidney Disease	☐	☐	
26. Learning Problems	☐	☐	
27. Lung Disease	☐	☐	
28. Menstrual Pain	☐	☐	
29. Oral Health/Dental	☐	☐	
30. Schizophrenia	☐	☐	
31. Sexual Problems	☐	☐	
32. Sexual Transmitted Disease	☐	☐	
33. Sleep Disorder	☐	☐	
34. Speech Problems	☐	☐	
35. Stomach/Bowel Problems	☐	☐	
36. Stroke	☐	☐	
37. Suicide Attempts/Thoughts	☐	☐	
38. Thyroid	☐	☐	
39. Tuberculosis	☐	☐	
40. Other	☐	☐	
41. Other	☐	☐	

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

NUTRITIONAL SCREENING Please check box if there have been any recent changes				
Height	ft. in	Height changed within past year?	☐Yes ☐No	If yes, by how much? (+ or -)
Weight	lbs.	Weight changed within past year?	☐Yes ☐No	If yes, by how much? (+ or -)
Has your thirst:	☐ Decreased	☐ Increased	☐ No change	
Has your appetite:	☐ Decreased	☐ Increased	☐ No change	
Do any of the following apply?	☐ Nausea	☐ Special diet? Please Specify:		☐ Vomiting
	☐ Picky Eater	☐ Trouble chewing or swallowing		

PAIN SCREENING
Does pain currently interfere with your activities? ☐ Yes ☐ No
If yes, what is the source of the pain and the treatment regimen?
If yes, how much does it interfere with your activities? ☐ Extremely ☐ Mildly ☐ Moderately ☐ Severely ☐ Not at all

PREGNANCY AND MENSTRUAL HISTORY (☐ does not apply)	
Currently pregnant? ☐Yes ☐No	If yes, expected delivery date:
Currently breastfeeding? ☐Yes ☐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:
☐ 1.None
☐ 2.Food:
☐ 3.Medication:
☐ 4.Other:

IMMUNIZATIONS Only required for children or individuals with developmental delays.		
☐ 1. Chicken Pox	☐ 5. Measles	☐ 8. Small Pox
☐ 2. Diphtheria	☐ 6. Mumps	☐ 9. Tetanus
☐ 3. German Measles	☐ 7. Polio	☐ 10. Other
☐ 4. Hepatitis B		

LAST PHYSICAL EXAMINATION

Client does not have a Primary Care Doctor ☐

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?

☐ 1. Ankle Swelling	☐ 14. Hair Change	☐ 27. Shakiness
☐ 2. Bed-wetting	☐ 15. Hearing Loss	☐ 28. Sleep Problems
☐ 3. Blood in stool	☐ 16. Lightheadedness	☐ 29. Night Sweats
☐ 4. Breathing Difficulty	☐ 17. Memory Problems	☐ 30. Swelling
☐ 5. Chest Pain	☐ 18. Mole/Wart Changes	☐ 31. Tingling in limbs
☐ 6. Confusion	☐ 19. Muscle Weakness	☐ 32. Tremor
☐ 7. Loss of Consciousness	☐ 20. Nervousness	☐ 33. Urination Difficulty
☐ 8. Constipation	☐ 21. Nosebleeds	☐ 34. Vaginal Discharge
☐ 9. Coughing	☐ 22. Numbness	☐ 35. Vision Changes
☐ 10. Cramps	☐ 23. Panic Attacks	☐ 36. Vomiting
☐ 11. Diarrhea	☐ 24. Penile Discharge	☐ 37. Other:
☐ 12. Falling	☐ 25. Pulse Irregularity	☐ 38. Other
☐ 13. Gait Unsteadiness	☐ 26. Seizures	

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	Substance	No Use	Past Use	Current Use
Alcohol/Beer/Wine				Hashish				Pain Medication			
Anxiety Medication				Heroin				Sleep Medications			
Cocaine/Crack				Inhalants				Stimulants			
Hallucinogens				Marijuana				Other			

Caffeine use: ☐ Yes ☐ No	**If yes, from:** (I.e. coffee, tea, pop, etc.)	**How much a week?** (I.e. cups, cans, bottles, etc.)
Tobacco use: ☐ Yes ☐ No	**If yes, from:** (I.e. cigarettes, smokeless, etc).	**How much a week?** (I.e. packs, cartridges, 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 (like Viagra, Albuterol, Nitroglycerin, etc.)

Medication	Dose	Frequency	Reason	Start date	Prescriber

ADDITIONAL INFORMATION

Feel free to use this space to include 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/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

Name: _____ Date of birth: _____ Today's date: _____

DISCLOSURE INFORMATION/RELEASE TO ACCESS FUNDS FOR SUBSIDIZED FEE

When a client qualifies for a subsidized fee (i.e. **Sliding Fee Service Agreement**), we must submit your name, address, and social security number to the claims payment system for the county where you reside, in order to receive reimbursement for services provided.

To protect your confidentiality, federal law (42CFR Part 2) stipulates that we can only release this information with your authorization. The purpose of this authorized release is to determine your eligibility for subsidy funds and to allow Syntero to be reimbursed for your treatment. The information will be disclosed to the State of Ohio and the ADAMH Board of Franklin County or the Delaware-Morrow County Mental Health and Recovery Services Board, depending on your county of residence. Identifying information will only be used to generate payments. Demographic information will be kept without any name attached and reported to Ohio Health Care Data Center, the State of Ohio, and the Board for your county. The information will not be available to any other sources or used for other purposes. Billing information will be kept in a secured facility or network for seven years after treatment ends. Only demographic information will be kept at that time.

If you reside in Franklin County, outcome data utilizing the Outcome Questionnaire (OQ) is shared with the ADAMH Board of Franklin County. Information is shared with the Board to verify outcome measures are completed by those who receive subsidized services. In addition, they are able to access general reports measuring the effectiveness of our services.

If you want more information about the county boards, our billing process, or confidentiality, please ask to speak to our Client Rights Advocate, she will gladly answer any questions.

You may revoke authorization for release of this information at any time. However, this would mean losing access to subsidy funds. If it is not revoked, your authorization will terminate when your last date of service provided has been billed and payment has been received.

Without an authorization for release of information, you will not be eligible for a public subsidized fee and will need to pay the full fee for services.

My signature below acknowledges my understanding and authorization for disclosure of information necessary to access funds for subsidized fees.

Sign

_____
Client Name

_____
Client Signature **Date**

_____
If client is a minor, signature of Parent/Guardian **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

Youth Outcome Questionnaire Name: _____ **ID:** _____ **Date:** ____/____/_____

Y-OQ®-30.2 English Youth Parent Form

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:

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. My child has headaches or feels dizzy.	O	O	O	O	O
2. My child doesn't participate in activities that used to be fun…….	O	O	O	O	O
3. My child argues or speaks rudely to others.	O	O	O	O	O
4. My child has a hard time finishing assignments or does…….. them carelessly.	O	O	O	O	O
5. My child's emotions are strong and change quickly.	O	O	O	O	O
6. My child has physical fights (hitting, kicking, biting, scratching) with family or others his/her age.	O	O	O	O	O
7. My child worries and can't get thoughts out of his/her mind.	O	O	O	O	O
8. My child steals or lies…….....	O	O	O	O	O
9. My child is has a hard time sitting still (or has too much energy).	O	O	O	O	O
10. My child uses alcohol or drugs…….	O	O	O	O	O
11. My child seems tense and easily startled (jumpy).	O	O	O	O	O
12. My child is sad or unhappy……...	O	O	O	O	O
13. My child has a hard time trusting friends, family members, or other adults.	O	O	O	O	O
14. My child thinks that others are trying to hurt him/her even …….. when they're not.	O	O	O	O	O
15. My child has threatened to, or has run away from home.	O	O	O	O	O
16. My child physically fights with adults……	O	O	O	O	O
17. My child's stomach hurts or feels sick more than others his/her age.	O	O	O	O	O
18. My child doesn't have friends or doesn't keep friends very long...	O	O	O	O	O
19. My child thinks about suicide or feels s/he would be better off dead.	O	O	O	O	O
20. My child has nightmares, trouble getting to sleep, oversleeping, or waking up too early.	O	O	O	O	O
21. My child complains or questions rules, expectations, or responsibilities.	O	O	O	O	O
22. My child breaks rules, laws, or doesn't meet others expectations on purpose	O	O	O	O	O
23. My child feels irritated	O	O	O	O	O
24. My child gets angry enough to threaten others…….……....	O	O	O	O	O
25. My child gets into trouble when he/she is bored.	O	O	O	O	O
26. My child destroys property on purpose…….....	O	O	O	O	O
27. My child has a hard time concentrating, thinking clearly, or sticking to tasks.	O	O	O	O	O
28. My child withdraws from family and friends……....	O	O	O	O	O
29. My child acts without thinking & doesn't worry about what will happen	O	O	O	O	O
30. My child feels like s/he doesn't have any friends and that no one likes them	O	O	O	O	O

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