

FOR OFFICE USE ONLY

DATE: _____

CID _____ NEW REOPEN UPDATE THERAPIST: _____

PHONE: _____ (HOME) _____ (CELL) _____ (WORK)

NAME: _____
LAST FIRST MIDDLE MAIDEN

ADDRESS: _____
STREET/ROUTE APT./P.O. BOX CITY STATE ZIP CODE

COUNTY: _____ DATE OF BIRTH: _____ SEX: _____

PRIMARY RACE _____ SECONDARY RACE _____ VETERAN: YES _____ NO

ENGLISH PROFICIENCY _____ MOTHER'S FIRST NAME: _____ RELIGION: _____

MARITAL STATUS: NEVER MARRIED _____ MARRIED _____ SEPARATED _____ DIVORCED _____ WIDOWED _____

REFERRAL SOURCE: _____ LEGAL GUARDIAN'S NAME: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL: _____

ADDRESS: _____

FAMILY MEMBERS PRESENTLY LIVING IN YOUR HOUSEHOLD:

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	EMPLOYER

** IF HOMELESS, CHOOSE ONE OF THE FOLLOWING: _____ CONTINUALLY HOMELESS FOR A YEAR OR MORE
_____ 4 OR MORE EPISODES OF HOMELESSNESS IN THE LAST 3 YEARS _____ HOMELESS BUT 1 OR 2 NOT APPLICABLE

EDUCATION (LAST YEAR COMPLETED) _____ SPOUSE'S EDUCATION _____

YOUR OCCUPATION: _____ EMPLOYER: _____

SPOUSE'S OCCUPATION: _____ EMPLOYER: _____

ARE YOU EMPLOYED NOW? YES _____ NO _____ FULL-TIME _____ PART-TIME _____

DURATION OF EMPLOYMENT _____ TOTAL JOINT YEARLY INCOME _____

SOURCE OF INCOME _____

SOCIAL SECURITY #: _____ MEDICARE #: _____

MEDICAID #: _____ INSURANCE COMPANY NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

PHYSICIAN: _____ DATE OF LAST PHYSICAL: _____

ARE YOU CURRENTLY PREGNANT? YES _____ NO _____ PREVIOUS PSYCHIATRIC HOSPITALIZATION: YES _____ NO

WHERE: _____ ADMISSION DATE: _____ DISCHARGE DATE: _____

PREVIOUS COUNSELING: YES _____ NO _____ WHERE: _____ DATES: _____

CURRENT MEDICATIONS: _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? _____

OFFICE USE ONLY

Private Pay Insurance	County City	Medicare TXIX	FeeMod/ Means	CID _____ EAP	APPLE _____ MAC _____
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DAKOTA COUNSELING INSTITUTE

CLIENT INSURANCE INFORMATION

Medicare Number: _____

Medicaid Number: _____

Health Insurance Company Name: _____

Insurance Company address: _____

Policy Number: _____ Group Number: _____

Insured's Name (Policyholder): _____

Insured's Date of Birth: _____

Insured's Address: _____

I authorize my health care provider to release information requested on my insurance form. I authorize payment of any benefits directly to Dakota Counseling Institute. I understand that I am fully responsible for any charges that are not covered by my insurance policy. This authorization will remain in effect until revoked by me in writing.

Patient / Parent / Guardian Signature: _____

DAKOTA COUNSELING INSTITUTE
FINANCIAL AGREEMENT

The typical fees for service are as follows:

Outpatient Intake Therapy	\$220.00
Outpatient Therapy	\$172.00
Psychiatric Evaluation	\$285.00
Medication Management	\$156.00

These rates are subject to adjustment due to the variance in the length of sessions and/or June 1st of each year due to contractual inflation.

Any insurance coverage or changes in coverage should be reported to the front desk. Pre-authorization of services is the responsibility of the insured. Dakota Counseling Institute is unable to guarantee payment by the insurance company due to the individuality of each plan. Some reasons for denial may be pre-existing condition, non-covered diagnosis, or no mental health benefits. The agency will assist with the filing of insurance, but all charges are the responsibility of the client from the date the service is rendered. As a reminder, your insurance contract is between you, your employer when applicable, and the insurance company.

Dakota Counseling Institute will work with patients on their outstanding balances as long as the payments are reasonable and regular. We accept cash, checks, Visa and MasterCard. Returned checks are subject to an additional collection fee. Balances older than 30 days are subject to interest charges of 1.5% per month.

I have read and understand the above information.

Signature of Client/Parent/Guardian

Date

Witness

Date

Dakota Counseling Institute, Inc.

About Our Notice of Privacy Practices

In compliance with the law, we are committed to protecting your personal health information.

The attached Notice of Privacy Practices state:

- Our obligation under law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this Notice and to obtain your written acknowledgment that you have received a copy of this Notice.

Patient Acknowledgment of Receipt

I, _____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices at Dakota Counseling Institute.

Client

Date

Parent/Guardian

Date

Documentation of Good Faith

- Attempted to distribute the Notice of Privacy Practices to the client/parent/legal guardian, but they declined to acknowledge receipt.
- The Notice of Privacy Practices was mailed to the client/parent/legal guardian.
- Other _____

Staff Member

Date

DAKOTA COUNSELING INSTITUTE TREATMENT CONTRACT

The following is a contract between Dakota Counseling Institute professional staff and you, the consumer, to provide treatment to you. By signing this contract, both parties acknowledge that they have read, understand and agree with the terms set forth in this document.

Informed Consent: By signing this contract, you give consent to receive treatment by DC Institute professional staff. You have a right to be informed of your diagnosis. You have the right to receive information about the nature, purpose, and risks of any tests, treatment, or procedures suggested to you. You are encouraged to ask the clinician working with you any questions you may have regarding your treatment and its potential outcome. If your treatment involves individual, group, couple, or family therapy sessions, you must understand that the issues, which brought you to seek therapy, may become worse before they get better. For example, you may feel more anxious or depressed in the beginning phases of treatment. In rare cases, you may experience loss of contact with reality, or you may experience strong suicidal intent, both of which could necessitate a period of hospitalization in a psychiatric facility. During the course of therapy, interpersonal relationships may change. If you have experienced significant trauma at some time in the past, you may experience flashbacks or a reliving of past experiences and feelings associated with these.

Confidentiality: Confidentiality means that the information you share with DC Institute and its employees will not be released to other individuals or outside agencies, with the following exceptions:

1. If you sign a release specifying to whom the information is released, what information you want released, and for what time period the release of information is valid.
2. Some insurance companies and EAP's request information about your treatment. When you sign on with an insurance company and/or EAP, you sign a waiver or a release of authorization for such information. Therefore, we will release the requested information to your insurance company and/or EAP unless you inform us in writing that you do not want us to do this. Once we receive your request in writing, all information gathered about you after the request is received will not be released to your insurance company and/or EAP. However, if you make such a request, you become solely responsible for the cost of your treatment.
3. Upon a proper court order, your records and/or the testimony of your primary mental health professional may be released.
4. All mental health professionals are mandated reporters. This means that the clinician working with you has to report child abuse or abuse of other dependent persons.
This process will follow all guidelines set forth by State Law.
5. If your primary mental health professional judges you to be a danger to yourself or others and you refuse voluntary hospitalization, necessary information will be released to outside agencies to insure your and others' safety and to insure continuity of treatment.
This process will follow all guidelines set forth by State Law.
6. Your financial obligation, name and address may be referred to outside collection agencies, including small claims court, if your account is delinquent.
7. Contact with your HMO for coordination of care.
8. If you are under the age of 18, or have a legal guardian, your parents/legal guardians have the right to obtain information about your treatment, and the right to sign releases of information to other agencies about your treatment on your behalf.
9. If services are funded, wholly or in part, through State Contract or Medicaid monies, the State of South Dakota, Division of Mental Health, will receive certain demographic information about you and may, periodically, review records to assure our compliance with contract requirements. At no time will we release your name or your address. If you have further questions about this, please ask staff.

If you receive services from more than one professional staff member of Dakota counseling Institute, members of your treatment team will likely exchange information in order to coordinate services and provide you with the best treatment available.

Grievance Procedure: Dakota Counseling Institute is committed to providing high quality mental health services through its various programs. Our goal is to provide the most effective services possible, and we want you to be satisfied with the services you receive. As is the case with any service provider, however, occasionally there will be times when a person receiving services is dissatisfied with the services provided by the agency. If you believe that you have a legitimate complaint regarding services provided to you, please try to discuss the situation or the nature of your dissatisfaction with the staff member providing services to you. Most problems are likely to be resolved at this level.

If the problem is not resolved by talking directly to the staff person providing services to you, you may submit a written explanation of your complaint to the Clinical Director of Dakota Counseling Institute. The Clinical Director will respond to your complaint verbally and in writing within 15 days of receiving it. If the problem is not resolved at this level, you may forward your complaint in writing to the Executive Director of Dakota Counseling Institute. The Executive Director will respond to your complaint verbally and in writing within 15 days of receiving it.

If you and the Executive Director do not resolve the problem to your satisfaction, you may contact the Division of Mental Health at the following address and phone number:

Division of Mental Health	Phone: 1-800-265-9684
Hillsview Properties Plaza, East Hwy 34	Fax: (605) 773-7076
c/o 500 East Capitol	
Pierre, SD 57501-5070	

I have read this treatment contract and agree with the terms set forth in this document.

_____	_____
Client	Date
_____	_____
Parent/Guardian	Date
_____	_____
Witness/Therapist	Date

Parental Consent: I, _____ parent/legal guardian of _____, hereby consent to have this child treated by Dakota Counseling Institute professional staff.

_____	_____
Parent/Legal Guardian Signature	Date
_____	_____
Witness/Therapist	Date

(Please initial)

_____ I have been provided with a copy of the Consumer's Rights.

DAKOTA COUNSELING INSTITUTE NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Dakota Counseling Institute, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding your Health Record/Information

Each time you visit Dakota Counseling Institute, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serve as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Dakota Counseling Institute, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164,522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Dakota Counseling Institute is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notices,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. You may request a copy of the current notice from any of our locations.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, contact the practice's Privacy Officer, Michelle Carpenter, Executive Director, at 605-996-9686 or at m.carpenter@dakotacounseling.net

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
US Dept of Health and Human Services
200 Independence Ave SW
Room 509F, HHH Building
Washington, DC 20201

DAKOTA COUNSELING INSTITUTE CONSUMER RIGHTS

As a consumer of Dakota Mental Health Center, your rights include, but are not limited to the following:

- The right to confidentiality and privacy of all medical records and information given in treatment.
- The right to be treated with respect and dignity.
- The right to receive treatment that is sensitive to you as an individual in a non-discriminatory manner.
- The right to actively participate in your treatment plans as well as any modification of that plan to insure your understanding and agreement with this plan.
- The right to know the reasons why a particular treatment is considered appropriate.
- The right to refuse any proposed treatment or medication unless in an emergency.
- The right to receive an explanation of diagnosis and prescribed medications and any side effects.
- The right to be fully informed of the fees for therapy.
- The right to locate alternative sources of assistance.
- The right to be informed of the volunteer or student status of a therapist.
- The right to review your case records unless conditions arise as specified by South Dakota Codified Law.
- The right to assert grievances if your rights are violated.
- The right to have access to advocacy services at any time.

To maximize beneficial consumer outcome, consumers should be aware of their responsibilities. The consumer is responsible for:

- Following recommended and agreed upon treatment plan
- Financial obligations of mental health services
- Punctuality of appointments and notification to center if unable to attend a session
- Consideration of the rights of the staff and other consumers
- Being respectful of the property of others
- Maintaining cleanliness and order
- Providing accurate medical and personal information

MICHELLE L. CARPENTER
Executive Director

ROSWITHA KONZ, M.A.
Clinical Director

JANAE OETKEN, CCDCIII
Clinical Supervisor



March 4, 2013

In our continuous effort to improve the process of requesting refills for previously prescribed medications, we have updated our policy. **All refill requests need to be made Monday thru Thursday. Refill requests are still to be called into your pharmacy, without exception.** Your pharmacist in turn will take care of receiving authorization for renewal of the medication from us.

As stated in previous communication, we recommend that you plan your refill needs carefully. You will need to plan at least 24 hours for your refill request to be processed, or the following Monday if your request was received on a Thursday. Please keep in mind that any prescriptions for controlled substances will not be renewed until 2-3 days before your refill is due.

Sincerely,

A handwritten signature in black ink, appearing to read "Roswitha Konz", written in a cursive style.

Roswitha Konz, M.A.
Clinical Director

MENTAL HEALTH

910 West Havens • Mitchell, SD 57301
605-996-9686 • fax: 605-996-1624

PATHWAY

900 West Havens • Mitchell, SD 57301
605-996-3723 • fax: 605-996-1126

STEPPING STONES

901 South Miller • Mitchell, SD 57301
605-995-8180 • fax: 605-995-8183

DAKOTA COUNSELING INSTITUTE

PARENTAL INFORMATION SHEET

CHILD: _____ TODAY'S DATE: _____

CHILD LIVES WITH:

(NAME)

(STREET ADDRESS)

(CITY/STATE/ZIP)

(TELEPHONE)

(RELATIONSHIP TO CHILD)

BIOLOGICAL
FATHER:

(NAME)

(STREET ADDRESS)

(CITY/STATE/ZIP)

(TELEPHONE)

BIOLOGICAL
MOTHER:

(NAME)

(STREET ADDRESS)

(CITY/STATE/ZIP)

(TELEPHONE)

PARENTS ARE:

(Please check one)

- married and living together married and separated
 legally divorced not married and living together
 not married and living separately

If divorced or living separately, please check one:

- both parents have legal custody
 mother's parental rights have been terminated
 father's parental rights have been terminated

INTAKE QUESTIONNAIRE – CHILD VERSION – AGES 8-12

NAME: _____ TODAY'S DATE: _____

GRADE IN SCHOOL _____

ADDRESS: _____

Who brought you to today's appointment? _____

Why does this person want you to be seen? _____

What kinds of things would you like to change about yourself or about your family? _____

What kinds of things do others say you need to change or improve upon? _____

Please answer the following questions by circling either YES or NO:

It is easy for me to make friends at school. YES / NO

I like my teacher. YES / NO

I get along with my parents most of the time. YES / NO

I sometimes wake up at night and have a hard time going back to sleep. YES / NO

I have one best friend with whom I play even outside of school. YES / NO

School work is hard for me. YES / NO

I keep thinking about bad stuff in my head. YES / NO

I worry almost all of the time. YES / NO

I think others like me. YES / NO

I think I am too fat. YES / NO

I feel safe at school. YES / NO

My brothers/sisters and I fight a lot. YES / NO

Sometimes I wish I were dead. YES / NO

Please tell us what kinds of things you like to do: _____

CIRCLE ALL THE FOLLOWING THAT DESCRIBE HOW YOU USUALLY INTERACT WITH OTHER PEOPLE:

I'M A FOLLOWER	SELF-SACRIFICING	ISOLATE MYSELF	MANIPULATIVE	CONFIDENT
COOPERATIVE	INDEPENDENT	QUIET	JOKER	ARGUMENTATIVE
EASILY HURT	I'M A LEADER	BRAGGING	SOCIABLE	RESPECTFUL

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD:

NAME	RELATIONSHIP TO YOU	AGE	DESCRIBE HOW YOU GET ALONG WITH HIM/HER
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PLEASE DESCRIBE YOUR RELATIONSHIP WITH YOUR PARENTS BY CIRCLING THOSE THAT APPLY:

WE ARGUE A LOT	THEY ARE TOO STRICT	WE JOKE AROUND TOGETHER	THEY SAY HURTFUL THINGS TO ME
I SNEAK AROUND THEM	WE EAT MEALS TOGETHER	WE ALL GO OUR OWN WAY	THEIR RULES ARE REASONABLE
THEY RESPECT ME	I RESPECT THEM	THEY YELL A LOT	THEY FIGHT ARGUE WITH EACH OTHER

I GET PHYSICALLY HURT BY THEM SOMETIMES

SCHOOL EXPERIENCE

NAME OF SCHOOL: _____ CURRENT GRADE LEVEL: _____

CURRENT GRADES (Please circle all that apply): A's B's C's D's F's

FAVORITE SUBJECT _____ LEAST FAVORITE SUBJECT _____

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING STATEMENTS

I generally like my teachers.	YES / NO
Others tease me at school.	YES / NO
I enjoy socializing with other students at lunch.	YES / NO
I skip class or a whole day of school a couple of times a month.	YES / NO
I like most of my classes.	YES / NO
I am tardy many days.	YES / NO
I felt mad enough to hurt people at school.	YES / NO
I feel respected at school.	YES / NO
I have been suspended/expelled from school in the past.	YES / NO
I enjoy extra-curricular activities.	YES / NO
School is very stressful for me.	YES / NO

INTAKE QUESTIONNAIRE – ADOLESCENT VERSION – AGES 13-17

NAME: _____ SEX: M F AGE: _____ DATE: _____

What are your reasons for coming in today? _____

What are your parents'/legal guardians' reasons for bringing you in today? _____

Please check any of the following experiences you have had during the past month:

- | | | |
|---|--|--|
| <input type="checkbox"/> SAD, BLUE OR DEPRESSED | <input type="checkbox"/> ANXIETY/WORRYING | <input type="checkbox"/> SUDDEN PANIC OR FEAR |
| <input type="checkbox"/> UNABLE TO HAVE FUN | <input type="checkbox"/> LESS NEED FOR SLEEP | <input type="checkbox"/> GETTING INTO FIGHTS |
| <input type="checkbox"/> FEELING WORTHLESS/HOPELESS | <input type="checkbox"/> CANNOT STAY FOCUSED | <input type="checkbox"/> INTRUSIVE THOUGHTS |
| <input type="checkbox"/> FEELINGS OF GUILT | <input type="checkbox"/> FEEL BETTER THAN USUAL | <input type="checkbox"/> CONFUSED THINKING |
| <input type="checkbox"/> I FEEL FAT/OVERWEIGHT | <input type="checkbox"/> RESTLESSNESS | <input type="checkbox"/> NIGHTMARES |
| <input type="checkbox"/> DIFFICULTY FALLING ASLEEP | <input type="checkbox"/> WORRY ALL THE TIME | <input type="checkbox"/> IRRITABLE WITH PARENTS |
| <input type="checkbox"/> DIFFICULTY STAYING ASLEEP | <input type="checkbox"/> MY THOUGHTS ARE RACING | <input type="checkbox"/> HEARING VOICES IN MY HEAD |
| <input type="checkbox"/> I WISH I WERE DEAD | <input type="checkbox"/> I CAN'T SIT STILL | <input type="checkbox"/> SEEING THOUGHTS |
| <input type="checkbox"/> USE OF ALCOHOL | <input type="checkbox"/> USE OF CIGARETTES | <input type="checkbox"/> USE OF OTHER DRUGS |
| <input type="checkbox"/> FEEL ANGRY A LOT | <input type="checkbox"/> I DON'T LIKE MYSELF | <input type="checkbox"/> I THINK I AM DUMB/STUPID |
| <input type="checkbox"/> GETTING TEASED AT SCHOOL | <input type="checkbox"/> GETTING BULLIED AT SCHOOL | <input type="checkbox"/> NO FRIENDS AT SCHOOL |
| <input type="checkbox"/> THROW UP AFTER I EAT | <input type="checkbox"/> FELT LIKE HURTING SOMEONE | <input type="checkbox"/> LOST/GAINED WEIGHT |

ARE YOU A VICTIM OF ABUSE? (CIRCLE YES OR NO)

- | | |
|--|----------|
| Has anyone ever touched you in your private parts? | YES / NO |
| If yes, have you told anyone about it? | YES / NO |
| Has an adult ever hit, kicked or otherwise hurt you? | YES / NO |
| If yes, have you told anyone about it? | YES / NO |
| Does someone say things to you everyday that make you feel bad inside? | YES / NO |
| Have you seen adults hit or fight in your home? | YES / NO |

CIRCLE ALL THE FOLLOWING THAT APPLY TO YOUR SOCIAL EXPERIENCE:

- | | | |
|----------------------------------|--------------------------------|--------------------------------------|
| ONE BEST FRIEND | DRUG USE WITH FRIENDS | SLUFFING SCHOOL |
| WITHDRAWN FROM SOCIAL SCENE | PHYSICAL VIOLENCE WITH FRIENDS | SEXUAL RELATIONSHIPS |
| PARTYING | GANG RELATED ACTIVITY | SPORTS RELATED ACTIVITY |
| SCHOOL DANCES | GOING TO MOVIES WITH FRIENDS | FEW FRIENDS |
| GOING TO THE GYM | DATING | BREAKING RULES |
| GETTING HURT | SHOWING OFF FOR PEOPLE | |
| WORRIED OR ANXIOUS AROUND PEOPLE | | DESTRUCTION OF PROPERTY WITH FRIENDS |

CIRCLE ALL THE FOLLOWING THAT DESCRIBE HOW YOU USUALLY INTERACT WITH OTHER PEOPLE:

I'M A FOLLOWER	SELF-SACRIFICING	ISOLATE MYSELF	MANIPULATIVE	CONFIDENT
COOPERATIVE	INDEPENDENT	QUIET	JOKER	ARGUMENTATIVE
EASILY HURT	I'M A LEADER	BRAGGING	SOCIABLE	RESPECTFUL

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD:

NAME	RELATIONSHIP TO YOU	AGE	DESCRIBE HOW YOU GET ALONG WITH HIM/HER
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PLEASE DESCRIBE YOUR RELATIONSHIP WITH YOUR PARENTS BY CIRCLING THOSE THAT APPLY:

WE ARGUE A LOT	THEY ARE TOO STRICT	WE JOKE AROUND TOGETHER	THEY SAY HURTFUL THINGS TO ME
I SNEAK AROUND THEM	WE EAT MEALS TOGETHER	WE ALL GO OUR OWN WAY	THEIR RULES ARE REASONABLE
THEY RESPECT ME	I RESPECT THEM	THEY YELL A LOT	THEY FIGHT ARGUE WITH EACH OTHER
I GET PHYSICALLY HURT BY THEM SOMETIMES			

SCHOOL EXPERIENCE

NAME OF SCHOOL: _____ CURRENT GRADE LEVEL: _____

CURRENT GRADES (Please circle all that apply): A's B's C's D's F's

FAVORITE SUBJECT _____ LEAST FAVORITE SUBJECT _____

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING STATEMENTS

I generally like my teachers.	YES / NO
Others tease me at school.	YES / NO
I enjoy socializing with other students at lunch.	YES / NO
I skip class or a whole day of school a couple of times a month.	YES / NO
I like most of my classes.	YES / NO
I am tardy many days.	YES / NO
I felt mad enough to hurt people at school.	YES / NO
I feel respected at school.	YES / NO
I have been suspended/expelled from school in the past.	YES / NO
I enjoy extra-curricular activities.	YES / NO
School is very stressful for me.	YES / NO