

# PASTORAL INSTITUTE

2022 15th Avenue | Columbus, Georgia 31901  
706-649-6500 | 800-649-6446 | Fax 706-649-6521

**For Office Use Only:**

Date of Visit: \_\_\_\_\_  
Patient #: \_\_\_\_\_  
Clinician: \_\_\_\_\_  
Payment Type: \_\_\_\_\_

## Counseling Center Minor Client Information

Name of Minor: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

School: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

Religion: \_\_\_\_\_ Church: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Preferred method of contact:  Mobile  Home  Work /  Voice  Text  Email

Marital Status:  Single  Live-In  Married  Divorced  Widowed

Military Status:  Active  Veteran  Disabled  Retired  Dependent

Spouse (if applicable): Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### Financial and Insurance Information

Primary Insurance: \_\_\_\_\_ Policy/Member ID #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Social Security #: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy/Member ID #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Social Security #: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

**In order to file your insurance, we must have a copy of your insurance card(s).**

**Mental Health Information:**

What has happened to cause you to seek counseling for your child? *(continue on back if needed)*

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Has your child received previous mental health care?  Yes  No

If so, what dates did your child receive treatment?

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**General Health Information:**

Is your child presently under the care of a physician?  Yes  No

Name of physician/psychiatrist: \_\_\_\_\_

Physician's telephone number: \_\_\_\_\_

Types and dates of surgeries: \_\_\_\_\_

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Does your child drink alcohol/do drugs?  Yes  No

If yes, how many drinks daily? \_\_\_\_\_

List medication(s) taken regularly: \_\_\_\_\_

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\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**SOCIAL MEDIA POLICY**

Pastoral Institute staff will not accept friend requests or contact requests from current or former clients on any social networking site; i.e., Facebook, LinkedIn, etc. Adding clients and/or family members as friends or contacts on these sites can compromise a client's confidentiality and our mutual privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions, please do not hesitate to discuss the issue with your clinician.

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby authorize the Pastoral Institute or any member of its staff, to release to my insurance company or companies any information acquired in the course of my examination or treatment necessary for payment of insurance claim. The insurance company is hereby authorized to pay the Pastoral Institute, Inc., basic benefits and/or major medical benefits for medical and/or treatment expenses, or to include their name on the check payable to patient for medical and/or expenses.

**For *Tricare Beneficiaries*: I consent to the Pastoral Institute, as a Military Treatment Facility (MTF) to send a copy of my Protected Health Information (PHI) to referring MTFs for continuity of care.**

\_\_\_\_\_  
Client Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Pastoral Institute Witness – Initial/Date

**FINANCIAL POLICY AND AGREEMENT**

For those with health insurance, the Pastoral Institute will assist in filing claims and seeking reimbursement. The Pastoral Institute cannot guarantee insurance reimbursement. It is the responsibility of the patient to follow up with the insurance company to make sure they pay the claims correctly. If the insurance company does not pay within 90 days, the unpaid balance is due from the Guarantor. Some insurance coverage for mental health services requires pre-authorization. The patient must call for authorization. The insurance company will not pay for services that have not been authorized. All fees charged are the direct responsibility of the client. Payment of any and all services rendered will be expected from the guardian that escorts the patient to his or her appointments. It is the policy of the Pastoral Institute to bill for any appointment cancelled without a 24-hour notice.

**Payment for co-pay or deductible is due at the time service is rendered.** Accounts that become more than ninety (90) days past due may be forwarded to a collection agency. All returned checks are forwarded to Check Care for collection. Check Care adds an additional fee for collection.

**Financial Agreement:**

I understand the above financial arrangements. I also understand I will receive a statement each month if there is a balance due from me. I agree that the statements are correct unless questioned within thirty (30) days in writing or by telephone contact with the Pastoral Institute Business Office.

\_\_\_\_\_  
Client Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Pastoral Institute Witness – Initial/Date

**PASTORAL INSTITUTE BROKEN APPOINTMENT POLICY**

Your appointment time has been reserved just for you. If you find it impossible to keep your appointment time, please call us at least 24 hours in advance. Failure to call our office and cancel your appointment 24 hours in advance will result in a charge of \$60.00 or more. We offer appointment reminder phone calls and/or texts 48 hours prior to your appointment. However, this is a courtesy and you are still responsible for cancelling your appointment at least 24 hours in advance.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**COUNSELING, CONFIDENTIALITY, PRIVACY PRACTICE AND NON-RECORDING AGREEMENT**

I am aware that the practice of counseling is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment by the Pastoral Institute’s (PI) staff members. I agree to collaborate with my therapist and other appropriate professional staff members of the PI for the purpose of assessment and evaluation of my current situation to work together to identify appropriate goals and methods of achieving them.

I understand that over the course of therapy, whatever assessments, tests or other clinical care that is recommended will be fully explained to me and that I have the option to accept or reject such care. I understand that the PI is committed to quality care. I may contact the Clinical Director regarding any questions about my therapist or concerns about quality of care. I understand that the PI may call my home or other designated location and leave a message on voice mail or in person to assist the practice in carrying out health care operations, such as appointment reminders, insurance concerns, and any call pertaining to my clinical care. I have read the above and give my consent to the counseling process of the PI. I have also read and understand the Pastoral Institute’s statement regarding the limits of confidentiality. In addition, I have had an opportunity to review the Pastoral Institute’s Notice of Privacy Practices and have had an opportunity to obtain a copy and ask questions to seek clarification I needed about these important materials.

Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally, the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

Client Name (Printed)	Date
Parent/Guardian Signature	Pastoral Institute Witness – Initial/Date

**E-MAIL CONTACT WITH THERAPIST CONFIDENTIALITY RELEASE AGREEMENT**

\_\_\_\_\_  
E-mail Address

I understand that confidentiality of e-mail communications with my therapist cannot be guaranteed. I further agree that I will not attempt to extend therapy via e-mails, but only use it to conduct business of information sharing such as cancelling or confirming an appointment. Any therapeutic issues I will handle either during the therapeutic face-to-face meeting or as appropriate, by telephone in emergencies. E-mail is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular e-mail will be read and responded to within a particular period of time. Possible e-mail-related concerns can include, but are not limited to the following:

- E-mails go through several intermediate stations before reaching their destination. Someone at any point along the line could access the e-mail and even store the message contained in it.
- E-mails may remain stored in various places of a computer system and could surface at a later time.
- Computers, particularly those on DSL lines, are vulnerable to electronic eavesdropping.

Knowing the above information and considering other possibilities not yet known that could further jeopardize confidentiality, I give my permission to my therapist to respond to my e-mails according to his/her professional judgment.

Client Name (Printed)	Date
Parent/Guardian Signature	Pastoral Institute Witness – Initial/Date

**EMAIL RELEASE FOR COMMUNICATION ABOUT PASTORAL INSTITUTE SERVICES**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have rights to privacy regarding myself or my minor child’s (or individual for which I have guardianship) protected health information. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of health information.

This release is strictly designated to give permission to my provider to send educational information, newsletters, announcements of upcoming services/programs and marketing materials via email and/or through the patient portal. My provider will have permission to send information via email and/or patient portal in the manner described above unless I request him/her to no longer use it. A written request form is available to decline permission.

- Yes:** I will allow my provider to send educational information, newsletters, announcements of upcoming services/programs and marketing materials via email and/or through the patient portal.
- No:** I decline that my provider can send educational information, newsletters, announcements of upcoming services/programs and marketing materials via email and/or through the patient portal.

\_\_\_\_\_  
Client Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Pastoral Institute Witness – Initial/Date

**RELEASE FOR IDENTIFICATION PHOTO**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have rights to privacy regarding my minor child’s (or individual for which I have guardianship) protected health information. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of health information.

This release is strictly designated to give permission to my provider to take a photo of my child (or individual for which I have guardianship) for identification purposes only. The photo will be part of their clinical record/chart which can be seen by their Pastoral Institute providers to assist us in ensuring their identification when conducting therapy, evaluations, group activities, etc. The photo will not be released to anyone, will not be used outside of the Pastoral Institute nor used for any other purpose. My provider will have permission to use this photo in the manner described above unless I request him/her to no longer use it. A written request form is available to decline permission.

- Yes:** I will allow my provider to take a digital photograph of my child (or individual for which I have guardianship) for chart identification purposes only.
- No:** I decline that my provider can take a digital photograph of my child (or individual for which I have guardianship) for chart identification purposes only.

\_\_\_\_\_  
Client Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Pastoral Institute Witness – Initial/Date

## **Informed Consent for Therapy with Parents/Guardians Divorce, Custody or Legal Issues**

As a mental health treatment practice, our primary focus, responsibility and goal is the treatment and well being of our identified patients. In the case of a minor child as the primary patient, it is essential that parents and legal guardians are in agreement as to the decision to treat, the treatment goals, appointment times and the need to maintain patient confidentiality. This Consent states that you, as the parent and/or any legal guardian with authority over the health care decisions of the child, agree to the terms contained herein and to communicate effectively with any other parent and/or legal guardian as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible for the patient.

Although our responsibility to your minor child, as the primary patient, may require our involvement in conflicts between parents and guardians, you hereby acknowledge that the Pastoral Institute's involvement will be strictly limited to those actions which will benefit and be in the best interest of the patient. Additionally, you agree to the following:

- Anything that is said in any individual or group therapy session is and shall remain at all times strictly confidential;
- The Pastoral Institute's role is limited to providing treatment to the patient, and you shall not attempt to utilize any information related to your minor child's treatment to your benefit or for your advantage in any legal proceeding relating to a divorce or to the custody of your child that is derived from the treatment of your child by the Pastoral Institute. You acknowledge and agree that the use of any such information shall be determined by a court appointed guardian ad litem or by an order from a court with competent jurisdiction;

You shall not request or require the Pastoral Institute, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the another in any legal proceeding relating to the care and custody of your child; Any communications between the minor patient and the clinician, whether during an individual or group session, are treated by the Pastoral Institute as privileged communications under applicable law. **You acknowledge that, prior to any clinician being required to testify or disclose any confidential and/or privileged communications between a patient and the clinician, a written waiver of the privileged communications shall be delivered to the Pastoral Institute. If you decide to subpoena your therapist, you will be responsible for his/her expert witness fees in the amount of a deposit of \$300.00 to be paid at the time we are notified of a subpoena to provide a deposition or appear in court. Any additional time the therapist spends would be billed at the rate of \$200.00 per hour including travel time. If your therapist is a licensed psychologist the fees are \$250.00 per hour including travel time. You understand that if you subpoena your therapist, he/she may elect not to speak with your attorney, and a subpoena may result in your therapist withdrawing as your counselor.**

- In the event of a group session, a written waiver of all participants shall be received by the Pastoral Institute prior to any disclosure. In the event the patient involves a minor child and the request is in connection with a divorce or child custody proceeding, you agree that a guardian ad litem shall be appointed by the court to make the determination as to whether the minor child should waive the privilege, and that you, as the parent and/or legal guardian, shall not retain the right to waive any privilege on behalf of a minor child under such circumstances;
- Any and all medical records retained by the Pastoral Institute are subject to the applicable Health Insurance Portability and Accountability Act of 1996 ("HIPAA") laws and regulations. Any requests for medical records of a patient shall be HIPAA compliant, and the Pastoral Institute will not disclose any medical records in its possession that would be in conflict with the applicable HIPAA requirements.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor **but we will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.**

In order for the Pastoral Institute to disclose privileged communications pursuant to any court order, such court order shall explicitly require the disclosure of any privileged communications of the patient.

I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my minor child under these terms and conditions set forth above by signing below.

I accept the responsibility of communicating with my child's therapist after every appointment to be updated regarding any change in the treatment plan related to my child's therapy. However, I acknowledge that I am not entitled to all of the communications and disclosures made by my minor child during any treatment sessions, and that such communications may consist of privileged communications which are afforded protection under applicable law.

I understand that as the custodial parent of the minor child, I am responsible for any and all payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, I acknowledge that the Pastoral Institute will look to me as the sole party responsible for the financial obligations of the account.

Name of Child/Client (Printed): \_\_\_\_\_

Parent/Guardian Name (Printed): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PI Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Pastoral Institute's Child and Family History** Client # \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Male  Female Age: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

(Does child Sign? \_\_\_\_\_) Race/Ethnicity: \_\_\_\_\_ Handedness:  Right  Left

Referred by: \_\_\_\_\_ Form completed by \_\_\_\_\_ (Relationship? \_\_\_\_\_)

**PLEASE CHECK CURRENT CONCERNS ABOUT YOUR CHILD**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Academic/Learning Difficulties       | <input type="checkbox"/> Eating Problems                     | <input type="checkbox"/> Memory Difficulties  |
| <input type="checkbox"/> Adoption Issues/Problems             | <input type="checkbox"/> Language Difficulties               | <input type="checkbox"/> Self-Harm  |
| <input type="checkbox"/> Suspected Alcohol/Drug Abuse         | <input type="checkbox"/> Health Concerns _____               | <input type="checkbox"/> Suicidal   |
| <input type="checkbox"/> Allegations of Abuse                 | <input type="checkbox"/> Home Schooling Issues               | <input type="checkbox"/> Visual Motor Coordination Difficulties/Writing; Difficulties |
| <input type="checkbox"/> Anger Issues                         | <input type="checkbox"/> Hearing Difficulties                | <input type="checkbox"/> Social Skills Difficulties                                   |
| <input type="checkbox"/> Anxiety                              | <input type="checkbox"/> Gifted Assessment                   | <input type="checkbox"/> Traumatic Brain Injury                                       |
| <input type="checkbox"/> Attention/Hyperactivity Difficulties | <input type="checkbox"/> Suspected Intellectual Difficulties | <input type="checkbox"/> Violent behaviors  |
| <input type="checkbox"/> Autism Spectrum Disorder             | <input type="checkbox"/> Family difficulties                 | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Behavior Difficulties                | <input type="checkbox"/> Grief issues                        | _____   |
| <input type="checkbox"/> Depression                           | <input type="checkbox"/> Gross Motor Delays/Clumsiness       | _____   |

**Living Arrangements:**

The Child currently lives with \_\_\_\_\_

How many other children live with child? \_\_\_\_\_ Ages: \_\_\_\_\_

How long has the child lived in the present living arrangements? \_\_\_\_\_

Does the child have pets?  Yes  No; what types? \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

**Highest Educational Level:**

Mother	
Father	
Step Parent	
Adoptive	
Guardian	

**Events Producing Family Stress:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Death of a family member                            | <input type="checkbox"/> Serious illness of a family member                                     | <input type="checkbox"/> Loss of home         |
| <input type="checkbox"/> Incarceration of a family member                    | <input type="checkbox"/> Loss of employment of a major wage earner                              | <input type="checkbox"/> Parental separation  |
| <input type="checkbox"/> Custody disagreement                                | <input type="checkbox"/> Unsafe home environment  | <input type="checkbox"/> Parental divorce     |
| <input type="checkbox"/> Parent emotionally/mentally ill/<br>substance abuse | <input type="checkbox"/> Birth/Adoption of another child  | <input type="checkbox"/> Sibling conflict     |
| <input type="checkbox"/> Abandonment by parent                               | <input type="checkbox"/> Parental disagreement about child-rearing                              | <input type="checkbox"/> Child neglect/abuse  |
| <input type="checkbox"/> Parental deployments # _____                        | <input type="checkbox"/> Involved with Social Services/Child Protective Services/Juvenile Court | <input type="checkbox"/> Financial problems   |
| <input type="checkbox"/> Other _____   |   | <input type="checkbox"/> Single-parent family |

## Prenatal/Birth History

- |   |  |
|---|--|
| <input type="checkbox"/> Child was born with no complications             | <input type="checkbox"/> Was born via C-section                |
| <input type="checkbox"/> Experienced anoxia at birth/assistance breathing | <input type="checkbox"/> Was born premature                    |
| <input type="checkbox"/> Experienced in utero exposure to drugs/alcohol   | <input type="checkbox"/> Weighed less than 5 ½ pounds at birth |
| <input type="checkbox"/> Experienced in utero trauma (e.g. cord wrapped)  | <input type="checkbox"/> Weight over 9 lbs                     |
| <input type="checkbox"/> Was born past due date                           | <input type="checkbox"/> Birth weight _____                    |
| <input type="checkbox"/> Gestational diabetes                             | <input type="checkbox"/> Rh incompatibility                    |
| <input type="checkbox"/> Toxemia  |  |

## Which of the following applied to the infant? (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Required Oxygen/Breathing problems   | <input type="checkbox"/> Feeding problems     |
| <input type="checkbox"/> Required incubator   | <input type="checkbox"/> Rash                 |
| <input type="checkbox"/> Sleeping problems  | <input type="checkbox"/> Bleeding into brain  |
| <input type="checkbox"/> Infections   | <input type="checkbox"/> Excessive crying     |
| <input type="checkbox"/> Placement in the NICU, if so how long? _____   | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Did the infant require: <input type="checkbox"/> X-rays <input type="checkbox"/> CT scans <input type="checkbox"/> Blood Transfusion |   |
| <input type="checkbox"/> Unusual appearance, describe: _____  |   |
| <input type="checkbox"/> Jaundice (were bilirubin lights used?) <input type="checkbox"/> Yes <input type="checkbox"/> No    How long: _____                   |   |
| <input type="checkbox"/> Length of stay in the hospital: _____ Mother: _____ Infant: _____  |   |
| <input type="checkbox"/> Other concerns _____   |   |

Developmental Milestones	Early	Typical	Late	Not Yet
Sitting Alone				
Crawling				
Fed self				
Fed self with spoon				
Gave up bottle				
Started solid foods				
Standing Alone				
Walking Alone				
Speaking First Words; age _____				
Speaking Short Sentences; age _____				
Using Toilet When Awake				
Staying Dry at Night				
Dressed Self				
Rides tricycle				
Rides Bike				

**When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?**

- Time out    Loss of allowance/privileges    Physical Punishment    Yelling  
 Ignoring    Grounding    Other, describe: \_\_\_\_\_

Who is mainly in charge of discipline? \_\_\_\_\_

What do you find most difficult about raising your child? \_\_\_\_\_

**Sensory Motor Skills:**

**Date of Last Testing**

**Results Normal Y/N**

Sensory Motor Skills:	Date of Last Testing	Results Normal Y/N
Vision Testing		
Hearing Testing		

**Medical/Psychiatric/Neurological Concerns:**

- No major medical/psychiatric concerns    Asthma    Depressive disorders  
 Attention deficit/hyperactivity disorder    Diabetes    Fetal alcohol syndrome  
 Chronic ear infections    Lead poisoning    Severe allergies  
 Seizure disorder    Spina bifida    Stomach problems  
 Surgeries    Other \_\_\_\_\_  
 Family History of Mental or Emotional problems \_\_\_\_\_  
 Food allergies \_\_\_\_\_

**Neurological Status:**

- No signs of neurological concerns    Episodes of head banging    Seizures or convulsions  
 A serious head injury    A motor tic    Periods of unconsciousness  
 An unusual number of accidents    Other \_\_\_\_\_

**Medication:**

Is he/she currently on any medications?  Yes  No If so, names of all medications: \_\_\_\_\_

**Education:**

Did he/she attend a formal pre-kindergarten?  Yes  No |  Fulltime  Halftime

Did he/she attend a formal kindergarten?  Yes  No |  Fulltime  Halftime

Has he/she been in the same school since initial enrollment?  Yes  No

Has he/she ever been held back?  Yes  No If yes, what grade(s)? \_\_\_\_\_

He/she is currently in:

**Attendance:**

- full time classes    part time classes    regular classes  
 gifted/talented courses    special education classes    homeschooled

He/she has:

**Attendance:**

- an excellent attendance record
- frequent excused absences
- no significant attendance problem
- frequent un-excused absences

**Conduct:**

- exemplary conduct record
- enrolled in correction program
- only minor disciplinary problems
- severe disciplinary problems
- frequent disciplinary problems
- suspension from school

**Academic Performance:**

- an outstanding academic record
- some academic difficulties
- no serious academic difficulties
- many academic difficulties

**Academic Testing:**

	Above Average	Average	Below Average
Reading			
Math			
Language			

**Describe School Issues:**

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**Services Received:**

- Speech
- Occupational Therapy
- Physical Therapy
- ABA Therapy
- Social Skills
- Early Child Special Edu.

**Extracurricular Activities**

- Sports Clubs/Hobbies: \_\_\_\_\_
- Spiritual Affiliation/Church: \_\_\_\_\_

**How does your faith impact these concerns?** \_\_\_\_\_

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**Strengths:** What are the child's greatest assets? \_\_\_\_\_

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What are the family's strengths? \_\_\_\_\_

**Level of family stress related to child's condition:**

Low			Moderate				High		
1	2	3	4	5	6	7	8	9	10