dr. stephen brown & associates
mentalhealthwyoming.com

P: 307.234.3638 F: 307.472.2259 2417 East 15th Street, Casper WY, 82609

Dr. Brown and his medical practitioners generally schedule outpatient appointments Monday through Thursday between 2:00 pm through 5:00. Therapists are accepting appointments Monday through Friday. We are closed on weekends and holidays, and our office takes half-days on Fridays.

*The first medical visit is a psychiatric evaluation that generally takes one to one and one-half hours. The charge is $295.00. An evaluation is for evaluative purposes only. Acceptance for treatment is at the discretion of Dr. Stephen Brown and Associates.

Payment is due at the time of service unless prior arrangements have been made. For your convenience, we accept MasterCard, Visa, and Discover. Prior payment arrangements require a signed agreement.

We are in network with Wyoming Medicaid, KidCare, Blue Cross Blue Shield ONLY. We will bill all other insurances as a courtesy at the time of service. Although we bill these insurances as a courtesy, the patient and/or policyholder is responsible for follow-up with their own insurance company if charges are presented to them for payment. We will not file any insurance unless the assignment of benefits is signed. It is your responsibility to contact your insurance company to preauthorize mental health services prior to the patient's initial appointment, with the exception of Wyoming Medicaid and KidCare.

You will be expected to pay in full for missed appointments unless you have given a minimum of one business day's prior notice. **This includes patients covered by Wyoming Medicaid and Kid Care. Insurance will not pay for missed Appointments.**

As of January 1, 2021:

*Stephen Brown M.D.	Rates	*Therapists	Rates
Office Visit (30 minutes)	$160.00	60 Minute Individual	$175.00
Office Visit (60 minutes)	$205.00	60 Minute Family	$175.00
Psychiatric Evaluation	$295.00		
Missed Appointment	$30.00 and up to the full Appointment charge		

*Please contact Kayla if you have questions about pre-arranging a contract.
I have read, understood, and agree with the above information.

Patient Name	Patient Guardian Signature	Date

Patient Information

Patient Full Name:_____
Last First Middle/Maiden
Street Address _____
Mailing Address (PO Box) _____
City _____State_____Zip_____
Date of Birth _____ Sex _____ Social Security Number _____
Marital Status _____ Spouse's Name _____
Home Phone _____ Cell Phone _____
Employer/School _____ Work Phone _____
Primary Care Physician _____

Guardian Information

Guardian's Full Name _____
Last First Middle/Maiden
Relationship to Patient _____
Street Address _____
Mailing Address (PO Box) _____
City _____State_____Zip_____
Date of Birth ____/____/_____ Sex _____Social Security Number _____
Marital Status _____ Spouse's Name _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____
Who is responsible for payment of the bill? _____
***Note: Billing a non-custodial parent is a courtesy. No-show fees are the guardians responsibility**

In the event of an emergency, whom should we contact?

Name _____ Phone Number _____
Relationship _____

Other Members in the Household

Name(s) First, Middle, Last	Birthdate (MM/DD/YYYY)	Relationship to Patient
1.		
2.		
3.		

Insurance Information

Do you have medical insurance? Yes _____ No _____
If you have insurance, please provide the front office with copies of your insurance cards. If at any time your insurance status changes, please notify our office as soon as possible.
Insurance Company _____
Insurance Company Claims Address _____
Group Number _____ Policy Number _____
Insured Party _____ Insured Party's Date of Birth _____
Insured Address and phone number (if different) _____

Financial Agreement and Authorization for Treatment

I authorize treatment of the person named above and understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. **I agree to pay all charges unless arrangements are agreed upon in writing. PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE unless A PRIOR agreement has been made with the billing department. I hereby authorize insurance payment directly to Stephen L. Brown, MD Psychiatric Services.** Charges shown by statements are agreed to be corrected and reasonable unless protested in writing within thirty days of the initial billing date. In the event legal action should become necessary to collect an unpaid balance due for services rendered to my family, or myself, I/we agree to pay reasonable attorney's fees or court costs. **I also understand I will be responsible for all non-covered services where allowed by law because of a lack of authorization or any other reason for denial. I understand and agree that I am responsible for obtaining all necessary pre-certification requirements from my insurance company regardless of my insurance status, I am ultimately responsible for payment of service rendered by the doctor and/or his associate.** I understand if I do not show up for my scheduled visit without canceling 24 hours in advance, **I can be held liable for the full charge of the missed appointment.** This applies to ALL patients and is not covered by insurance, including Medicaid or Medicare.

PLEASE NOTE: This office does not honor Medical Advanced Directives

Signature of Patient or Legal Guardian	**Date**	**Printed Patient's Name or Legal Guardian**

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Privacy Practice

PATIENT CONFIDENTIALITY: I understand that my information and my medical record will be kept in the utmost confidential manner. Information will be released only with my written authorization or under the Tarasoff Case rule of "DUTY TO WARN". This requires healthcare professionals to warn person(s) of threats by a patient. "Privacy ends when peril to the public begins."

By signing this form, you are granting consent to Dr. Stephen Brown & Associates to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information.

You have the legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notices by stopping by one of our facilities/offices. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

Signature of Patient or Legal Guardian	**Date**	**Printed Patient's name or Legal Guardian**

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Confidentiality of Minors

This signature page is to document in writing my intentions as a parent/guardian or custodial parent of a minor during therapy with the staff of Stephen L. Brown, M.D. It is my intention to provide him/her confidentiality of the therapeutic content as verbally outlined at the initial intake and consultation session. It is my understanding that therapeutic content will be kept confidential between the physician and/or his staff within the limits of the Tarasoff Law regarding threats of injury to self or others. Therapeutic progress and/or process will be explained as requested or warranted.

I am aware that under article 20-2-113 (f) of the Family Code of the State of Wyoming, the non-custodial parent has the same right of access to health care records as the custodial parent/guardian unless otherwise ordered by the court.

I agree to confidentiality of therapeutic content between _____ and the physician and/or his staff.

Signature of Minor	**Date**	**Signature of Parent**

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Appointment Reminders

Patient Name _____

Legal Guardian Name _____

Legal Guardian's Phone Number _____

I hereby authorize Dr. Stephen L. Brown & Associates to send appointment reminders electronically via text message to my mobile phone. By accepting these terms, I agree that anyone associated with my account and phone number may receive alerts referencing the patient's appointments. I understand that this service is offered free of charge, however, standard text messaging rates from my mobile carrier may apply. I understand it is my responsibility to keep my contact information up to date with this office.

_____ _____

Signature **Date**

Adolescent/Child Health History

In order for your physician to best care for him/her, it is VERY important to have an accurate health history.

Person completing form/Relationship: _____ Date:_____

Child's Name: _____ Birth Date: _____ Age: _____

School: _____ Grade: _____

Physician(s):_____

Child in legal custody of: _____

Referred by: _____

Family and Social History

Name of Natural Father: _____

Address: _____

Occupation: _____

Education: _____

Name of Natural Mother: _____

Address: _____

Occupation: _____

Education: _____

Name of Step-Father or Adoptive Father: _____

Address: _____

Occupation: _____

Education: _____

Name of Stepmother or Adoptive Mother: _____

Address: _____

Occupation: _____

Education: _____

Names of other children in the family	Age	Grade	Full-Sibling	Step-Sibling	Adopted	Half-Sibling

Family History

Disease	Yes	No	Who
Cancer			
Heart Disease			
High Blood Pressure			
Epilepsy			
Diabetes			
Psychiatric Problems			
Suicide			
Addiction			
Measles			
Mumps			
Chicken Pox			
Scarlet Fever			
Rheumatic Fever			
Seizures			
Encephalitis/Meningitis			
Heart Problems			
Whooping Cough			
Lead Poisoning			
Headaches			
Frequent Earaches			
Frequent Sore Throats			
Head Injury			
Frequent Nose Bleeds			
Fainting Spells			

Disease	Yes	No	Who
Dizziness			
Broken Bones			
Joint Problems			
Back Problems			
Asthma			
Chest Pain			
Shortness of Breath			
Constipation			
Diarrhea			
Problems with Urination			
Bed-wetting			
Problems with Bowel Habits			
Other			

General:

1. Does your child take any medications? (Including non-prescription, homeopathic, vitamins, etc.) Please indicate dosage and frequency.)

   _____
   _____
   _____
   _____

2. Does your child have any food or drug allergies?

   _____
   _____
   _____
   _____

3. Does your child smoke, drink alcohol, or use other drugs?

   _____
   _____
   _____
   _____

4. Has your child had any surgeries or serious illnesses? Any hospitalization?

_____

_____

_____

_____

	Yes	No
5. Has your child had all of their vaccinations?	_____	_____
6. Has your child had the Hepatitis B Series?	_____	_____
7. Does your child have any dental problems?	_____	_____

Dentist's name: _____

Date of Last Visit: _____

8. Does your child have any vision problems?	_____	_____

Glasses _____

Contacts _____

Prenatal History

9. How was the mother's health during pregnancy?	Good	_____
	Fair	_____
	Poor	_____
	Unknown	_____

10. How old was the mother when the child was born? _____ years

11. Were any of the following substances or medications used during pregnancy?

Beer or Wine		Hard Liquor	
_____	Never	_____	Never
_____	Once or Twice	_____	Once or Twice
_____	3-9 times	_____	3-9 times
_____	10-19 times	_____	10-19 times
_____	20-39 times	_____	20-39 times
_____	40+ times	_____	40+ times

Coffee or other Caffeine		Cigarettes	
_____	Never	_____	Never
_____	Once or Twice	_____	Once or Twice
_____	3-9 times	_____	3-9 times
_____	10-19 times	_____	10-19 times
_____	20-39 times	_____	20-39 times
_____	40+ times	_____	40+ times

12. Were any of the following used during pregnancy?

	Yes	**No**
Valium (Librium, Xanax)	_____	_____
Tranquilizers	_____	_____
Anti-Seizure Medications (Dilantin)	_____	_____
Treatment for Diabetes	_____	_____
Antibiotics (for viral infections)	_____	_____
Sleeping Pills	_____	_____
Illegal Drugs (please specify)	_____	_____
Other (please specify)	_____	_____

	No	Yes	Unknown
13. Did the mother have toxemia or eclampsia?	_____	_____	_____
14. Was there an Rh factor incompatibility?	_____	_____	_____
15. Was the mother given any drugs to ease the pain of labor?	_____	_____	_____
16. Were there any indications of fetal distress during labor or birth?	_____	_____	_____
17. Was the baby born on time?	_____	_____	_____

At _____ months of pregnancy

18. What was the duration of labor? _____ hours

19. Was delivery:

Normal _____

Breech _____

Caesarian _____

Forceps _____

Induced _____

20. Were there any health complications following birth?

_____

_____

_____

_____

21. What was the child's birth weight? _____ Pounds _____ Ounces

Postnatal and Infancy

	Yes	No	Unknown
22. Were there any infancy feeding problems?	_____	_____	_____
23. Was the child colicky?	_____	_____	_____
24. Were there early infancy sleep patterns problems?	_____	_____	_____
25. Were there problems with the infants responsiveness (alertness)	_____	_____	_____
26. Did the child experience any health problems during infancy?	_____	_____	_____
27. Did the child have any congenital problems?	_____	_____	_____
28. Was the child an easy baby (Did they cry a lot?)	_____	_____	_____
29. Did the child follow a schedule fairly well?	_____	_____	_____

30. How did the baby behave with other people?

More sociable than average _____

Average sociability _____

Less sociable than average _____

Unknown _____

31. When the child wanted something, how insistent were they?

Very Insistent _____

Pretty Insistent _____

Average _____

Not Very Insistent _____

Not at all Insistent _____

Unknown _____

Development Milestones

32. At what age did the child sit up? _____ months _____ unknown

33. At what age did the child crawl? _____ months _____ unknown

34. At what did the child walk?

Under 1 year _____

1 - 2 years _____

2 - 3 years _____

Unknown _____

35. At what age did the child speak single words?

(Other besides “mama” or “dada”)

9 months - 1 year _____

1 - 2 years _____

3 years _____

4 years _____

Unknown _____

36. At what age did the child string two or more words together?

9 months - 1 year _____

1 - 2 years _____

3 years _____

4 years _____

Unknown _____

37. At what age was the child toilet trained? (bladder control)

Under 1 year _____

1-2 years _____

2-3 years _____

3-4 years _____

Unknown _____

38. At what age was the child toilet trained? (bowel control)

Under 1 year _____

1-2 years _____

2-3 years _____

3-4 years _____

Unknown _____

39. Approximately how much time did toilet training take from onset to completion?

Less than 1 month _____

1-2 months _____

2-3 months _____

More than 3 months _____

Medical History

40. How would you describe his/her health?

Very Good _____

Good _____

Fair _____

Poor _____

41. How is the child's hearing?

Good _____

Fair _____

Poor _____

42. How is the child's vision?

Good _____

Fair _____

Poor _____

43. How is the child's gross motor coordination?

Good _____

Fair _____

Poor _____

44. How is the child's fine motor coordination?

Good _____

Fair _____

Poor _____

45. How is the child's speech articulation?

Good _____

Fair _____

Poor _____

46. Has your child had any accidents resulting in the following?	**Yes**	**No**
Broken Bones	_____	_____
Severe Lacerations	_____	_____
Head Injury	_____	_____
Severe Bruises	_____	_____
Stomach Pumped	_____	_____
Eye Injury	_____	_____
Lost Teeth	_____	_____
Sutures	_____	_____

Other (specify) _____

_____

47. How many accidents have there been in total? _____

48. Has the child ever had surgery for any of the following conditions?	**Yes**	**No**
Tonsillitis	_____	_____
Adenoids	_____	_____
Hernia	_____	_____
Appendicitis	_____	_____
Eye/Ear/Nose/Throat	_____	_____
Digestive Disorder	_____	_____
Urinary Tract	_____	_____
Leg and Arm	_____	_____
Burns	_____	_____

Other (specify)

_____

_____

49. How many surgeries has the child had? _____

50. How many surgeries required overnight hospitalizations? _____

51. What was the duration of the hospitalization? _____

	Yes	**No**
52. Is there any suspicion of alcohol or drug use?	_____	_____
53. Is there any suspicion of physical/sexual abuse?	_____	_____
54. Does the child have difficulties falling asleep?	_____	_____
55. Does the child experience sleep continuity disturbances?	_____	_____
56. Does the child experience early morning awakening?	_____	_____
57. Is the child a restless sleeper?	_____	_____
58. Does the child have night bladder control problems? If yes, how often? _____	_____	_____
If yes, does the child ever have accidents during the day? If so, how often? _____	_____	_____

	Yes	No
59. Does the child have night bowel control problems? If yes, how often? _____	_____	_____
If yes, does the child ever have bowel accidents during the day? If so, how often? _____	_____	_____
60. Does the child have any appetite problems? If yes, what? (overeat, undereat, vomiting) _____	_____	_____
61. Any weight changes? (Please specify) _____	_____	_____

Treatment History

62. Has the child ever been prescribed any of the following?

	Yes	No	Duration of Use
Stimulants for ADHD (Adderall, Concerta, Metadate, Focalin, etc.)	_____	_____	_____
Antihistamines	_____	_____	_____
Anticonvulsants	_____	_____	_____
Antidepressants	_____	_____	_____

Other prescriptions (Please specify the medication, dosage, and directions)

_____

_____

_____

63. Has the child had any of the following forms of treatment?

	Yes	No	Duration of Treatment
Individual Psychotherapy	_____	_____	_____
Group Psychotherapy	_____	_____	_____
Family therapy with child	_____	_____	_____
Inpatient evaluation/Treatment	_____	_____	_____

Who provided the treatment and when?_____

_____

_____

School History

Please summarize the child's academic progress (social, testing) within each of the following grade levels:

Preschool _____

Kindergarten _____

Grades 1 through 3 _____

Grades 4 through 6 _____

Grades 7 through 12 _____

64. Has the child been in any type of special type of special education programs?

	Yes	No	Duration of Use
Learning Disabilities Class	_____	_____	_____
Behavioral/Emotional Disorder Class	_____	_____	_____
BASS Class	_____	_____	_____
Alternative School	_____	_____	_____
Resource Room	_____	_____	_____
Speech & Language Therapy	_____	_____	_____
IQ Testing	_____	_____	_____
Other	_____	_____	_____

65. Has the child ever been:

	Yes	No	Duration
Suspended From School	_____	_____	_____
Expelled From School	_____	_____	_____
Retained A Grade	_____	_____	_____

Please explain reasons for suspensions/expulsions and when they occurred _____

_____

_____

65. Have any additional instructional modifications been attempted?

	Yes	No	Duration
None	_____	_____	_____
Daily/Weekly Report Cards	_____	_____	_____
Behavioral Modification	_____	_____	_____
Other (Specify)	_____	_____	_____

Social History

66. How does the child get along with their siblings?

Doesn't have any _____

Worse than average _____

Average _____

Better than average _____

67. How easily does the child make friends?

Doesn't have any _____

Worse than average _____

Average _____

Better than average _____

68. On average, how long do these friendships last?

Less than 6 months _____

6 months to 1 year _____

More than 1 year _____

Unknown _____

Current Behavioral Concerns

Primary Concerns _____

_____

_____

_____

Other (related) Concerns _____

_____

_____

_____

69. What strategies have been implemented to address these problems? (Please check which have been successful)

Verbal Reprimands _____

Time Out (isolation) _____

Removal of Privileges _____

Avoidance of Child _____

Rewards _____

Physical Punishments _____

Acquiesce to Child _____

Other (specify) _____

_____

70. On average, what percentage of the time does your child comply with initial commands?

0-20% _____

20-40% _____

40-60% _____

60-80% _____

80-100% _____

71. On average, what percentage of the time does your child eventually comply with commands?

0-20% _____

20-40% _____

40-60% _____

60-80% _____

80-100% _____

72. To what extent are you and your spouse consistent with respect to disciplinary strategies?

None of the time _____

Some of the time _____

Most of the time _____

73. Have any of the following stress events occurred within the past 12 months?

Parents divorced/separated	_____	Family accident or illness	_____
Death in the family	_____	Parent changed job	_____
Changed school	_____	Family Moved	_____
Family financial problems	_____	Other (please specify)	_____

_____

_____

<u>Diagnostic Criteria</u>

74. Which of the following are considered to be a significant problem at the present time?

	Yes	**No**
Unrealistic worry about the future	_____	_____
Unrealistic guilt	_____	_____
Unrealistic concern about competence	_____	_____

Unfounded physical complaints (to avoid school, homework, etc.)	_____	_____
Marked self-consciousness	_____	_____
Excessive need for reassurance	_____	_____
Marked inability to relax	_____	_____

When did these problems begin? (Specify age) _____

75. Which of the following are considered to be a significant problem at the present time?

	Yes	**No**
Fidget	_____	_____
Difficulty remaining seated	_____	_____
Easily Distracted	_____	_____
Often interrupts/intrudes upon others	_____	_____
Often loses things	_____	_____
Difficulty following instructions	_____	_____
Often does not listen	_____	_____
Difficulty sustaining attention	_____	_____
Often talks excessively	_____	_____
Difficulty playing quietly	_____	_____
Difficulty awaiting turn	_____	_____
Shifts from one activity to another	_____	_____

When did these problems begin? (Specify age) _____

76. Which of the following are considered to be a significant problem at the present time?

	Yes	**No**
Lies often	_____	_____
Stolen without confrontation	_____	_____
Deliberate fire setting	_____	_____

Breaking and entering	_____	_____
Often truant	_____	_____
Difficulty following instructions	_____	_____
Cruel to animals	_____	_____
Difficulty playing quietly	_____	_____
Stolen with confrontation	_____	_____
Difficulty playing quietly	_____	_____
Physically cruel to people	_____	_____
Shifts from one activity to another	_____	_____
Often blurts out answers to questions before they contemplate	_____	_____
Often engages in dangerous activities	_____	_____

When did these problems begin? (Specify age) _____

77. Which of the following are considered to be a significant problem at the present time?

	Yes	**No**
Often loses temper	_____	_____
Often blames others for own mistakes	_____	_____
Often angry and resentful	_____	_____
Often swears or uses obscene language	_____	_____
Often argues with adults	_____	_____
Often touchy or easily annoyed by others	_____	_____
Often defies/refuses adult requests or rules	_____	_____
Often deliberately does things to annoy others	_____	_____

When did these problems begin? (Specify age) _____

78. Which of the following are considered to be a significant problem at the present time?

	Yes	No
Unrealistic/persistent worry about harm to attachment figure	_____	_____
Persistent school refusal	_____	_____
Persistent refusal to sleep alone	_____	_____
Persistent avoidance of being alone	_____	_____
Repeated nightmares regarding separation	_____	_____
Unfounded physical complaints (to avoid school, homework, etc.)	_____	_____
Excessive distress in anticipation of separation from attachment figure	_____	_____
Excessive distress when separated from home or attachment figure	_____	_____

When did these problems begin? (Specify age) _____

79. Which of the following are considered to be a significant problem at the present time?

	Yes	No
Depressed/irritable mood most of the day nearly every day	_____	_____
Diminished pleasure in activities	_____	_____
Decrease/increase in appetite associated with possible failure to make weight gain	_____	_____
Insomnia (difficulty sleeping) or hypersomnia (oversleeping) nearly every day	_____	_____
Psychomotor agitation or retardation	_____	_____
Fatigue or loss of energy	_____	_____
Feelings of worthlessness or excessive inappropriate guilt	_____	_____
Diminished ability to concentrate	_____	_____
Suicidal idealization or attempt	_____	_____

When did these problems begin? (Specify age) _____

80. Which of the following are considered to be a significant problem at the present time?

	Yes	No
Poor appetite or overeating	_____	_____
Low energy or fatigue	_____	_____
Low self-esteem	_____	_____
Poor concentration or difficulty making decisions	_____	_____
Feeling of hopelessness	_____	_____
Never without symptoms for more than 2 months over a year period	_____	_____

When did these problems begin? (Specify age) _____

Other Concerns

81. Has the child exhibited any of the following symptoms?

	Yes	No
Stereotype mannerisms (repeated behavior)	_____	_____
Odd postures	_____	_____
Excessive reaction to noise or failure to react to loud noises	_____	_____
Overreacts to touch	_____	_____
Compulsive rituals	_____	_____
Motor tics (involuntary muscle movements)	_____	_____
Vocal tics (involuntary noise making)	_____	_____

82. Which of the following are considered to be a significant problem at the present time?

	Yes	No
Isn't able to follow a conversation or discussion	_____	_____
Has strange ideas, sees or hears people that aren't there	_____	_____
Often mumbles or talks to themselves	_____	_____
Disoriented, confused, staring, or "spacey"	_____	_____
Complains of people talking about following them	_____	_____

83. Has the child exhibited any symptoms of emotional disturbance, including any of the following?

	Yes	No
Excessive happiness or sadness without a change of environment	_____	_____
Explosive temper with minimal provocation	_____	_____
Excessive clinging, attachment, or dependence of adults	_____	_____
Unusual fears	_____	_____
Panic Attacks	_____	_____
Very quiet, sad, blank type of emotional availability	_____	_____
Situationally inappropriate emotions	_____	_____

84. Has the child exhibited any symptoms of emotional disturbance, including any of the following?

	Yes	No
Little or no interest in peers	_____	_____
Significantly indiscreet remarks	_____	_____
Initiates or terminates interactions inappropriately	_____	_____
Qualitatively abnormal social behavior	_____	_____
Excessive reactions to change in routine	_____	_____
Abnormalities of speech	_____	_____
Self-mutilation (cutting, burning on self, pulling hair out, etc.)	_____	_____

85. How long have you and the child's other parent been married? Please note whether the child is a product of the 1st, 2nd, etc. marriage) _____

86. Is your marriage stable? _____

87. Are there any particular marriage stressors? _____
_____
_____
_____

Please comment on your child's mood, behaviors, peer relations, and academics

Mother's Relatives

Check all yes boxes	Patient's Mother	Patient's Grandmother	Patient's Grandfather	Patient's Uncle	Patient's Aunt	Other Who?	Other Who?
Problems with aggressiveness, defiance, & oppositional behavior as a child							
Problem with attention, activity, & impulse control as a child							
Learning Disabilities							
Failed to graduate from high school							
Cognitively Delayed							
Bipolar Disorder or Manic Depression							
Depression for more than 2 weeks							
Psychosis or Schizophrenia							
Anxiety Disorder that impaired adjustment							
Tics or Tourette's							
Alcohol Abuse							
Substance Abuse							
Antisocial Behavior (assault, theft,time in jail, etc.)							
Arrests, # of times, crimes committed							
Physical Abuse Victim (V) Physical Abuse Perpetrator (P)							
Sexual Abuse Victim (V) Sexual Abuse Perpetrator (P)							
Suicide Attempts							
Suicide Completions							

Father's Relatives

Check all yes boxes	Patient's Father	Patient's Grandmother	Patient's Grandfather	Patient's Uncle	Patient's Aunt	Other Who?	Other Who?
Problems with aggressiveness, defiance, & oppositional behavior as a child							
Problem with attention, activity, & impulse control as a child							
Learning Disabilities							
Failed to graduate from high school							
Cognitively Delayed							
Bipolar Disorder or Manic Depression							
Depression for more than 2 weeks							
Psychosis or Schizophrenia							
Anxiety Disorder that impaired adjustment							
Tics or Tourette's							
Alcohol Abuse							
Substance Abuse							
Antisocial Behavior (assault, theft,time in jail, etc.)							
Arrests, # of times, crimes committed							
Physical Abuse Victim (V) Physical Abuse Perpetrator (P)							
Sexual Abuse Victim (V) Sexual Abuse Perpetrator (P)							
Suicide Attempts							
Suicide Completions							

Patient's Siblings

Check all yes boxes	Name	Name	Name	Name	Name
Problems with aggressiveness, defiance, & oppositional behavior as a child					
Problem with attention, activity, & impulse control as a child					
Learning Disabilities					
Failed to graduate from high school					
Cognitively Delayed					
Bipolar Disorder or Manic Depression					
Depression for more than 2 weeks					
Psychosis or Schizophrenia					
Anxiety Disorder that impaired adjustment					
Tics or Tourette's					
Alcohol Abuse					
Substance Abuse					
Antisocial Behavior (assault, theft,time in jail, etc.)					
Arrests, # of times, crimes committed					
Physical Abuse Victim (V) Physical Abuse Perpetrator (P)					
Sexual Abuse Victim (V) Sexual Abuse Perpetrator (P)					
Suicide Attempts					
Suicide Completions					