

# HERITAGE YOUTH SERVICES

## ADMISSIONS APPLICATION

\*\*\* Please Complete Forms Fully and Legibly.

Today's Date: \_\_\_\_\_ Person Completing the Form: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

### STUDENT INFORMATION

Student Name:	Age:	Gender:
Grade in School:	Date of Birth:	SSN:
Current Address:	City:	State/Zip Code:
Place of Birth:	Eye Color:	Hair Color:
Height:	Weight:	Race:
Natural child?	Adopted?	If adopted, when?
Who has <b>legal</b> custody of the student?		
Who has <b>physical</b> custody of the student?		
Is the non-custodial parent going to be involved in the student's treatment at Stara? If yes, will they be permitted to access the student's treatment information?		
<b>*Please include a current picture with the application</b>		

### PARENT INFORMATION

At this time, with whom does the student reside?
Are the student's parents married? Were the student's parents ever married?
Are the parents divorced or separated? If yes, when?  How has the separation or divorce affected the student?
<b>*A certified copy of the legal custody documentation is required. Please include a copy or bring it at the time of admission.</b>
Has a parent been lost to death?  If yes, please explain the circumstances and the student's reactions to this loss.

Is there any information regarding the parent's relationship which might be helpful during the student's therapy? If yes, please describe:

**MOTHER'S INFORMATION**

Name:	Age:	Date of Birth:
Occupation:	Business Phone:	
Address:	City:	State/Zip Code:
Home Phone:	Cell Phone:	Email:
Fax Number:	SSN:	Highest Level of Education:
Is there anything significant, unusual or stressful about the student's relationship with their mother?		
Please list any major illnesses and/or emotional, physical or mental problems of the mother or the mother's family:		

**FATHER'S INFORMATION**

Name:	Age:	Date of Birth:
Occupation:	Business Phone:	
Address:	City:	State/Zip Code:
Home Phone:	Cell Phone:	Email:
Fax Number:	SSN:	Highest Level of Education:
Is there anything significant, unusual or stressful about the student's relationship with their father?		
Please list any major illnesses and/or emotional, physical or mental problems of the father or father's family:		

**SIBLING INFORMATION**

Name:	Birth Date & Age:	Sex:	Current Residence:	Relationship with Student: Good ----- Average ----- Poor


Is there anything significant, unusual or stressful about the student's relationship with any of her siblings?

**STEPMOTHER'S INFORMATION**

Name:	Age:	Date of Birth:
Occupation:	Business Phone:	
Address:	City:	State/Zip Code:
Home Phone:	Cell Phone:	Email:
Fax Number:	SSN:	Highest Level of Education:

Is the stepmother deceased?  
 If yes, date of death:  
 How has the stepmother's death impacted the student?

Will stepmother be involved in treatment at HYS?

Is there anything significant, unusual or stressful about the student's relationship with their stepmother?

**STEPFATHER'S INFORMATION**

Name:	Age:	Date of Birth:
Occupation:	Business Phone:	
Address:	City:	State/Zip Code:
Home Phone:	Cell Phone:	Email:
Fax Number:	SSN:	Highest Level of Education:

Is the stepfather deceased?  
 If yes, date of death:  
 How has the stepfather's death impacted the student?

Will the stepfather be involved in treatment at HYS?

Is there anything significant, unusual or stressful about the student's relationship with their stepfather?

If the student was adopted please provide the name(s) of their biological parents and describe their relationship (if any) with their biological family:

**EMERGENCY CONTACT INFORMATION**

Name:	Relationship:	Home Phone:
Cell Phone:	Business phone:	Email:
Address:	City:	State/Zip Code:
Fax Number:		

**REFERRAL INFORMATION**

<b>How did you learn about HYS?</b>	
<input type="checkbox"/> Education Consultant:	<input type="checkbox"/> Therapist:
<input type="checkbox"/> Website:	<input type="checkbox"/> Other:
<input type="checkbox"/> Former Client:	

**FINANCIAL SPONSOR INFORMATION**

Name:	Home Phone:	Cell Phone:
Business Phone:	Fax Number:	Email:
Address:	City:	State/Zip Code:
Contact Name:	Department:	Group #:
Policy #:	Insured Name:	Insured SSN:
Insured Employer:	Insured Birth Date:	Relationship to Student:

Heritage Youth Services, does not bill insurance companies. However, we will provide documentation the parent/guardian requests to be sent to the insurance company for the purposes of billing. Although we will NOT provide individual, group or family session clinical notes we will provide dates, times and durations of sessions, treatment plans and treatment plan reviews.

**STUDENT TREATMENT HISTORY**

Has the student received psychotherapy or counseling before?

If yes, please provide the name, address, phone number of the therapist (psychologist or psychiatrist) along with the frequency of the visits, the duration of treatment and the reason for termination of the treatment.

Name: Address & Phone Number: Frequency and Duration of Visits: Reason for Termination: How was the experience?

Has the student been in previous placements outside of the home:

If yes:

Placement:

Dates:

Reason for Leaving:

Has the student received psychological testing before?

If yes, which psychological test(s) were performed, by whom and when? Please send copies of all completed testing.

What events precipitated your decision to place the student with HYS?

**TREATMENT GOALS**

What are your goals and objectives for the student while they are at HYS? (personal, academic, social)

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What are your goals and objectives for your family during your participation in a HYS program?

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What are your plans for your student when they graduate from HYS?

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**STUDENT & FAMILY HISTORY**

**DEVELOPMENTAL HISTORY**

Were there any complications during the pregnancy or birth of the student?  
If yes, please explain:

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Was there any substance use during pregnancy?  
If yes, please explain:

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Were there any birth injuries, congenital defects or inherited illnesses?  
If yes, please explain:

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Did the student achieve developmental tasks on time?

If no, please explain:

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Were there any significant injuries, surgeries or childhood illnesses?

If yes, please explain:

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Please describe the overall personality of your child in the following three phases:

Birth to Six years of age:

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Seven to Twelve years of age:

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Thirteen years of age to present:

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Has your student been diagnosed with a learning disability? (for example, dyslexia)  
If yes, please explain:

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Has your student been involved in any accident (for example a car accident) or traumatic experience?  
If yes, please explain:

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If your child was adopted were there any unique circumstances surrounding their adoption?

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**FAMILY HISTORY**

What are the strengths of your family? What areas would you like to see improvement in your family?

What does your family enjoy doing together? (For example, picnics, hiking, movies, sports..)

What support systems does your family have? (For example, extended family, church, neighbors...)

What family routines or traditions have you developed within your family?

Has your family experienced any financial difficulties?  
If yes, how have these difficulties impacted your family?

Have there ever been any physical confrontations between your child and either parent or siblings? If yes, please explain:

**STUDENT HISTORY**



Please answer the following four questions regarding your child's emotional responses:

Do they seem to be more sensitive than most?

Do you think your child has an immediate and often intense emotional reaction to life events?

Does it seem that it takes your child longer than most to get over emotional reactions?

Can your child get all her tasks done when she's in a good mood, but accomplish very little when she's in a bad mood?

If you answer yes to any question, please describe:

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~ Questions from Dr. Michael Hollander's Helping Teens Who Cut

How does your student express anger?

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Does your student exhibit low self-esteem or lack self-confidence?

If yes, please explain:

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If your student has used drugs or abused alcohol please describe their history of abuse below:

(Include the substance used, the frequency of use, how much, age started, what may have been a precursor to the use to the best of your knowledge)

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Has your student been sexually active?

If so, to your knowledge did (does) your student engage in risky sexual behaviors? If yes, please describe:

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Has your student had any changes in behavior and/or mood (for example, sad, anxious, withdrawn, angry, aggressive, suspicious, excited...)

If yes, please explain when the change occurred:

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Has your student had any abnormal thoughts?

If yes, please describe:

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Has your student hear (heard) imaginary voices or see things that are not there? If yes please describe her experiences to the best of your knowledge and include whether the voices ever accuse or instruct her?

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Has your student demonstrated violent, aggressive, cult or gang-related behavior?

If yes, please describe the behaviors you have observed:

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Has your student had any involvement with the legal system? (Please include arrests, charges, convictions and dates of incidents)

If yes, please describe:

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If your student has run away from home or another treatment program please describe the situations below:  
(Please include, when, where, how long they were gone and if they contacted anyone while they were missing and if known, how they spent their time while they were gone)

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Please describe any history of lying, dishonesty or deceit:

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Please describe any history of stealing:

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Please describe any eating disorder behaviors or body image concerns:

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Please describe your child's relationships with peers and friends:

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Do you have any concerns about the peers your student associates with?  
If yes, please explain:

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How many close friends would you say your student has?  
Please describe a general history of your student's social life, especially if there have been any recent changes:

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Does your student have any special needs related to gender, age, sexual orientation, culture, religion, nationality, race or ethnic identity?

If yes, please describe:

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Does your student have a chosen religion preference?

If so, what religion?

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Does the student believe in a higher power?

Is the family or your student involved in spiritual pursuits?

If yes, please explain:

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Describe your student's strengths, talents, and hobbies:

Describe your student's support systems: (for example, close friends, family members, or teachers)

Describe the situations in which your student usually experiences success:

**VOCATIONAL HISTORY**

If your child has had vocational or employment please complete the following information:

Place of Employment Duties Length of Employment (include dates)

Please describe your student's success with her employment:

Please describe any work-related difficulties they have had:

**ACADEMIC HISTORY**

<b>Name of Current School:</b>	<b>Phone Number:</b>	<b>Address:</b>	<b>Type of School: (private, public..)</b>
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**Previous School History:**

<b>Name of School</b>	<b>Grade(s)</b>	<b>Year(s)</b>	<b>Reason for Leaving</b>

Describe your student's attitude towards school: (anxious, disinterested, enjoys...)

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Has your student had any academic testing in the last 2 years?  
If yes, please explain:

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Has your student been academically assessed?  
If yes, please explain:

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Please describe any difficulties your child has had in school: (for example, truancy, suspension, expulsion, dropping or failing grades, behavior problems, special education services)

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Please describe any special achievements your student has made in school:

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What are your child's favorite classes/subjects in school?

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What are your student's least favorite classes/subjects in school?

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**MEDICAL HISTORY**

Name, Phone Number & Address of Family Doctor:	Name, Phone Number and Address of Family Dentist:
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Name, Phone Number & Address of Family Optometrist:	Name, Phone Number and Address of Family Orthodontist:
Does your student wear contacts or glasses? If so, when are they required to read them? Please attach a prescription	Date of last Dental Exam: Does your student wear braces or retainer(s)? If yes, date of last Orthodontic Exam:
Date of last Physical Exam:	Does your student have any problems with speech or hearing? If yes, please describe:
Does your student have any current medical conditions? If yes, please describe:	Has your student EVER been hospitalized for any reason? If yes, please describe:
Has your student ever broken a bone? If yes, please describe:	Is your student currently on any medication? If yes, please list the medication, dosage and frequency:

What is your student's history with taking medication? (overdosing, refusing to take, randomly skips doses...)

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Have any medications been recently REMOVED from your student's medication regimen?

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Is your student currently experiencing any side-effects from their current medication regimen or have they experienced any side-effects with medications in the past?

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Has your student been on her current medications long enough to be stabilized?

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Is your student allergic to any of the following:

	Reaction
( ) Bee or Wasp Sting	_____
( ) Penicillin	_____
( ) Sulfa Drugs	_____
( ) Aspirin	_____
( ) Shellfish	_____
( ) Insect Bites	_____
( )	_____
Other:	_____

Does your student have any other allergies such as Hay fever, Asthma, Hives or allergic reactions to food?

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Is your student current on all vaccinations?

Immunizations Dates

Diphtheria, Tetanus, and Pertussis (DTP)

Diphtheria-Tetanus (DT)

Tetanus

Measles, Mumps and Rubella (MMR)

Tuberculosis

Hepatitis B

Polio

Chicken Pox

Other Immunizations:

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**Please include a CURRENT copy of your student's's immunization with your admissions application.**

**HERITAGE YOUTH SERVICES**  
**Assignment of Insurance Benefits**

Patient Name: \_\_\_\_\_ Admissions Date: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Address of Insurance Company: \_\_\_\_\_  
Telephone Number of Insurance Company: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Insured Social Security #: \_\_\_\_\_  
Insured Employer: \_\_\_\_\_  
Insured Birthdate: \_\_\_\_\_

For the purpose of paying all or part of monies owing to **Heritage Youth Services** for services it has or will render to above patient, the undersigned hereby irrevocably assigns to **Heritage Youth Services** any payments payable for the benefit of said patient by the above insurance company or companies and all rights and interest in said policy but only to the extent necessary to pay **Heritage Youth Services** in full. Undersigned agrees to accept liability for payment of the full amount of all monies billed by **Heritage Youth Services** as a result of rendering services to the above mentioned patient. Liability will be reduced by the amount of benefit payments received hereunder. Undersigned understands that the nature of patient's disability may be such that no benefit payments will be payable under the policy specified above. Any monies owed by the undersigned under the terms of this agreement shall be paid in full within thirty (30) days after billing by **Heritage Youth Services** unless other arrangements have been made. In the event that collection efforts are undertaken by **Heritage Youth Services** to enforce any of the terms of this agreement, all expenses associated therewith, including reasonable attorney's fees will be paid by the undersigned.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Policy Holder and/or Parent or Guardian

\_\_\_\_\_  
Date

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

Please mark or highlight any symptom that your student has displayed in the past year or that you are worried about. Some symptoms are listed twice—**please mark your answer twice** because the symptoms are grouped according to diagnosis and it will assist our clinicians in the diagnostic process.

<input type="checkbox"/> Depressed mood most of the day	<input type="checkbox"/> Irritable mood	<input type="checkbox"/> Diminished interest in pleasurable or goal directed activity	<input type="checkbox"/> Significant weight loss when not dieting
<input type="checkbox"/> Significant weight gain (change of 5% of body weight in a month)	<input type="checkbox"/> Decrease in appetite	<input type="checkbox"/> Increase in appetite	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Hypersomnia	<input type="checkbox"/> Psychomotor agitation	<input type="checkbox"/> Psychomotor retardation	<input type="checkbox"/> Significant fatigue
<input type="checkbox"/> Loss of energy	<input type="checkbox"/> Feelings of worthlessness	<input type="checkbox"/> Excessive or inappropriate guilt	<input type="checkbox"/> Diminished ability to think or concentrate
<input type="checkbox"/> Indecisiveness	<input type="checkbox"/> Recurrent thoughts of death	<input type="checkbox"/> Recurrent suicidal ideation	<input type="checkbox"/> Suicide plans
<input type="checkbox"/> Past suicide attempt	<input type="checkbox"/> Feelings of hopelessness	<input type="checkbox"/> Low self-esteem	<input type="checkbox"/> Social Isolation
<input type="checkbox"/> Inability to express herself to significant others			

<input type="checkbox"/> A period of abnormally elevated, or irritable mood for 1 week or more		<input type="checkbox"/> Psychomotor agitation		
<input type="checkbox"/> Inflated self-esteem	<input type="checkbox"/> Grandiosity	<input type="checkbox"/> Decreased need for sleep	<input type="checkbox"/> More talkative than usual	<input type="checkbox"/> Pressured speech
<input type="checkbox"/> Flight of ideas	<input type="checkbox"/> Distractible	<input type="checkbox"/> Increase in goal directed activity	<input type="checkbox"/> Excessive involvement in activities that have a high potential for painful consequences (shopping sprees, sexual indiscretion)	

<input type="checkbox"/> A pattern of negative behavior	<input type="checkbox"/> Hostile behavior	<input type="checkbox"/> Defiant behavior	<input type="checkbox"/> Often loses temper	<input type="checkbox"/> Argues with adults
<input type="checkbox"/> Actively defies or refuses to comply with adults' requests or rules	<input type="checkbox"/> Deliberately annoys people	<input type="checkbox"/> blames others for her mistakes or misbehavior		
<input type="checkbox"/> Touchy or easily annoyed by others	<input type="checkbox"/> Angry	<input type="checkbox"/> Resentful	<input type="checkbox"/> Spiteful or vindictive	<input type="checkbox"/> Sense of entitlement
<input type="checkbox"/> Dishonesty	<input type="checkbox"/> Shoplifting	<input type="checkbox"/> Running away from home	<input type="checkbox"/> Truant from school	<input type="checkbox"/> fails to give attention to details
<input type="checkbox"/> makes careless mistakes in school, work or other activities	<input type="checkbox"/> Has difficulty sustaining attention in task or play activities	<input type="checkbox"/> Fails to finish schoolwork or chores		
<input type="checkbox"/> Often does not seem to listen when spoken to directly	<input type="checkbox"/> Has difficulty organizing tasks and activities	<input type="checkbox"/> Does not follow through on instructions		
<input type="checkbox"/> Avoids or dislikes engaging in tasks that require sustained mental effort	<input type="checkbox"/> Often loses things necessary for task or activities (for example, homework, pencil, books)	<input type="checkbox"/> Often feels restless		
<input type="checkbox"/> Is often easily distracted by extraneous stimuli	<input type="checkbox"/> Often leaves seat in the classroom or in other situations in which remaining seated is expected	<input type="checkbox"/> Talks excessively		
<input type="checkbox"/> Has Difficulty playing or engaging in leisure activities quietly	<input type="checkbox"/> Often blurts out answers before questions have been completed	<input type="checkbox"/> Has difficulty waiting turn		
<input type="checkbox"/> Often interrupts or intrudes on others				

<input type="checkbox"/> She experienced or witnessed an event that involved actual or threatened death, serious injury or threat to the physical integrity of self or others		
<input type="checkbox"/> Her response to the experience involved intense fear, helplessness or horror	<input type="checkbox"/> She experiences recurrent and intrusive distressing recollections of the event	<input type="checkbox"/> She experiences recurrent distressing dreams of the event
<input type="checkbox"/> She acts out or feels as if the traumatic event were recurring	<input type="checkbox"/> She experiences intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	

<input type="checkbox"/> Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	<input type="checkbox"/> Efforts to avoid thoughts, feelings or conversations associated with the trauma	
<input type="checkbox"/> Efforts to avoid activities, places or people that arouse recollection of the trauma	<input type="checkbox"/> Inability to recall an important aspect of the trauma	<input type="checkbox"/> Feelings of detachment or estrangement from others
<input type="checkbox"/> Markedly diminished interest or participation in significant activities	<input type="checkbox"/> Restricted range of moods	<input type="checkbox"/> Sense of foreshortened future
<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Hyper vigilance	<input type="checkbox"/> Exaggerated startle response
<input type="checkbox"/> Excessive anxiety or worry for at least 6 months	<input type="checkbox"/> Difficulty controlling the worry	<input type="checkbox"/> Restlessness or feeling keyed up or on edge
<input type="checkbox"/> Being easily fatigued	<input type="checkbox"/> Difficulty concentrating or mind going blank	<input type="checkbox"/> Irritability
<input type="checkbox"/> Muscle tension	<input type="checkbox"/> Sleep disturbances	

<input type="checkbox"/> Discrete periods of intense fear or discomfort	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Pounding heart
<input type="checkbox"/> Accelerated heart beat	<input type="checkbox"/> Sweating	<input type="checkbox"/> Trembling or shaking
<input type="checkbox"/> Sensations of shortness of breath or smothering	<input type="checkbox"/> Feelings of choking	<input type="checkbox"/> Chest pain or discomfort
<input type="checkbox"/> Nausea or abdominal distress	<input type="checkbox"/> Feeling dizzy, unsteady lightheaded or faint	<input type="checkbox"/> De-realization or self-detachment
<input type="checkbox"/> Fear of losing control or going crazy	<input type="checkbox"/> Fear of dying	<input type="checkbox"/> Numbness or tingling limbs
<input type="checkbox"/> Chills or hot flashes	<input type="checkbox"/> Anxiety about being in places that can bear embarrassing	<input type="checkbox"/> Fear of crowds
<input type="checkbox"/> Fear of being alone	<input type="checkbox"/> Fear of standing in lines	<input type="checkbox"/> Fear of heights
<input type="checkbox"/> Fear of closed places	<input type="checkbox"/> Fear of leaving home	<input type="checkbox"/> Fear of flying
<input type="checkbox"/> Fear of animals	<input type="checkbox"/> Fear of speaking in public	

<input type="checkbox"/> Recurrent thoughts or impulses that cause marked anxiety or distress (that are not about real life problems)	<input type="checkbox"/> attempts to deal with the thoughts with some other thought or action	
<input type="checkbox"/> She knows that they are a product of her own mind	<input type="checkbox"/> Repetitive behaviors or mental acts that she feels driven to perform in response to an obsession	<input type="checkbox"/> Behaviors or mental acts are aimed at preventing some dreaded event
<input type="checkbox"/> Checking things over and over again	<input type="checkbox"/> Washing her hands over and over again	<input type="checkbox"/> Ritualistic behavior
<input type="checkbox"/> Being uncomfortable when things are not in perfect order (clothes, food on a plate, towels)		

<input type="checkbox"/> Cannabis (marijuana)	<input type="checkbox"/> Amphetamines	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Hallucinogens
<input type="checkbox"/> Inhalants	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Nicotine/Tobacco	<input type="checkbox"/> Other

<input type="checkbox"/> Tolerance-need for increased amounts of the same substance to achieve desired effect OR marked diminished effect with the same amount of substance	<input type="checkbox"/> Withdrawal-classic withdrawal symptoms OR taking a similar substance to avoid withdrawal symptoms	
<input type="checkbox"/> Substance is taken in larger amounts or over a longer period of time than what she intended	<input type="checkbox"/> Persistent desire or unsuccessful attempts to cut down on usage	<input type="checkbox"/> Use is continued despite knowledge of harm to self and others
<input type="checkbox"/> Recurrent use resulting in failure to fulfill a major role or obligation (school, work, family)	<input type="checkbox"/> Use in situations that are physically hazardous (cars, needles)	<input type="checkbox"/> Related legal problems (arrest, under-age use)
<input type="checkbox"/> Continued use despite having recurrent relationship problems (arguments, family stress, social problems, school problems)		

<input type="checkbox"/> Recurrent episodes of binge eating	<input type="checkbox"/> Eating in a discrete period of time	<input type="checkbox"/> Eating amounts of food that are definitely larger than most people would eat
<input type="checkbox"/> A sense of lack of control over eating	<input type="checkbox"/> Recurrent inappropriate compensatory behavior in order to prevent weight gain	<input type="checkbox"/> Self induced vomiting
<input type="checkbox"/> Misuse of laxatives	<input type="checkbox"/> Is sick often	<input type="checkbox"/> Cuts on the back of hands
<input type="checkbox"/> Recent tooth decay	<input type="checkbox"/> A history of physical complaints that occur over a long period of time	<input type="checkbox"/> Seem to be preoccupied with physical problems
<input type="checkbox"/> Self evaluation is unduly influenced by body shape and weight		

<input type="checkbox"/> Several discrete episodes of failure to resist aggressive impulses that result in serious assault acts or destruction of property
<input type="checkbox"/> Degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating stressors

<input type="checkbox"/> Impairment in the use of multiple nonverbal behaviors (eye to eye gaze, facial expressions, body postures, gestures)		
<input type="checkbox"/> Failure to develop age appropriate peer relationships	<input type="checkbox"/> Lack of spontaneous seeking to share enjoyment or interest	<input type="checkbox"/> Lack of social or emotional reciprocity
<input type="checkbox"/> Preoccupation with restricted patterns	<input type="checkbox"/> Inflexible adherence to routines or rituals	<input type="checkbox"/> Stereotyped and repetitive motor mannerisms
<input type="checkbox"/> Preoccupation with parts of objects		

<input type="checkbox"/> Pattern of failing grades, underachievement, truancy, dropping out of school				
<input type="checkbox"/> Physical abuse of your student		<input type="checkbox"/> Sexual abuse of your student		
<input type="checkbox"/> Non-compliance with out-patient therapy, medication, probation, in-patient treatment				
<input type="checkbox"/> IQ Below 70	<input type="checkbox"/> IQ between 71-84	<input type="checkbox"/> IQ between 85-115	<input type="checkbox"/> IQ between 116-130	<input type="checkbox"/> IQ above 131
<input type="checkbox"/> Bereavement	<input type="checkbox"/> Abortion	<input type="checkbox"/> Loss of loved one	<input type="checkbox"/> Suicide of close friend	<input type="checkbox"/> Divorce

<input type="checkbox"/> Unstable relationships	<input type="checkbox"/> Unstable moods	<input type="checkbox"/> Highly impulsive
<input type="checkbox"/> Frantic efforts to avoid abandonment		<input type="checkbox"/> Intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
<input type="checkbox"/> Unstable self-image or sense of self	<input type="checkbox"/> Impulsive in at least 2 dangerous areas (spending, sex, substance abuse, reckless driving, binge eating)	
<input type="checkbox"/> Recurrent suicidal behaviors, gestures or threats	<input type="checkbox"/> Self mutilating behavior	<input type="checkbox"/> Intensely reactive moods
<input type="checkbox"/> Chronic feelings of emptiness	<input type="checkbox"/> Inappropriate and intense anger	<input type="checkbox"/> Difficulty controlling anger
<input type="checkbox"/> Stress related paranoid thoughts	<input type="checkbox"/> Dissociative symptoms	

<input type="checkbox"/> High emotionality and attention seeking	<input type="checkbox"/> Uncomfortable in situations which she is not the center of attention
<input type="checkbox"/> Interaction with others is characterized by inappropriate sexually seductive or provocative behavior	
<input type="checkbox"/> Rapidly shifting and shallow expression of emotion	<input type="checkbox"/> Speech is impressionistic and lacking in detail
<input type="checkbox"/> Use of physical appearance to draw attention to self	<input type="checkbox"/> Shows self-dramatization, theatricality and exaggerated expression of emotion
<input type="checkbox"/> Suggestible or easily influenced by others	<input type="checkbox"/> Considers relationships to be more intimate than they actually are

General Health

<input type="checkbox"/> Good Physical Health	<input type="checkbox"/> Allergies	<input type="checkbox"/> Recent operation
<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Broken bones	<input type="checkbox"/> Tooth decay

Problems with Primary Support Group

<input type="checkbox"/> Educational problems	<input type="checkbox"/> Problems related to interaction with the legal system or a crime	
<input type="checkbox"/> Change of residence	<input type="checkbox"/> Recent break up with a serious boyfriend	<input type="checkbox"/> Drug detoxification
<input type="checkbox"/> Recent Parental divorce		

Symptoms relating to parents

<input type="checkbox"/> Impaired Communication	<input type="checkbox"/> Overprotection	<input type="checkbox"/> Enmeshment
<input type="checkbox"/> Inadequate discipline	<input type="checkbox"/> Intense relationship	<input type="checkbox"/> Obvious lack of functionality
<input type="checkbox"/> Unresolved issues	<input type="checkbox"/> Lack of respect	<input type="checkbox"/> Out of control feelings

## VISITATION

All visits to your student must be pre-approved by your therapist and the treatment team.

All visitors must check-in with staff upon arrival. Visits are contingent on your student's advancement in the program.

Student's Name:

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## APPROVED TELEPHONE LIST

Calling privileges are according to the Program.

My student, \_\_\_\_\_ may telephone the following people (Please list immediate family members first, then extended family members, then friends)

NAME/RELATIONSHIP	PHONE NUMBER	REVIEWED BY THERAPIST

## APPROVED MAIL LIST

All incoming and outgoing mail will be matched with this list

E-mail will be received, but your student will not be able to send e-mail

Mail privileges are according to the program

<b>NAME/RELATIONSHIP</b>	<b>ADDRESS</b>	<b>AGE</b>	<b>PHONE NUMBER/EMAIL</b>	<b>Approved by Therapist</b>