ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666   Fax: (301) 951-3339

Dear

I am honored to have the opportunity to work with you and/or your family. In the enclosed packet you should find:

A ***Clinical Services*** sheet summarizing my background and training (and Christine Yeannakis' background and training if testing services are requested).

2 copies of the ***Psychotherapy Policies and Fees*** contract. Please read this contract over carefully and sign and return one copy prior to our first session. The second copy is for your records. If you have questions or concerns, please feel free to contact me.

A white ***Medical History Form***. Please fill this out before our first session.

An ***Obtaining Health Insurance Reimbursement*** sheet. The information on this sheet should come in handy if you choose to use your health insurance benefits for psychotherapy. If you have questions regarding the "pros" and "cons" of doing so, please do not hesitate to ask.

Directions to help you find us!

* If you are coming in for a social/emotional assessment or for a learning disability/ADD evaluation, this packet will also include a sheet entitled ***Psychological Testing for Children – A Guide to Frequently Asked Questions***.

Again, if you have any questions, comments or concerns, please contact me at 301-951-5666 or Christine Yeannakis at 703-739-2620 (if you are coming in for testing). My voice mail is confidential.

Thank you again.

Joel Adler, Psy.D.
Licensed Clinical Psychologist

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

Professional Background

Joel Adler, Psy.D. has directed Assessment Associates since January 2000. Prior to moving to the Washington Metropolitan area, he worked in Charlotte, North Carolina for 7 years, 5 of which were spent in a multi-disciplinary practice that evaluated and treated children with a wide range of learning, attentional and emotion problems.

Dr. Adler's undergraduate training was completed at Alfred University in upstate New York, with a major in Sociology and a minor in Religious Studies. He went on to earn his Masters of Theological Studies (M.T.S.) from Harvard Divinity School, focusing on the interplay between religion, psychology, and human development. He received his Masters (M.A.) and Doctor of Psychology (Psy.D.) from the California School of Professional Psychology in San Diego, California. Dr. Adler completed his internship training at Springall Academy, a school specializing in the education and treatment of learning disabled children, and at the Counseling and Psychological Services Department at San Diego State University and San Diego City College. Dr. Adler is a Maryland licensed psychologist. He is also a member of the American Psychological Association, The Maryland Psychological Association, and the National Registrar for Health Service Providers in Psychology.

Specialty areas include, yet are not restricted to, Comprehensive Psycho-educational and ADHD Testing, ADHD interventions, socialization and/or process oriented groups for kids and teens, eating disorders, self-injurious behaviors in teens and pre-teens, anxiety, depression, life adjustment and transition issues, parenting and child development consultation, and sports psychology interventions.

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666   Fax: (301) 951-3339

PSYCHOTHERAPY POLICIES & FEES

FEES:

Individual/Couples/ Family Therapy: $175 for 50-minute session
Group Therapy: $80 for 50-minute session

All my professional time will be billed at a $175 rate. This includes report preparation, letters on your behalf to insurance companies, legal correspondences, and phone calls (of more than 5 minutes in duration). Calls after 11:00 p.m. are charged at 150% of usual rate (I will not respond to calls at this time unless they are truly a life or death emergency).

For work outside my office, such as seeing clients in the hospital or house calls, I charge my individual rate "door to door" – that is for the time I am out of the office on your behalf.

PAYMENTS:

Full payment is due at the beginning of each session. Please make out your check before the session begins. My fee is not open to further negotiation.

Outstanding balances: I run a fee for service practice so I do not have to deal with the extra overhead of billing. For this reason, I expect outstanding balances (i.e. "I forgot my checkbook" or "I forgot we had an appointment") to be made up at the following session. In such instances that outstanding balances are over 30 days you will be assessed a finance charge of 2% compounded monthly. You will be billed at the first of each month. There is a $15 rebilling fee for every statement sent out after the first billing. There is also a $30 fee for all checks returned for insufficient funds. After 90 days with no payment or effort to arrange payment, accounts will be turned over to a collecting agency and will impact your credit rating.

Insurance: I will give you a receipt with a copy for your insurance company. Please specify if you intend to submit a claim due to the extra information required for insurance reimbursement – including a diagnosis of a mental disorder. Moreover, your insurance carrier may require my providing them with *detailed* background, including substance abuse and sexual history. You may understandably elect not to use your insurance to protect your confidentiality or to avoid the "mental disorder" label.

Your health insurance policy is a contract between you and your insurance company. I am not a party to that contract. I would be considered an out-of-network provider, and you will need to inquire as to your benefits in light of this fact. I no longer contract directly with insurance companies as a network provider so I am responsible and accountable *only* to you. Thus, my loyalties are not divided and there are no conflicts of interest.

Usual and customary Fees: Our practice is committed to providing the best treatment possible at a reasonable rate. For the Washington metropolitan area, our fees are in line with other therapists in the community given comparable levels of experience and expertise. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

SESSION ETIQUITTE:

You don't need to knock on the front door when you come in for your appointment. Come in and sit down in the waiting area. I'll come and get you promptly at the first of the hour. Our time will end 10 minutes to the hour. I use the 10 minutes between sessions to return phone calls, collect my thoughts, process our session,

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

write case notes and keep up with the increasing paperwork demands. Please help me stay on time by having your check written prior to the beginning of the session. There is a bathroom and usually bottled water for your use in the office.

CONFIDENTIALITY:

In all matters having to do with your psychotherapy, confidentiality will be maintained unless you have signed a written release of information to a specific individual or agency. If your insurance uses managed health care, I may be required to write reports or discuss your case with a case manager. I will not send a report without your first reviewing and approving it. There are two exceptions to the confidentiality policy: If a think a client is of imminent danger to herself or others; or if I decide that consultation with a colleague will help in your treatment. In the latter situation, your name will not be used. Your signature below signifies your granting permission for such consultation.

APPOINTMENTS:

At the end of our first session we will make arrangements for further sessions. You can either have the same time or day each week, or if your own schedule does not allow for this we can vary the time and day. Due to my caseload there are usually limited possibilities as far as open times. I set appointments on the hour from 8:00 a.m. to 5:00 p.m. I often take off from 12:00 to 1:00 , with the exception of the days I do assessments. If there is a change in my normal office hours, I will inform you promptly. As many people want times convenient to their work or after school schedules, the most popular times are 9:00, 3:00, 4:00 and 5:00. These are often filled.

If you cannot keep an appointment time, please give me 24 hours notice so I can make the time available for others who need to see me. If you miss an appointment without notifying me or cancel with less than 24 hours notice, I will need to charge you my full fee for the time. NOTE: Insurance companies do not reimburse for missed appointments.

PHONE CALLS & MESSAGES:

I strive to promptly return phone calls, but inevitably there can be delays. If I am unreachable for a period of several days (such as vacations, etc.), I will specify this on my confidential voice mail. If there is an emergency, please call me at 301-908-4147. If for some reason, you are not able to get in touch with me, please contact the nearest hospital emergency room. If I am out of town, emergency calls will be transferred to an “on call” therapist in our practice or in another practice.

NOTICE OF TERMINATION:

You are not obliged to see me any specified number of sessions. It is important, however, to give me one session’s notice before ending. What I want to avoid is a situation where you cancel and then don’t reschedule without explanation. A clean ending to our time together will be important for both of us.

I understand and agree to the terms of the specified above:

Client’s Signature ________________________ Date__________________________

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666   Fax: (301) 951-3339

OBTAINING HEALTH INSURANCE REIMBUSMENT

WARNING!

When considering the use of your insurance for the reimbursement of my services you need to be aware that, at a minimum, I must give them a diagnosis. Even with a seemingly benign diagnosis like “Adjustment Disorder” you have a mental disorder label that can result in your being denied an application for disability, life, or other health insurance. Further, I cannot guarantee what the insurance company does with this information. If you have an insurance policy that is reviewed by one of the managed health care companies, I must provide them detailed information as to your personal history, sexuality, HIV status, drug and alcohol use, problems and progress. Failure to do so will mean denial of benefits. I cannot guarantee this information will not be leaked in some cases, albeit rare (*and illegal*), to your employer or Medical Information Bureau (a National database used by insurance companies).

1. AUTHORIZATION:

Most insurance membership cards have a 1-800 phone number that you need to call for authorization of mental health benefits. Your insurance company may direct you to a managed care company whose job it is to “manage” your use of my services (in effect, keep the cost down). Call the number and:

a. Ask if I am covered as an out-of-network provider.
If they ask my credentials:
- Licensed Psychologist
  License #04234
- My liability is current at 1millioin/3million
- My tax ID number is 56-20922-02

b. If they tell you I am a preferred provider and on their list or general panel, tell them I have resigned effective July 1st, 1998 from all provider panels. Clarify if my contract with them requires me to give them more than 60 days notice, or requires me to continue treating you under the terms of the contract until your current course of treatment is terminated. If this is the case, request a copy of these stipulations be forwarded to my office.

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

c. You then will need to know:

1. What are your benefits? Deductible, co-pay, annual limits, maximum paid per session, number of approved sessions, type of approved sessions (some do not pay for group or couples session or psychological testing). Any other restrictions or limitations?
2. What is required of me, as your therapist, i.e. written report or case review by phone? Have them forward this information (with an understanding that there will be a charge for my time meeting these requirements).
3. Is there an Authorization Number?

2. FILING A CLAIM:

a. Ask your insurance company to provide you with an insurance claim form. Fill in the top portion, including your authorization number**. Do not sign the box authorizing payment directly to me.** *If they do send the check to me I will sign it over to you, or if your prefer credit it to your account.*

b. I will provide you with a receipt for services at the end of each session. Keep one for your own records and attach one to your insurance claim form. This receipt will serve in lieu of the *Physician or Supplier Information* Section.

c. Start a file, and keep track of what insurance actually pays for. Be prepared for them to make a mistake, and for payments to take about 2-3 months. If it takes longer, act assertively, "bug them mercilessly" and "stay on their case".

Note: If you have problems with your insurance or managed health care company be sure the Benefits Office of the Human Resources Department is aware of your difficulties.

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

DIRECTIONS TO ASSESSMENT ASSOCIATES AND DR. ADLER'S OFFICE

Dear Mrs./Mr.________________

______________ has an appointment is on __________________ at ____________

From most Northern Virginia locations:

1. Take 495 North (towards Maryland)
2. Merge **RIGHT** onto the **River Road** exit (a few miles after crossing the Potomac) and stay to your right
3. Exit **RIGHT** off the ramp onto **River Road**
4. Take a **LEFT** onto **Goldsboro Road** (about 2 to 3 miles) and stay on it until it ends (at the intersection of Bradley Blvd.)
5. Take a **RIGHT** onto **Bradley Blvd**.; Cross **Wisconsin Avenue**. and **Connecticut Avenue.** until Bradley Blvd. turns in to **Bradley Lane**)
6. Follow **Bradley Lane** until it ends (intersection of **Bradley Lane** and **Brookville Road**). You likely will not see the **Brookville Road** street sign
7. Take a **LEFT** onto **Brookville Road** for about 100 yards. You will see the Brookville Rd. shopping Center on your right
8. You should see the blue **Assessment Associates** sign above the barber shop and dry cleaners. The entrance to the practice is on the door marked 7013 A-B. Walk up the steps and veer to your left

From most Maryland locations:

1. Take 495 South (towards Virginia)
2. Merge **RIGHT** onto the **Connecticut Avenue** exit and stay to your left
3. Take a **LEFT** onto **Connecticut Avenue** and stay on Connecticut Avenue for **exactly 1.6 miles**
4. Take a **LEFT** onto **Taylor Street** (you will see the National 4-H center on your right)
5. Follow **Taylor Street** until it ends. Cross over **Brookville Road** (intersection of Taylor Street and Brookville Road) into the side and back parking areas.
6. You should see the blue **Assessment Associates** sign above the barber shop and dry cleaners. The entrance to the practice is on the door marked 7013 A-B. Walk up the stairs and veer to your left when you reach the top

Parking
Parking is free. You can park in the front, back or side of the shops. You can also park on the streets in the surrounding neighborhoods if the parking lot is full, which is highly unlikely.

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

Today's Date___________

Child's Name:____**Sex**______**Race**____

Date of Birth:________________ **Age**: _____**years** _____**months** **Adopted? Y N. Age**_____

Responsible Party:__________________________________**Relationship:**____________________

Address:___________________**City**___________________**State**_____**Zip**____________________

Home Phone____________**Work Phone**____________**Cell**________**E-Mail**___________________

Mother:______________________________________**Work Phone:**__________________________

Address:______________________**City**_______________________**State**______**Zip**_____________

Home Phone____________**Work Phone**____________**Cell**________**E-Mail**___________________

Employer________________________**Occupation**____

Father____**Work Phone:**__________________________

Address:_____________________**City**________________________**State**______**Zip**_____________

Home Phone____________**Work Phone**____________**Cell**________**E-Mail**___________________

Employer________________________**Occupation**____

Parents' marital status:____ **Step-parents involved:**_____________________________________

Legal custody arrangements:____

Pediatrician:________________________________**Address**__________________________________

Other Physician:______________________________**Specialty:**______________________________

Referred by:__________________________________**Affiliation:**_____________________________

Current School:______________________________**Grade:**____**Teacher/Advisor:**______________

Others in home. List all adults and children who live in home with clients, other than parents.

Name	Age	Relationship to Client

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

What specific questions or concerns do you have about your child? Please list these here.

____

____

____

Pregnancy

Length of Pregnancy: _____weeks Weight gain: _____

Medical care began in the ____ month of pregnancy.

Please review this risk list. If the mother of this client experienced any of these risks, please circle "Yes" and explain **when** in the pregnancy the problem occurred, details about the problem, the treatment prescribed and any other relevant information.

Excessive nausea/vomiting	Yes	No	________________________
Weight gain of 25 lbs plus	Yes	No	________________________
Weight gain of less than 10 lbs	Yes	No	________________________
RH problems	Yes	No	________________________
Abuse of alcohol	Yes	No	________________________
Abuse of drugs	Yes	No	________________________
Cigarette smoking	Yes	No	________________________
Medications (other than vitamins)	Yes	No	________________________
High blood pressure	Yes	No	________________________
Toxemia	Yes	No	________________________
Severe headaches	Yes	No	________________________
Spotting or bleeding	Yes	No	________________________
Severe accident/injury	Yes	No	________________________
X-rays	Yes	No	________________________
False labor	Yes	No	________________________
Special diet	Yes	No	________________________
Unusual physical strain	Yes	No	________________________
Unusual emotional strain	Yes	No	________________________
Other illness/medical problem	Yes	No	________________________
Other problem or risk factor	Yes	No	________________________

Birth

Length of hospital stay:________If extended, please explain:___________________

Length of labor:______________Labor induced?_____ Anesthesia? Y N, If yes, type_________

Type of birth: Vaginal Breech Multiple :_____(number) Caesarean--planned emergency

Forceps used: Yes No Did the mother have complications during labor and delivery? Yes No

If yes, please explain:____

Was the baby in distress during labor and delivery? Yes No. If yes, please check any of the following that apply and explain.

Unable to start breathing without help Yes ____
Cord twisted around neck Yes____
Heart rate a concern before delivery Yes____
Heart rate a concern after delivery Yes____
APGAR at 1 minute less than 9 Yes____
APGAR at 5 minutes less than 9 Yes____
Other pre-natal concerns Yes____
Other neo-natal concerns Yes____

APGAR at 1 minute:______ APGAR at 5 minutes:_______ Birth Weight___________________

First Month of Life

If the client experienced any of the following during the first month of life, please indicate by circling and explaining below.

1. cyanosis ("blue baby")	5.failure to thrive	9. infection	13. stiff	17. anemia
2. jaundice (yellow)	6. floppy	10. hard to feed	14. skin rash	18. anemia
3. injury	7. excessive crying	11. jittery	15. deformity	19. colic
4. breastfed	8. convulsions/seizures	12. trembling	16. diarrhea	20. heart problems

Explanations:-
____

____
_

Early Development

Milestone	**Approximate Age Achieved**
Sucked well from bottle and/or breast	
Made single sounds	
Used words	
Combined words in short sentences	
If child is under age five, circle present vocabulary size	
No words	
1-25	
26-50	
51-75	
76-100	
Over 100	
Drank from cup	
Ate solid baby food	
Ate table food exclusively	
Smiled	
Tracked objects with eyes	
Reached for objects	
Rolled over	
Sat without support	
Crawled	
Pulled to stand	
Walked alone	
Bladder trained	
Bowel trained	
Undressed self	
Used toilet alone	
Buttoned clothes	
Dressed self	
Rode tricycle	
Rode bicycle	
Drew circle	
Skipped	

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

Thinking about the client's early childhood (approximately ages 2-5 years), do any of the following describe the client? If yes, please explain.

Seems to hear poorly, at least sometimes Yes ______________________________
Communicating mostly by gestures Yes______________________________
Communicating mostly by crying Yes______________________________
Speech hard to understand by family Yes______________________________
Speech hard to understand by others Yes______________________________
Child started to use words and stopped Yes______________________________
Child stuttered Yes______________________________
Child's speech was not fluent Yes______________________________
Child choked frequently while eating Yes______________________________
Child drooled beyond teething years Yes______________________________

Medical History

Client is currently taking the following medications (attach page if necessary):

Medication Name	Dosage (mg/number of times daily)	Reason Prescribed	Prescribed by	Comments

Client has or has had the following medical problems:

Problem	Age Problem Began	Currently a Problem?	Other Information
Seizures, convulsions			
Meningitis			
Head injury (even minor)			
Fainting spells			
Immunization reaction			
Measles			
Vision difficulty (specify)			
Ear infection			
Other infections			
Chronic illness (specify)			

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666   Fax: (301) 951-3339

Allergies (specify)			
Chronic cough			
Asthma			
Heart disorder (specify)			
Gastro-intestinal disorder			
Other (specify)			
Other (specify)			
Other (specify)			

Please list all hospitalizations, including Emergency Room visits, below:

Month/Year (approx)	Reason	Hospital--City, State	Outcome

Pre-Academic and Academic Skills

Problem	Is this a current concern?	This was a concern when client was age:	Additional information	Not a concern
Poor physical coordination				
Poor handwriting				
Poor short-term memory				
Poor long-term memory				
Left-right dominance not established				
Left-right dominance established late, **at age ____**				
Late to name letters				
Poor word recognition skills				
Weak reading comprehension				
Weak knowledge of				

basic phonics				
Weak knowledge of advanced phonics				
Trouble getting ideas on paper				
Math problems				
Poor spelling in daily work				
Can't get homework done				
Attention span a problem in class				
Conflict with teacher				
Standardized test scores have dropped				

Evaluations

Please record all the client's publicly and privately funded assessments and evaluations in the chart below. Doctors' visits may be included when they resulted in a diagnosis that is related to the current problem (e.g. ADHD).

Month/Year (approx)	**Evaluator**	**Affiliation**	**Reason for Evaluation**	**Diagnosis, if any**	**Resulting interventions, if any**

****Please provide <u>copies</u> of as many of these evaluations, treatment plan, IEPs and progress reports as possible for the evaluation team's review.****

Education, Intervention and Treatment History

If both parents worked outside the home, who cared for the client during business hours? Please explain arrangements for the client from birth until school age:

Did the client attend a formal early childhood education program, such as preschool? Yes No.
If yes, at what age did the client begin? ________________

Please circle the phrases that apply to each year of the client's early childhood education:

Program Descriptors	**Age Two in September**	**Age Three**	**Age Four**	**Age Five**

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

Program Descriptors	Age Two in September	Age Three	Age Four	Age Five
Half-day				
Full-day				
Five days/week				
Four days/week				
Three days/week				
Two days/week				
Mornings				
Afternoons				
Co-operative				
Day Care Center				
Family Day Care				
Faith-Affiliated				
Academic focus				
Play-based				
Bilingual				
Part of an elementary school				
Public				
Private				
Special education				
Language immersion				
Parent or caregiver taught basics at home				
Other				
Other				
Other				

Did the client continue in preschool ***after*** he or she was of "legal age" to enter kindergarten? ___

Has the student repeated a grade? _____. If yes, which grade? ______.

Please list all schools attended, begin with pre-school.

School, city, state	Grades	School Years	Reason for Leaving

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

Please list special services, supports, interventions, treatments, therapies and tutoring this client has received. Included those funded by the public schools, the family, insurance and other sources. **Example: Counseling—2/99-6/99—Dr. Jones—distressed by move to new state.**

Service	Month/Year to Month/Year (approx)	Provider	Reason

Social, Emotional and Behavioral Concerns

Problem	Is this a current concern?	This was a concern when client was age:	Additional information	Not a concern
Difficult to discipline				
Gets upset easily				
Temper tantrums				
Nail biting				
Thumb sucking				
Trouble falling asleep				
Trouble staying asleep/wakes in the night				
Won't fall asleep alone				
Won't stay asleep alone				
Sleeps too much				
Wakes too early				
Has nightmares				
Wets bed				
Destroys property				
Prefers to be alone				
Unusually active				
Fidgety				
Unusually inactive				
Lethargic				
Seems sleepy, though has had enough sleep				
Apathetic				
Unusual difficulty getting along with brothers and sisters				
Unusual difficulty getting along with other children				
Inattentive				
Distractible				
Blames others for own mistakes				

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

Problem	Is this a current concern?	This was a concern when client was age:	Additional information	Not a concern
Expresses no guilt for own mistakes				
Lying				
Stealing				
Truancy				
School refusal				
Physical violence against persons				
Physical violence against property				
Repeated alcohol use (minor children)				
Alcohol abuse (adults)				
Illegal drug use				
Misuse of prescribed medications				
Unrealistic worry				
Pessimistic attitude				
Anxiety				
Headaches				
Stomachaches				
Nausea				
Sadness, crying				
Self-conscious/easily embarrassed				
Avoids peer interactions				
Avoids other non-familiar social contacts				
Argumentative				
Stubborn				
Excessive concern with weight				
Chronic over-eating/under-eating				
Motor and-or vocal tics				
Wetting self				
Soiling self				
Cutting self				
Resistance to change				
Self-injurious behaviors				
Unusual speech or motor movements				
Panic attacks				
Decreased productivity				
Chronic fatigue				
Decreased interest in previously pleasurable activities				

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666 Fax: (301) 951-3339

Problem	**Is this a current concern?**	**This was a concern when client was age:**	**Additional information**	**Not a concern**
Thoughts of death or suicide				
Hallucinations				
Delusions				
Insomnia (can't sleep)				
Hypersomnia (sleeps too much)				
Decreased inhibitions				
Odd ideas				
Odd language/speech				
Changes in personal hygiene				
Overly dependent/helpless				
Procrastinates				

If the client is a child, please answer the following questions regarding discipline.

- **Who usually disciplines the child?______________________________**
- **What methods of discipline are used?___________________________**
- **Do parents agree on when and how to discipline the child?______**
- **If no, please explain the nature of the disagreement and how it is managed.**

What are this client's interests and strengths? What does the client like to do for fun? What does the client do well? Please tell what brings this person joy and success.

ASSESSMENT ASSOCIATES

7013-A Brookeville Road
Chevy Chase, MD 20815
Phone: (301) 951-5666   Fax: (301) 951-3339

Please think about the last six to nine months. Have there been any major changes or events in the client's life that could be important? Consider the client's family, school and social relationships and the health of the client as well as that of close family members. Note anything you think might be important here:

What have we forgotten? Please use the rest of this sheet, and additional paper, as necessary, to tell us anything we have not asked about, but which you think will help us in understanding your child.