

Thank you for considering Providence Pass for your daughter.

The following admissions application is designed to help us understand you and your child. Please fill out all applicable information as completely and honestly as possible.

Please print a hard copy of the document to complete it and return to me by fax or email. Once we have reviewed the application we will get in touch with you to let you know the acceptance status of your child.

If you have any questions, please feel free to contact Jennifer at 828-777-9428 or teenkeyoflight@gmail.com

We look forward to the opportunity to work with your family.

Sincerely,

Jennifer Del-Giudice

Executive Director

**GENERAL INFORMATION**

Your Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

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Your Preferred Method of Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When are you hoping to enroll your daughter? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Health Insurance

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Student’s Name

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 Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments or Questions You Have for Us:

PARENT QUESTIONNAIRE FOR CONSIDERATION OF ENROLLMENT

The following sections will help you describe your child’s issues in greater detail and also identify problems that might otherwise go unnoticed:

**Behaviors** *Please check/mark each of the following that often apply to your child*

* Overeating  Performs repeated  Chronic worrying
* Suicidal attempts senseless acts  Taking drugs
* Withdrawal  Temper outbursts  Odd behavior symptoms  Vomiting  Smokes
* Drinking  Crying  Nervous tic
* Procrastination  Working too much  Impulsive acts
* Sleeps too much  Poor concentration  Senseless fears
* Problems with jobs  Loss of control  Insomnia
* Panic attacks  Nightmares  Destructive acts
* Eating problems  Laziness  Aggressive behavior

**Feelings** *Please check/mark each of the following that often apply to your child*

* Anger  Guilty  Restless
* Annoyed  Happy  Lonely
* Sad  Conflicted  Contended
* Depressed  Regretful  Excited
* Anxious  Hopeless  Optimistic
* Fearful  Hopeful  Tense
* Panic  Relaxed  Unhappy
* Energetic  Jealous
* Envious  Bored

**Physical** *Please check/mark each of the following that describes your child*

* Headaches   Doesn’t like to be
* Dizziness  Bowel disturbance touched  Fainting spells  Skin problems  Tension
* Hearing problems  Burning/itching  Muscle spasms
* Visual problems skin  Twitches
* Watery eyes  Swelling  Tremors
* Dry mouth  Sexual disturbances  Tingling
* Chest pain  Blackouts  Numbness
* Rapid heart beat  Hears things  Fatigue
* Back pain  Tics  Unable to relax
* Stomach trouble

**Perception of Self** *Please check/mark each of the following your child may feel*

* Worthless  Evil  Trustworthy
* Useless  Crazy  Honest
* Unlovable  Degenerate  Considerate
* Unattractive  Deviant  Attractive
* Incompetent  Intelligent  Sensitive
* Stupid  Confident  Full of regrets
* Naïve  Worthwhile  Inadequate
* Ambitious  Ugly  Confused
* Undesirable  Loyal

**Attitudes** *Please fill in/highlight the number that best fits your child’s perspective*

*KEY: Strongly Disagree (1) Disagree (2) Neutral (3) Agree (4) Strongly Agree (5)*

I should not make mistakes ① ② ③ ④ ⑤

I should be good at everything I do ① ② ③ ④ ⑤

When I don’t know, I should pretend to know ① ② ③ ④ ⑤

I should not disclose personal information ① ② ③ ④ ⑤

I am a victim of circumstances ① ② ③ ④ ⑤

My life is controlled by outside forces ① ② ③ ④ ⑤

Other people are happier than I am ① ② ③ ④ ⑤

Play it safe; don’t take any risks ① ② ③ ④ ⑤

I don’t deserve to be happy ① ② ③ ④ ⑤

If I ignore my problems, they will disappear ① ② ③ ④ ⑤

It is my responsibility to make others happy ① ② ③ ④ ⑤

I should strive for perfection ① ② ③ ④ ⑤

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Reason for Referral

In your own words, what is the reason you’re referring your child for treatment?

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What other problems do you see that might be contributing to your child’s need for treatment?

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Has your child made suicide attempts in the past, to your knowledge? If so, please explain:

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Has your child ever threatened or planned to kill someone else? If so, please explain:

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child ever expressed hearing noises or voices that others do not hear? If so, please explain:

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Has your child ever expressed seeing things or people that others do not see? If so, please explain:

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How does your child deal with their emotions in general?

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How does she express anger?

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# Previous Treatment

Has your child been in treatment (hospital or outpatient) previous to this treatment center?

*Hospital Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Stay \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of Stay \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name of Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Beginning Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ending Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

# Family

List all people living at home. Include yourself:

*Name Sex Age Relationship to Client Career*

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List immediate family members who are not currently living in your home:

*Name Sex Age Relationship to Client Marital Status Career*

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*Name When deceased Age at Death Relationship to Client*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What tragedies or major life events in your family may have contributed to your child’s current problems?

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What religion is predominant in your family?

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Is your family active in that religion?

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## Developmental

Was there an unusual pregnancy, labor or delivery with this child? Yes  No 

If so, explain:

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Did your child ever have extremely high fevers, convulsions or injuries? Yes  No 

If so, please explain:

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Did your child have any difficulty learning to walk, climb, hop or skip? Yes  No 

If yes, please explain:

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Has she ever been clumsy or awkward for her age? Yes  No 

If yes, please explain:

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Is there a language other than English spoken in the home? Yes  No 

Which is the principle language used?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child currently have any unusual sleeping habits? (Nightmares, late retiring, bed wetting, morning fatigue, etc.) If so, please explain:

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Has your child been separated from either parent longer than a month in the past 3 years? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child ever run away from home? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Drugs and Alcohol

What drugs has your child used in her lifetime of which you are aware?

Please fill in the following:

*Substance Used When Started When Stopped Amount Used Each Time How Often Used*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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In your estimation, what percentage of her friends have used drugs/alcohol? \_\_\_\_\_\_\_%

Has substance abuse led to family, school and/or peer problems for her? Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What does your child like to do in her free time?

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Has anyone in your family had a history of drug or alcohol addiction? If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Medical

Does she now have a chronic illness? Yes  No 

 Hearing problems? Yes  No 

Vision problems? Yes  No  Speech problems? Yes  No 

 Lung disorder? Yes  No 

 High blood pressure? Yes  No 

 Nervous disorder? Yes  No 

 Heart trouble? Yes  No 

 Any form of cancer? Yes  No 

 Vision problems? Yes  No 

 Digestive disorder? Yes  No 

 Muscular disorder? Yes  No 

 Blood disorder? Yes  No 

 Disease of the kidney? Yes  No 

 Diabetes? Yes  No 

 Arthritis? Yes  No 

 Hepatitis? Yes  No 

 Malaria? Yes  No 

 Physical deformity? Yes  No 

 Any contagious disorder? Yes  No 

 Any life-threatening condition? Yes  No 

Please explain if you answered “yes” to any of the above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe any drug sensitivity or allergies she may have:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has she been treated by a physician or been disabled or hospitalized in the last year?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has she been advised to have a surgical operation in the last 5 years? If so, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe important medical problems of her mother:

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Date of last physical:

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Any other medical information that we should be aware of:

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## Legal

Does your child have any charges/convictions in the juvenile court system?

*The Offense Date of Offense Been to Court? Parole? Next Court Date*

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## Sexual

Are you aware if your child is sexually active? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has she discussed this with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, how old was she when she had her first sexual experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many sexual partners are you aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other information about your child’s sexual activity?

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Has your child had any problems with pornography? Explain:

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Has your child been physically or sexually abused by a family member or anyone else? Explain:

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Has anyone in your family or extended family been accused or convicted of physical or sexual abuse? If so, please explain:

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## School/Work

What is your child’s present school GPA? \_\_\_\_\_\_\_\_\_\_\_

What is her present school situation? Has she been attending? Are there any present school problems? Has your child ever been or is your child presently expelled? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What employment experiences has your child had?

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## Medication

Is she now or ever been on any kind of regular medication for:

|  |  |  |
| --- | --- | --- |
| Depression  |   | Yes  No   |
| Seizures  |   | Yes  No   |
| Hyperactivity  |   | Yes  No   |
| Other?  |   | Yes  No   |

If you answered yes to any of the above, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child on any current medication? If so, please list below:

*Medication Purpose Amount per dose X’s per Day Refill when?*

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## Strengths and Weaknesses

As a mother, what do you see as your child’s strengths?

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As a mother, what do you see as your child’s weaknesses?

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As a father, what do you see as your child’s strengths?

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As a father, what do you see as your child’s weaknesses?

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## Goals

As a mother, what goals would you like your child to accomplish?

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As a mother, what are your aspirations and hopes for your child in her life?

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As a mother, what opportunities of growth or change do you see for yourself and for other family members (or for family in general) while your child is in treatment?

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As a father, what goals would you like your child to accomplish?

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As a father, what opportunities of growth or change do you see for yourself and for other family members (or for family in general) while your child is in treatment?

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