4545 Bellaire Dr. S. Ste 6
Fort Worth, TX 76109

817-657-1115

Website
www.counselingbypenny.com
Email
penny.haight@yahoo.com

Counseling
by Penny Haight, M.Ed., LPC-S

AFTER READING AND SIGNING THE DOCUMENTS IN THIS PACKET, PLEASE EMAIL IT TO ADMIN@COUNSELINGBYPENNY.COM, PRIOR TO YOUR APPOINTMENT

THANK YOU

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INFORMED CONSENT- MINOR

TRAINING AND BACKGROUND

Penny Haight MEd., LPC is a Licensed Professional Counselor licensed by the Texas State Board of Examiners of Professional Counselors and a Licensed Chemical Dependence Counselor – Intern licensed by the Texas Department of State Health Services.

Penny Haight MEd., LPC has worked with individuals of all ages, ethnicity, gender, religion, sexual orientation, and socio-economic status. Penny Haight MEd., LPC is trained in multiple methodologies including Eye Movement Desensitization Reprocessing Therapy (EMDR), Gottman Method, Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Solution Focused Brief Therapy (SFBT), Art Therapy, Play Therapy, and Sand Tray Therapy.

FEES

The fee is $150.00 per 50-55 minute session. Payment in full is due at the time services are rendered. Fees must be paid at the beginning of each session. When payments are collected at the end of a session, the momentum of the session can be de-railed.

Should Penny Haight MEd., LPC need to attend parent/teacher conferences, attend ARD meetings, conducting classroom observations, communicate with lawyers, communicate with insurance companies, complete documentation for medical needs, complete documentation for psychological evaluations, complete FMLA forms, complete ESA documentation, etc. **Penny Haight MEd., LPC charges a fee is $80 per half-hour**. Should you request Penny Haight MEd., LPC to complete any documentation or attend any meetings without 48 hours' notice an additional expedited fee of $40 will be assessed. Should you subpoena Penny Haight MEd., LPC as a factual case witness or involve him in any court-related processes, **Penny Haight MEd., LPC charges a fee of $2,500.00 for legal depositions, case preparation, travel, and witness time**.

There will be a $30 transfer fee assessed if you confirm an in-person appointment and switch to telehealth, but do not notify the office within 24 hours of your appointment time.

_____ Parent Initials

SESSION GUIDLINES

Sessions are 50 – 55 minutes. Sessions begin on the hour and end at the scheduled time. Late arrival on your part will not extend the scheduled ending time for a session. The frequency of sessions and the length of the psychotherapy are aspects of the work that you and Penny Haight MEd., LPC will decide together. Brief therapy is usually around 10 sessions. Some clients need additional sessions to reach their treatment goals. If there is a set time and day that works best for you and your

child's schedule (e.g., every Monday at 5 PM) a recurring appointment may be arranged if that time and day is available. However, after 2 cancellations that recurring spot will be forfitted.

As a parent you have an input in the counseling relationship and may choose at any time to end the therapeutic relationship, but please be aware that at all times the client is your child – not the parents/guardians nor any siblings or other family members of the child. If at any time you are dissatisfied with Penny Haight MEd., LPC's services as a therapist, you have a right to let him know. If you do not feel that Penny Haight MEd., LPC will resolve your complaint, you may file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

You are responsible for any appointments that are not canceled at least 24 hours prior to the appointment time with the EXCEPTION OF AN EMERGENCY. **If you need to cancel an appointment a 24 hours notice must be given otherwise a fee will be charged of $150 for the missed appointment**.

_____ Parent Initials

PARENT AUTHORIZATION FOR A MINOR'S MENTAL HEATLH TREATMENT

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. **If you are separated or divorced from the other parent of your child, please provide a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.**
If you are separated or divorced from the child's other parent, please be aware that it is policy to notify the other parent that the therapist is meeting with your child. It is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, the therapist will strive to listen carefully so that they can understand your perspectives and fully explain their perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, that Penny Haight Med., LPC will honor that decision, unless there are extraordinary circumstances. However, in most cases, it is best to have a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of treatment of your child, that Penny Haight MEd., LPC may meet with the child's parents/guardians either separately or together.
If Penny Haight MEd., LPC meets with you or other family members in the course of your child's treatment, he will make notes of that meeting for your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Informed Consent/Insurance

Mandatory Disclosures of Treatment Information

In some situations, that Penny Haight Med., LPC is required by law or by the guidelines of the profession to disclose information, whether or not he has the parent's or your child's permission. Confidentiality cannot be maintained when:

- Child clients disclose they plan to cause serious harm or death to themselves, and there is belief they have the intent and ability to carry out this threat in the very near future. Steps must be taken to inform a parent/guardian or others of what the child has disclosed and how serious this threat to is and to try to prevent the occurrence of such harm.
- Child clients disclose they plan to cause serious harm or death to someone else, and there is belief they have the intent and ability to carry out this threat in the very near future. In this situation, steps to inform a parent/guardian or others must be taken, including informing the person who is the target of the threatened harm [and the police].
- Child clients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, clinical judgment will be used to decide whether a parent/guardian should be informed.
- Child clients disclose, directly or indirectly, that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, Penny Haight MEd., LPC is [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.
- When Penny Haight MEd., LPC is ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is Penny Haight MEd., LPC's policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then he will need to use clinical judgment to decide whether your child is in serious and immediate danger of harm. If he feels that your child is in such danger, he will communicate this information to you.

> ***Example***: If your child tells the therapist that they have tried alcohol at a few parties, he would keep this information confidential. If you child tells him that they are drinking and driving or is a passenger in a car with a driver who is drunk, he would tell you. If your child tells him, or if he believes based on things he learns about your child, that they are addicted to drugs or alcohol, he would tell you.

You can always ask questions about the types of information you would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Informed Consent/Insurance

Even when you have agreed to keep your child's treatment information confidential if Penny Haight MEd., LPC believes that it is important for you to know about a particular situation that is going on in your child's life he will encourage your child to tell you, and he will help your child find the best way to do so. Also, when meeting with you, he may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of Texas may give parents the right to see any written records kept about your child's treatment, by signing this agreement, you are agreeing that your child should have a "zone of privacy" in their therapy sessions. The Texas State Board of Examiners for Licensed Professional Counselors requires to notify you who would maintain my records in the case of my death or disability. Donald Haight is the named custodian of my records and he has agreed to follow the guidelines set forth by the above-mentioned board. Additionally, you may sign a release form granting Penny Haight MEd., LPC permission to designated third parties to receive and send information that you request. Penny Haight MEd., LPC will never disclose your child's information for any reason without your knowing of his intent.

Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Penny Haight MEd., LPC's responsibility is to your child but may require his helping to address any conflicts between the parents, his role will be strictly limited to providing treatment to your child.

If Penny Haight MEd., LPC is required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, he will provide information as needed, if appropriate releases are signed or a court order is provided, but he will report determinations as to what is in the best interest of the child's mental health. Furthermore, if he is required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for Penny Haight MEd., LPC's participation agrees to reimburse at the rate of **$2,500 per day** for time spent speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Parent/Guardian of Minor Patient:

Please initial after each line indicating your agreement to respect your child's privacy:

- I will refrain from requestiong detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate intherapy sessions as needed. _____ Parent Initials
- Although I may have the legal right to request written records/session notes since my child is aminor, I agree NOT to request these records in order to respect the confidentiality of mychild's/adolescent's treatment UNLESS required by court. _____ Parent Initials

- I understand that I will be informed about situations that could endanger my child. I know thisdecision to breach confidentiality in these circumstances is up to the therapist's professionaljudgment, unless otherwise noted above. _____ Parent Initials

CONTACT INFORMATION

You may leave a message for Penny Haight MEd., LPC on a private, confidential voice mail (817-657-1115) at any time. Messages are checked daily, and he will return your call as soon as possible. However, this number is not an emergency phone number**. Penny Haight MEd., LPC does not provide 24-hour crisis counseling. Should your child experience an emergency necessitating immediate mental health attention call 9-1-1 or go to an emergency room for assistance.**

Penny Haight Med., LPC Contacting You

- Penny Haight Med., LPC may leave appointment reminders or contact me via texting/calling this phone number

  _____

- Penny Haight Med., LPC may leave appointment reminders via email

  _____

- Penny Haight Med., LPC can call this emergency contact in the event I can not be reached

  _____

I have read the information contained in this Informed Consent. I consent to treatment for my child as described in this form. I have read a copy of Counseling By Penny Haight MEd., LPC's Confidentiality/HIPAA Practices. I understand this agreement.

Parent/Guardian Signature _____ **Date**_____

INSURANCE

Insurance card with this form to be photocopied

Name of Insured: _____ SSN: _____

Insured's DOB: _____ Insurance Carrier: _____

Benefit/Eligibility Phone Number: (_____) _____ - _____

ID#: _____ Group#: _____

Deductible: _____

Person responsible for bill: _____

Address: _____ CITY: _____ ST: _____

ZIP: _____

Insured's Employer: _____

Informed Consent/Insurance

Address: _____ CITY: _____ ST: _____

ZIP: _____

I authorize the release of any medical or other information necessary to process this claim.
_____ Parent Initials

I authorize payment of medical benefits to the provider of services. I understand that I am responsible for my bill, not my insurance company. I am aware that if my insurance company declines payment, I am responsible for my bill.
Parent/Guardian Signature _____ **Date**_____

Intake

Please describe your reason(s} for seeking treatment for you child at this time (Include when the problem started):

_____

_____

_____

How would you know your child is doing better than before you started counseling?

_____

_____

_____

Please list other health care professionals your child currently sees:

_____

_____

_____

Please list any other health problems your child may have:

_____

_____

_____

Please list any current medications and dosage: _____

_____

_____

Has your child ever received counseling before? If yes, please indicate when, for how long, with whom, and reason(s} for treatment: _____

_____

_____

Please list any relevant family history (family members, mental health diagnosis, abuse, divorce, etc.} or additional information related to your child's mental health: _____

_____

_____

_____

Please indicate past or current struggles:

___ Depression	___ Family Conflict	___ Anger
___ Chronic Illness	___ Grief/Loss	___ Domestic Violence
___ Relationship Issues	___ Eating or Weight Problems	___ Phobias/Fears
___ Anxiety	___ Behavioral Problems	___ Obsessions/Compulsions
___ Chronic Pain	___ ADHD	___ Manic Episodes
___ Sexuality/Sexual Issues	___ Abuse/Victimization	___ Trauma
___ Stress	___ Schizophrenia/Psychosis	___ Legal Matters
___ Loneliness/Isolation	___ Drug/Alcohol	___ Suicidal Thoughts

Other- Please explain _____

_____

Counseling
by Penny Haight, M.Ed., LPC-S

Informed Consent for Online Counseling/Telehealth

I (Client name)_____ agree and give consent for psychotherapy and treatment by_____ (Therapist) using an Internet based platform/software. I understand that the platform/software is considered secure and encrypted and meets HIPAA standards of use. I understand that there are certain risks involved in entering into this therapeutic relationship and that those risks have been explained to me.

I understand that online counseling services include, but are not limited to, consultation and treatment using interactive audio, video, and/or data communications. I understand that online counseling services involve the communication of my medical/mental health information to the above referenced provider. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any benefits to which I would otherwise be entitled. I understand that the laws that protect the confidentiality of my medical information also apply to online counseling services. I understand that the dissemination of any information is under the same HIPAA standards as traditional therapy.

Although rare, I understand that there are risks to Internet based services including, not limited to, the possibility, despite reasonable efforts on the part of the online platform being used and/or Therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

By participating in online therapy services, I am aware of potential benefits and risks. Some benefits may include improved access to services, being able to choose the therapist I want with specialty experience, the convenience of not having to travel to a therapist and using whatever means of communication I am comfortable with. Although risks are rare, I am aware there are possible risks which include that the information I am able to give may not be sufficient to allow for a diagnosis, that there may be delay in response from my therapist due to technical failures or unforeseen events, and that I may not be able to respond to my therapist due to my own technology failures or unforeseen events. I understand that my therapist may not be able to provide certain services to me.

Informed consent continues throughout the course of therapy and my therapist will continue to talk with me about risks, benefits or educate me on the process of therapy as we go along. I agree to pay the stated cost for services, and understand that there are no refunds for services rendered.

By signing below, we have read, understood and agreed to the Statement of Informed Consent for Online Counseling/Telehealth:

Client: _____ Date _____

Counselor/Therapist: _____ Date_____

Counseling
by Penny Haight, M.Ed., LPC-S

4545 Bellaire Dr. S. #6, Fort Worth, 76109, 817-657-1115

Client Financial Contract

Sessions and Fees:

This contract outlines Counseling by Penny Haight and her associates' financial and business policies. Payment is expected at the time of each session in the form of cash, check, or credit card. All sessions are 53 to 60 minutes in length. The fee for sessions with a Licensed Professional Counselor is $150.00.

The professional services of Counseling by Penny Haight, Taff Wennik, Ricardo Contreras, Malissa Otunba, and Melissa Martinez are covered by insurance companies that we are credentialed with. All therapists are credentialed with Blue Cross Blue Shield of Texas. Penny, Taff, and Ricardo are also credentialed with Aetna.

Many insurance policies, particularly self-funded policies, outsource their mental health to other companies where we are considered out of network. When we call to obtain your benefits, this information is not always revealed, and the insurance company gives a disclaimer that "the quote of benefits is not a promise to pay." As such when we give you the quote of your benefits, it is not a guarantee of what the insurance company will pay. After your claim is filed, the Explanation of Benefits will determine patient financial responsibility. You are financially responsible for what is not covered by your insurance company including any designated co-payments and/or deductibles or the full payment if your insurance company does not pay the claim

Returned Checks/Credit Card:

Returned checks that are written or declined card transactions, submitted to Counseling by Penny or any of her associates, will result in a $40 NSF charge.

We request a credit or debit card be placed on file for clients receiving counseling services. Your financial information is stored in QuickBooks and is secured more so than in a locked filing cabinet.

No Show or Cancellation without 24-hour notice

We request a credit or debit card be placed on file. We'll obtain the cancellation fee of $150.00, the price of a session, as we can not file insurance on a no show. Counseling by Penny reserves your appointment for you and your counselor prepares for your session. Most of our counselors have waiting lists and could fill your appointment slot if you notified us 24 hours in advance. We understand there are emergencies and you are allowed one emergency. Our system sends a reminder by email 5 days prior to session and a text the night before to confirm the appointment. If you need to cancel the appointment, just cancel the appointment when the reminder is sent.

Additionally, there will be a $30 transfer fee assessed if you confirm an in-person appointment and switch to telehealth, but do not notify the office within 24 hours of your appointment time.

Counseling by Penny is required to give you 24-hour notice if a counselor needs to cancel your session. Your next session will be free if this occurs. Your counselor is allowed one emergency as well.

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Client Financial Contract

Insurance

There are times when we are unable to verify benefits with your insurance company due to various reasons, usually because the insurance company benefits system is down, or we are caught in a loop of recordings. When this occurs, we ask that you pay the entire fee of the claim which is dependent on the insurance carrier. If your insurance carrier pays the claim, we will refund your payment.

Counseling by Penny will file claims on your behalf to the primary, in-network insurance carrier you provide. If your insurance is out of network, we will supply you the documentation to file the claim.

Please understand that you are ultimately responsible for any counseling fees not covered by your insurance carrier. Co-pays and any non-covered services are payable at the time of service. You will be billed for non-covered sessions. Assessments, such as the Gottman Marriage Checkup, will not be filed with your insurance company and are your responsibility.

Assignment of Insurance Benefits:

In consideration of services provided by Counseling by Penny Haight and associates, I hereby assign and transfer to Counseling By Penny Haight and any of her associates any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Counseling by Penny Haight or any of her associates to me or to one of my dependents. I authorize payment of all insurance benefits to be made directly to Counseling by Penny or any of her associates for services provided to me.

I UNDERSTAND THAT CERTAIN INFORMATION MAY BE REQUIRED BY THIRD PARTY SOURCES FOR THE PURPOSE OF TREATMENT PAYMENT (INCLUDING COLLECTIONS OF PAST DUE ACCOUNTS) AND HEALTH CARE OPERATIONS. I HEREBY CONSENT TO COUNSELING BY PENNY HAIGHT RELEASING MY HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. I HEREBY ASSIGN TO THE PRACTICE ALL BENEFITS/PAYMENTS NOT COVERED BY MYSELF AND/OR MY DEPENDENTS. I UNDERSTANDTHAT I AM RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY MY INSURANCE.

Financial Contract Agreement

MY SIGNATURE BELOW ALSO ACKNOWLEDGES THAT I HAVE READ AND AGREE TO THE CLIENT FINANCIAL CONTRACT.

Client's Printed Name: _____

Client's Signature: _____ Date: _____

Guardian's Printed Name: _____

Guardian's Signature: _____ Date: _____

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817-657-1115 CounselingByPenny.Com

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information:			
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____			
Cardholder Name (as shown on card):			
Card Number:			
Expiration Date (mm/yy):			
Cardholder ZIP Code (from credit card billing address):			

I,_____, authorize Counseling By Penny Haight, M.Ed. to charge my credit card above for agreed upon services/purchases. I understand that my information will be saved to file for future transactions on my account.

A credit card convenience fee will be added at the time of service:

$20 - $50: $1.00	$51 - $100: $1.50	$101 - $150: $2.50	$151 & higher: $5.00

_____ _____

Customer Signature Date

_____

Phone #

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Careqiver

Today's Date: _____

Child's Name: _____ *Date of birth:* _____

Your Name: _____ *Relationship to Child:* _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion