Compass North

502 10th Street SE Grand Rapids, MN 55744
(P) (218)999-0051 (F) (218)999-7020 admin@compassnorthmn.com

Minor Client Intake Information

Date: _____

Client Information

Name: _____ Date of Birth: _____
Age: _____ Gender: ☐ Male ☐ Female ☐ Other: _____

Preferred Language: _____

Ethnic Background: (Check all that Apply)
☐ Hispanic or Latinx ☐ Not Hispanic or Latinx ☐ Both Hispanic and Non-Hispanic
☐ Other: _____

Race: (Check all that Apply)
☐ Asian ☐ Black/African ☐ Caucasian ☐ Hispanic/Latinx
☐ Native American ☐ Alaska Native ☐Hawaiian Native
☐ Pacific Islander ☐ Prefer not to Answer ☐ Other: _____

Marital Status: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced
☐ Domestic Partnership/Civil Union ☐Widowed

Physical Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell/Other Phone: _____

Parent / Guardian Information

Parent / Guardian Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell/Other Phone: _____

Parent / Guardian Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell/Other Phone: _____

Please Provide a Copy of Documentation to the Office for Records

Emergency Contact Information

Contact Name: _____ Relation to Client: _____
Contact Phone Number(s): _____

Insurance Information

Primary Insurance: _____

Identification Number: _____ Group Number: _____

Policy Holder Name: _____ Birth Date: _____

Primary Insurance: _____

Identification Number: _____ Group Number: _____

Policy Holder Name: _____ Birth Date: _____

Policy Holder Information

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell/Other Phone: _____

Appointment Reminder(s)

I opt to receive my appointment reminders via:

☐ Telephone

☐ Home ☐ Mobile at Phone Number: _____

May we leave a message if you are not home or do not answer? ☐ Yes ☐ No

☐ Text to my Mobile phone Number: _____

☐ Email reminder to my email address: _____

Email reminders only available if you are not requesting text reminders

☐ I opt NOT to receive appointment reminders.

NOTE: Correspondence about late cancelations and no shows will be sent via the same option you choose for appointment reminders. If you opt NOT to receive reminders, you will receive your correspondence via letters.

ATTENTION:

This section must be completed if you are entering the Chemical Health Program

County of Residence: _____

Workplace: _____

Net Income: _____

Gross Income: _____

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BILLING AUTHORIZATION

I authorize the release of any medical, Rule 25 chemical dependency evaluations, or other information necessary to process this claim.

I also request payment of medical benefits from either a government or non-government source to Compass North.

I authorize Compass North to initiate a complaint to the insurance Commissioner on my behalf.

I further understand that I am responsible for all costs not covered by my insurance company. I will be legally responsible for all collection costs involved with the collection of this account if Compass North is unable to collect payment from me in a reasonable amount of time.

I affirm that the information on this form is accurate and true. I understand, acknowledge, and accept the billing authorization terms above. I consent to treatment at Compass North under those terms.

Client Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT RECIPT

Client Name: _____ Date of Birth: _____

Compass North is required by law to maintain the privacy of and provide individuals with the attached Notice of our privacy practices with respect to protected health information.

I hereby acknowledge that I have been provided with a copy of the HIPAA Notice of Privacy Practice document.

Individual or legal representative signature

Signature: _____ Date: _____

Witness: _____ Date: _____

FOR OFFICE USE ONLY

We made the following efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

However, acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency prevented us from obtaining acknowledgement

☐ Other: _____

Staff Signature: _____ Date: _____

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All Minors (16+) Information and Acknowledgement Form

This information pertains to all Minors 16 and older receiving services at Compass North.

Minnesota Statute 144.3431 states allow minors aged 16 and older to give effective consent for nonresidential outpatient mental health services and the consent of no other person is required.

Here is how that statue affects all minor clients 16 and older.

- Clients will sign their own treatment plans.
- Clients will need to sign a release of information if they would like their provider to be able to speak with the parent/guardian about their progress in therapy.
- Clients will need to sign a release of information if they would like their parent/guardian to be able to receive copies of records.
- Clients will be able to make and cancel their own appointments.

This form must be signed by the client and if applicable the client's parent/guardian.

Client Signature: _____ Date: _____

Parent/ Guardian Signature: _____Date: _____

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Minors (16+) Acknowledgment Form

This form only needs to be completed by minor clients 16 and older that are consenting to outpatient mental health services without their parent and/or guardian's consent.

Please initial the following sections acknowledging that you have read and understand the information.

____ I acknowledge that consenting to services without consent from parent/guardian that I am financially responsible for my appointments and services. Services mean outpatient services such as individual sessions, family sessions, group sessions and diagnostic assessments.

____ I acknowledge that if my services are covered by an insurance policy through my parent/ guardian that Compass North is not responsible for any information sent to my parent/guardian through the insurance company (explanation of benefits).

_____ I acknowledge that if I want information sent, given or expressed to my parent, guardian, other provider or person that I will be required to complete a release of information. This includes things such as treatment updates, medical records, billing statements, appointment times, ability to make/cancel appointments, etc.

This form must be initialed and signed by the client

Client Signature: _____ Date: _____

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Medical Information Form

Date: _____

Client Name: _____ Date of Birth: _____

Have you had a Diagnostic Assessment or Psych Evaluation?
By Whom? _____ Date of Evaluation: _____

Have you received therapy, or other mental health services?
By Whom? _____ Date(s): _____

Primary Care Physician: _____

Clinic / Hospital: _____

Additional Emergency Contact(s)
Name: _____ Relationship: _____
Phone Number(s): _____

Name: _____ Relationship: _____
Phone Number(s): _____

Current Medication(s):

_____

_____

Medical Condition(s):

_____

_____

Known Allergies:

_____

_____

Adverse Reactions:

_____

_____

Accommodations:

_____

_____

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Telemedicine Patient Consent/Refusal Form

Patient Name _____ Date of Birth _____

Purpose: The purpose of this form is to obtain your consent to participate in telemedicine appointments in connection with the following mental health services that you are currently receiving:

_____

_____

_____

Nature of Telemedicine Appointments: During the telemedicine appointment:

a. Details of your mental health status, history, and treatment will be discussed with other mental health professionals to promote effective treatment and services for your mental health.
b. Video, audio, and/or photo recordings may be taken during your mental health sessions to ensure continued effectiveness of your mental health services.

Medical Information and Recordings: All existing laws regarding your access to medical information and copies of your medical records apply to these telemedicine appointments. Please note not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for these telemedicine interactions will not be shared with outside entities without your prior approved consent.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine appointments and all existing confidentiality protections under federal and Minnesota state law apply to information disclosed during these telemedicine appointments. As a part of your agreement to participate in telemedicine appointments your accepting responsibility for securing confidentiality on your end of the telemedicine appointment. Any outside individual that you allow into your telemedicine session on your end is automatically assumed to have authorization from you to be in attendance for your telemedicine appointment. Compass North Psychological Services, Inc., and its employees, will not be held responsible for any information obtained by an outside individual that you allow access to during your telemedicine appointments. As a precautionary measure Compass North Psychological Services, Inc., will remind you about this policy if they become aware that you have allowed access to an outside individual during your telemedicine appointment.

Rights: You may withhold or withdraw consent to the telemedicine appointments at any time without affecting your right to future care or treatment from Compass North Psychological Services, Inc.

Disputes: You agree that any dispute arising from the telemedicine appointments will be resolved in Minnesota and that Minnesota state law will apply to all disputes.

Risks, Consequences, & Benefits: You have been advised of all the potential risks, consequences, and benefits of telemedicine appointments. Your health care practitioner has discussed with you the information above. You have had the opportunity to ask questions about the information presented

on this form and the telemedicine appointments. All your questions have been answered, and you understand the written information provided above.

I agree to participate in telemedicine appointment for the mental health services as described:

Signature: _____Date: _____

Signers Relationship to client: _____

I refuse to participate in telemedicine appointments for the mental health services described above.

Signature: _____Date: _____

Signers Relationship to client: _____

FOR OFFICE USE ONLY

Providers present during the completion of this form must sign below.

Provider Signature: _____ Date: _____

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Psychotherapy Information Disclosure Statement

Therapy is a relationship that works best with having clearly defined roles and responsibilities held by each person. As a client in psychotherapy, certain rights are important to know before beginning the therapeutic relationship. It is your responsibility to be aware of your personalized goals to achieve your optimal health.

Responsibilities of the Therapist

Service providers are required to follow The Code of Ethics which includes; helping clients with their needs and connecting them to the appropriate services, advocating for social justice, valuing everyone with dignity and worth, enhancing human relationships, maintaining professionalism with integrity and truthfulness staying within professional training competence and maintaining licensing standards.

I. Confidentiality

You have the right to the confidentiality of your therapy, except for certain specific situations described below. A therapist cannot and will not tell anyone else what you have told them, or even that you are in therapy without your prior verbal or written permission. Under the provisions of the Health Care Information Act of 1992, a therapist may legally speak to another health care provider or a member of your family about you without your prior consent, but they will not do so unless the situation is an emergency. As a client you may direct the therapist to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever a therapist transmits information about you electronically (e.g. sending bills for faxing information), it will be done with special safeguards to insure confidentiality.

If you elect to communicate with a therapist by email at some point in your work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or the therapist's internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to read by the system administrator(s) of the internet service provider. Any email received from you by a therapist, and any responses that the therapist sends to you, will be kept in your treatment file.

The following are legal exceptions to your right to confidentiality. The therapist would inform you of any time when they think they will have to put these into effect.

1. If a therapist has good reason to believe that you will harm another person. The therapist must attempt to inform that person and warn them of your intentions. They must also contact the police and ask them to protect the intended victim.

2. If a therapist has good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give the therapist information about someone else who is doing this, they must inform Child Protective Services within 24 hours and Adult Protective Services immediately. If you are between the ages of 16 and 18 and you tell the therapist that you are having sex with someone more than four years older than you, or sex with a teacher or a coach, they must also report this to CPS.

3. A therapist will explore your symptoms with you in session and assess your safety if deemed necessary. If you are unwilling to take steps to guarantee your safety and the therapist believes that you are in imminent danger of harming yourself, they may legally break confidentiality and call the police or the local crisis response team (2-1-1).

4. If you tell a therapist of the behavior of another named health or mental health care provider that this person has either A) engaged in sexual contact with a client, including yourself or B) is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires them to report this to their licensing board at the MN Department of Health. The therapist would inform you before taking this step.

The next is not a legal exception to your confidentiality. However, it is policy you should be aware of if you are in couples' therapy.

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in the joint sessions unless you tell the therapist otherwise. The therapist will remind you of this policy before beginning such individual sessions.

II. Record-Keeping

The Diagnostic Assessment (using the Diagnostic and Statistical Manual of Mental Disorders, fifth edition) will be reviewed with you, and the treatment plan will be approved with your authorized signature. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of the Diagnostic Assessment and Treatment Plan at any time. Copies of the Diagnostic Assessment and Treatment Plan may be requested with the understanding that Compass North Psychological Services, Inc. will no longer be able to guarantee privacy once the documents leave the facility. Progress notes are kept confidential for each therapy session which include your presentation status, therapeutic modalities used during the session, goals and objectives as well as session responses to your individualized treatment plan. You have the right to request a review of your progress notes at any time. You have the right to request that any errors be corrected in your file. You have the right to request that a copy of your Diagnostic Assessment and/or Treatment Plan be given to any other health care provider at your written request. Your records are maintained in a secure location that cannot be accessed by anyone else.

III: Managed Mental Health Care

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, or to decide the time period within which you must complete your therapy. They may also determine if a provider is not within their network. Managed care firms usually require verification of treatment necessary for authorization to access benefits. Your therapist will do all they can to maximize the benefits you receive by filing

necessary forms and gaining required authorizations for treatment and assist you in advocating with the managed care firm as needed.

Therapy Basics

Therapy has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find the therapeutic relationship to be a source of strong feelings, some painful at times. It is important that you consider carefully whether these risks are worth the benefits that therapy can provide. Most people who take these risks find therapy is helpful.

You will normally be the one who decides therapy will end with a few exceptions. If the presenting issues you disclose are outside the scope of practice for the therapist, the therapist will inform you of this fact and refer you to another therapist who may better meet your needs. If you do violence to, threaten, verbally or physically, or harass the therapist, the office, any office staff or family members of the therapist or office staff, the therapist reserves the right to terminate you unilaterally and immediately from treatment. If they terminate you from therapy, they will offer you referrals to other sources of care.

A therapist may be away from their office several times in the year for vacation or to attend professional meetings. A therapist will tell you well in advance of any anticipated lengthy absences. If you are experiencing an emergency when your therapist is away, you can call the office to see if another therapist is available to see you. If you are experiencing an emergency outside of regular office hours, please call the local Crisis Response Team at 2-1-1. If you believe that you cannot keep yourself safe, please call 9-1-1, or go to the nearest hospital emergency room for assistance.

Your Responsibilities as a Therapy Client

Clients are expected to be on time for scheduled sessions. If you are late, the session will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than 24 hours' notice, this will count as a no call no show. The answering machine has a time and date stamp which will keep track of the time you called to cancel. The only exception to this rule about cancellations is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires), or if you or someone whose caregiver you are has fallen ill suddenly. If you no call no show for three sessions and do not attempt to reschedule, you will be notified that all future scheduled appointments are canceled. If this occurs, you have the right to call your individual therapist to
discuss the option of you returning to therapy.

If you are self-pay you are responsible for paying for your session prior to that session. The fee for the session is based on the services provided during that session. If you have insurance, you are responsible for providing complete insurance identification information, and a copy of your card. You must pay your co-payment, or any amount deemed your responsibility by your insurance company, at each session. You must arrange for any pre-authorizations necessary. If a check is mailed to you to cover your balance due, you are responsible for paying that amount at the time of your next appointment. If the insurance overpays your account will be credited or you will be refunded if you would prefer that.

Credit cards, check, money order, or cash are accepted forms of payment. Payment plans are available for any overdue bills that cannot be paid in full. If your bill is overdue a payment plan needs to be set up before services can continue. If you eventually refuse to pay your debt, or default on your payment plan, Compass North Psychological Services, Inc. reserves the right to give your name and amount due to a collection agency.

Grievances

Clients unsatisfied with services or treatment modalities are encouraged to notify their therapist. Therapists have the responsibility to address client concerns with care and respect. If issues are not addressed appropriately, Alexander Meyer, CEO of Compass North or the therapist's Licensing Board may be contacted.

Client Consent to Psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to the release of that information and other information necessary to complete the billing process. I understand my rights and responsibilities in the therapeutic relationship and agree to participate in therapy with Compass North Psychological Services, Inc. I know I can end therapy at any time and may refuse recommendations or suggestions within therapy.

Client Name (Printed) _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If a minor)

Therapist's Signature: _____ Date: _____

The CRAFFT Questionnaire (version 2.1)

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none. ☐ # of days

2. Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none. ☐ # of days

3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Put "0" if none. ☐ # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.**

	Circle one	
4. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	**No**	**Yes**
5. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	**No**	**Yes**
6. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	**No**	**Yes**
7. Do you ever FORGET things you did while using alcohol or drugs?	**No**	**Yes**
8. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	**No**	**Yes**
9. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	**No**	**Yes**

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent.

For more information and versions in other languages, see **www.crafft.org**

Mental Health Symptoms & Clinical Concerns Pre-Assessment Questionnaire

Please complete this questionnaire before your mental health assessment.

Client Name: _____ **Date of Birth:** _____ **Date:** _____

Purpose: This questionnaire helps identify symptoms and concerns to discuss during your assessment. It is not a diagnosis. If you mark YES, complete the baseline fields for that concern. Your provider will review and may clarify or change your answers.

FREQUENCY

Rarely • Occasionally • Several times/week • Daily • Multiple times/day • Constant • Varies

DURATION

<2 weeks • 2w–1m • 1–3m • 3–6m • 6–12m • >1 year • Unsure

IMPACT/SEVERITY

Mild: manageable • Moderate: some interference • Severe: significant interference

Complete Frequency, Duration, and Severity for EVERY concern marked YES. Your provider will review and confirm your answers during the assessment.

Symptom/Concern	Yes/No	Frequency	Duration	Impact on Daily Life
Depressed mood, or feeling sad, down, empty or hopeless	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Irritability or becoming easily annoyed or frustrated	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Loss of interest or pleasure in activities you normally enjoy	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Significant weight loss, weight gain, or major changes in appetite	☐Yes ☐No	_____	_____	☐M ☐Md ☐S

		_	_	
Trouble sleeping, sleeping too much, or other sleep problems	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Feeling unusually slowed down, restless, or agitated	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Fatigue, low energy, or feeling tired much of the time	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Feelings of worthlessness, excessive guilt, or feeling like a burden	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Difficulty concentrating, thinking, or making decisions	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Thoughts of death, dying, or suicide	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
****If you are currently having thoughts of suicide or believe you may be in immediate danger, please do not wait for your scheduled assessment. Contact 211 or notify our office immediately. ****				
Periods of unusually elevated mood, high energy, less need for sleep, racing thoughts, increased talking, or risky/impulsive behavior	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S

Excessive or difficult to control worry	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Anxiety or fear in social situations or fear of being judged	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Panic attacks or sudden episodes of intense fear	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Fear or avoidance of places/situations because leaving or getting help may be difficult	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Obsessions, unwanted repetitive thoughts, or compulsive behaviors	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Nightmares	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Intrusive or unwanted thoughts or memories	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Flashbacks or feeling as though a traumatic event is happening again	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Other anxiety symptoms	☐Yes ☐No	_____	_____	☐M ☐Md ☐S

		_	_	
Inattention or distractibility	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Hyperactivity or impulsivity	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Oppositional or defiant behaviors	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Disruptive or difficult to control behaviors	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Hearing, seeing, or experiencing things others do not seem to experience	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Strong beliefs or suspicions that others do not share or that others have said may not be accurate	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Other unusual thoughts, perceptions, or experiences	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S
Feeling disconnected from yourself, your surroundings, your memories, or feeling that things are unreal	☐Yes ☐No	_____ _	_____ _	☐M ☐Md ☐S

Physical/bodily complaints that may be related to stress or emotional concerns	☐Yes ☐No			☐M ☐Md ☐S
Memory problems or concerns	☐Yes ☐No			☐M ☐Md ☐S
Other concerns related to thinking, memory, or cognitive functioning	☐Yes ☐No			☐M ☐Md ☐S
Trauma, abuse, neglect or another significant event that continues to affect you	☐Yes ☐No			☐M ☐Md ☐S
Having physically, emotionally, or sexually harmed or assaulted another person	☐Yes ☐No			☐M ☐Md ☐S
Anger or difficulty managing anger	☐Yes ☐No			☐M ☐Md ☐S
Distress or concerns related to sexuality, sexual identity, or gender identity	☐Yes ☐No			☐M ☐Md ☐S
Concerns related to eating, restricting, binge eating, purging, or weight/body image	☐Yes ☐No			☐M ☐Md ☐S

A recent significant stressor or life change that has been difficult to adjust to	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
A medical condition or health concern that may be affecting your mood, thinking, behavior, or mental health	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Learning difficulties or concerns about learning or processing information	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Developmental concerns, including social communication or autism related concerns	☐Yes ☐No	_____	_____	☐M ☐Md ☐S
Personality traits or patterns that significantly interfere with relationships, emotions, or daily functioning	☐Yes ☐No	_____	_____	☐M ☐Md ☐S