Fred Frankel, Ph.D. ABPP
Founder

Cynthia Whitham, L.C.S.W.
Director

Robert Myatt, Ph.D.
Associate Director

SEMEL INSTITUTE UCLA

Clinic Coordinator Contact Information:

310-825-0142 ph
310-206-4446 fax
www.semel.ucla.edu/socialskills
parenting@mednet.ucla.edu

UCLA PEACE Program

Enclosed you will find a number of forms that will help us to determine the appropriateness of our program for you and your child. Filling out these forms is equivalent to a one hour interview at no cost to you. It is important that you complete each questionnaire before you return them.

Please return your packet promptly as enrollment is limited to each group!

- ☐ **Child Background Form**
- ☐ **SNAP-IV Rating Scale**
- ☐ **WING**
- ☐ **CBQ**
- ☐ **Issues Checklist**
- ☐ **Insurance Information Form**

When complete, you may return the packet to us:

1. Mail to: UCLA PEACE Program, 760 Westwood Plaza, Rm 27-384 Los Angeles, CA 90095, Mail Code 175919
2. Fax to 310-206-4446 (please email parenting@mednet.ucla.edu to confirm we received the fax)

Once we receive the packet, we will contact you to schedule a phone screen and one-hour intake appointment for enrollment in an upcoming group.

Thank you for your time. We look forward to meeting you. If you have any questions, please call our Clinic Coordinator at **310-825-0142**.

STEWART & LYNDA RESNICK
NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Child and Adolescent Psychiatry Clinic
Background Information Sheet

Patient Identification

Child's Full Name: _____ Today's Date: _____

Child's Age: _____ Child's Gender: _____

Birth Date: ___ /____ /_____ Place of Birth: _____

Child's Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic/Latino ☐ Asian/Pacific Islander ☐ Native American
☐ Other: _____

Language Spoken at Home: ☐ English ☐ Other: _____

Child's Home Address: _____

_____

***Please indicate the best phone number to contact**

Parent/Guardian 1:

Name: _____ Home: (___) _____ Cell: (___) _____ Email: _____

Relationship to Child: _____ Age: _____ Occupation: _____

Parent/Guardian 2:

Name: _____ Home: (___) _____ Cell: (___) _____ Email: _____

Relationship to Child: _____ Age: _____ Occupation: _____

Other (if applicable, i.e. biological parent, step parent):

Name: _____ Home: (___) _____ Cell: (___) _____ Email: _____

Relationship to Child: _____ Age: _____ Occupation: _____

The child lives with:

☐ Both Biological/Adoptive Parents
☐ Single Parent: Please note: ☐ Mother or ☐ Father
☐ Mother and step-father
☐ Father and step-mother
☐ Equal time with separated/divorced parents
☐ Other: _____

Current marital status of biological parents:

Married ☐ How long: _____
Separated ☐ How long: _____
Divorced ☐ How long: _____
Other ☐ Describe: _____

If parents separated/divorced, who has legal custody in terms of physical/mental healthcare? _____

Is child legally adopted? ☐ No ☐ Yes If yes, age at adoption: _____

STEWART & LYNDA RESNICK
NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Patient Identification

Parents' education (highest level completed): **Parent 1** **Parent 2**

1. Some school but less than completion of high school ☐ ☐
2. Up to high school diploma or equivalent (GED) ☐ ☐
3. Technical/trade school or some college ☐ ☐
4. College graduate or equivalent (B.A., B.S.) ☐ ☐
5. Post graduate/Professional degree (M.A., Ph.D., M.D., J.D.) ☐ ☐

Child's siblings (list names and ages)
Full brothers: _____
Full sisters: _____
Half/step siblings: _____

Child's Current School: ☐ Public ☐ Private ☐ Homeschooled ☐ Not in School ☐ Other: _____
Name of School: _____
Address: _____
Phone: (___) _____ Teacher: _____ Grade: _____
If completing during summer break, please indicate grade level for **next academic year*

How many years at current school: _____

School History

Has your child:	Currently	In the Past
1. Had an Individualized Education Plan (IEP)?	☐	☐
2. Had a 504 or other accommodations?	☐	☐
3. Attended resource, remedial, or special education classes?	☐	☐
4. Ever repeated or failed a grade?	☐	☐
5. Had difficulty making/keeping friends?	☐	☐
6. Had behavioral problems in school?	☐	☐
7. Been suspended or expelled from school?	☐	☐

What is your child's current school performance:
☐ Failing ☐ Below Average ☐ Average ☐ Above Average

STEWART & LYNDA RESNICK
NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Patient Identification

Developmental History

When did your child:

Say his/her first words: _____
Put two or more words together: _____
Take his/her first steps: _____
First become toilet trained: _____

Child Mental Health History *Please fill in the relevant diagnoses.*	**Age**	**Who Diagnosed?**	**Treatment Received?**
Obsessive Compulsive Disorder	____	_____	_____
Tourette's/Other Tic Disorder	____	_____	_____
Anxiety Disorder	____	_____	_____
Attention Deficit Hyperactivity Disorder	____	_____	_____
Depression	____	_____	_____
Bipolar Disorder	____	_____	_____
Eating Disorder	____	_____	_____
Autism Spectrum Disorder	____	_____	_____
Mental Retardation	____	_____	_____
Posttraumatic Stress Disorder	____	_____	_____
Psychotic Disorder	____	_____	_____
Substance Abuse	____	_____	_____
Learning Disorder	____	_____	_____
Oppositional Defiant Disorder	____	_____	_____
Other: _____	____	_____	_____

Has your child ever had thoughts of wanting to hurt himself/herself? ☐ Yes ☐ No

Medical History (type and date):

Allergies: _____

Significant illnesses: _____

Significant injuries: _____

Significant operations/medical procedures/hospitalizations: _____

STEWART & LYNDA RESNICK
NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Patient Identification

Child Medication History

Medication	Start Date	End Date (if applicable)	Current/Final Dose	How Effective? Any Side Effects?

Child History of Psychiatric Hospitalizations: ☐ No ☐ Yes
If yes, please describe:

Hospital	Admission Date	Discharge Date

Has your child ever had legal problems? ☐ No ☐ Yes, please describe: _____

Family History of psychiatric / emotional problems:

- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Autism Spectrum Disorder
- ☐ Posttraumatic Stress
- ☐ Learning Disorder
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Eating Disorder
- ☐ Mental Retardation
- ☐ Psychotic Disorder
- ☐ Depression
- ☐ Obsessive Compulsive Disorder
- ☐ Tourette/Other Tic Disorder
- ☐ Substance Abuse
- ☐ Other: _____

STEWART & LYNDA RESNICK
NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Patient Identification

Child's Pediatrician/Primary Care Physician

Name: _____

Address: _____

_____

Phone: _____

Does your child have any other doctors or clinicians?

Name: _____

Address: _____

_____

Phone: _____

Discipline: ☐ Psychiatrist ☐ Psychologist ☐ Neurologist ☐ Other: _____

Name: _____

Address: _____

_____

Phone: _____

Discipline: ☐ Psychiatrist ☐ Psychologist ☐ Neurologist ☐ Other: _____

_____ _____

(Signature of Patient, Parent or Legal Guardian) (Date and Time signed)

_____

(Printed Name)

Child Name: _____ Date:_____

Completed By: ☐ Mother ☐Father ☐Other: _____

Please rate your child's behavior below. Please note: If your child is currently taking medication please answer the questions below according to your child's behavior when they are off the medication.

SNAP-IV RATING SCALE

James M. Swanson, Ph.D

Check the column which best describes this child:	Not at All	Just a Little	Pretty Much	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	☐	☐	☐	☐
2. Often has difficulty sustaining attention in tasks or play activities	☐	☐	☐	☐
3. Often does not seem to listen when spoken to directly	☐	☐	☐	☐
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	☐	☐	☐	☐
5. Often has difficulty organizing tasks and activities	☐	☐	☐	☐
6. Often avoids, dislikes, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework)	☐	☐	☐	☐
7. Often loses things necessary for tasks or activities (e.g., school assignments, pencils, books, tools, or toys)	☐	☐	☐	☐
8. Is often easily distracted by extraneous stimuli	☐	☐	☐	☐
9. Often forgetful in daily activities	☐	☐	☐	☐
10. Often fidgets with hands or feet, squirms in seat	☐	☐	☐	☐
11. Often leaves seat in classroom or in other situations in which remaining seated is expected	☐	☐	☐	☐
12. Often runs about or climbs excessively in situations where it is inappropriate	☐	☐	☐	☐
13. Often has difficulty playing or engaging in leisure activities quietly	☐	☐	☐	☐
14. Is always "on the go" or acts if "driven by a motor"	☐	☐	☐	☐
15. Often talks excessively	☐	☐	☐	☐
16. Often blurts out answers to questions before the questions have been completed	☐	☐	☐	☐
17. Often has difficulty awaiting turn	☐	☐	☐	☐
18. Often interrupts or intrudes on others (e.g., butts into other's conversations or games)	☐	☐	☐	☐
1. Often loses temper	☐	☐	☐	☐
2. Often argues with adults	☐	☐	☐	☐
3. Often actively defies or refuses adult requests or rules	☐	☐	☐	☐
4. Often deliberately does things that annoy other people	☐	☐	☐	☐
5. Often blames others for his or her mistakes or misbehavior	☐	☐	☐	☐
6. Often touchy or easily annoyed by others	☐	☐	☐	☐
7. Is often angry and resentful	☐	☐	☐	☐
8. Is often spiteful or vindictive	☐	☐	☐	☐

Office Use Only:			
Total item ratings =	_____/9	_____/9	_____/8
Avg rating per item =	_____	_____	_____

Child Name: _____ Date:_____

Completed By: ☐ Mother ☐Father ☐Other: _____

WING

This child stands out as different from other children of his/her age in the following way:

	NO	SOMEWHAT	YES
1. Is old-fashioned or precocious.	☐	☐	☐
2. Is regarded as an " eccentric professor" by the other children.	☐	☐	☐
3. Lives somewhat in a world of his/ her own with restricted idiosyncratic intellectual interests.	☐	☐	☐
4. Accumulates facts on certain subjects (good rote memory) but does not really understand the meaning.	☐	☐	☐
5. Has a literal understanding of ambiguous and metaphorical language.	☐	☐	☐
6. Has a deviant style of communication with a formal, fussy, old-fashioned or " robot like" language	☐	☐	☐
7. Invents idiosyncratic words and expressions	☐	☐	☐
8. Has a different voice or speech.	☐	☐	☐
9. Expresses sounds involuntarily; clears throat, grunts, smacks, cries or screams.	☐	☐	☐
10. Is surprisingly good at some things and surprisingly poor at others.	☐	☐	☐
11. Uses language freely but fails to make adjustment to fit social contexts or the needs of different listeners.	☐	☐	☐
12. Lacks empathy	☐	☐	☐
13. Makes naïve and embarrassing remarks.	☐	☐	☐
14. Has a deviant style of gaze.	☐	☐	☐
15. Wishes to be sociable but fails to make relationships with peers.	☐	☐	☐
16. Can be with other children but only on his/her terms.	☐	☐	☐
17. Lacks best friend.	☐	☐	☐
18. Lacks common sense.	☐	☐	☐
19. Is poor at games; no idea of cooperating in a team, scores " own goals"	☐	☐	☐
20. Has clumsy, ill coordinated, ungainly, awkward movements or gestures.	☐	☐	☐
21. Has involuntary face or body movements.	☐	☐	☐
22. Has difficulties in completing simple daily activities because of compulsory repetition of certain actions or thoughts.	☐	☐	☐
23. Has special routine; insists on no change	☐	☐	☐
24. Shows idiosyncratic attachment to objects.	☐	☐	☐
25. Is bullied by other children.	☐	☐	☐
26. Has markedly unusual facial expression.	☐	☐	☐
27. Has markedly unusual posture.	☐	☐	☐

UCLA PEACE

Parent/ Caregiver Name_____ Date_____

CBQ-PARENT

Think back over the **last week** at home. The statements below have to do with you and your child.

Read the statement, and then decide if you believe the statement is true or false. You must circle either *true* or *false,* but never both for the same item. Answer for yourself, without talking it over with your spouse. Your answers will not be shown to your child. Answer each item according to the **past WEEK ONLY**.

1. My child is easy to get along with.	1. true	false
2. My child is receptive to criticism.	2. true	false
3. My child is well behaved in our discussions.	3. true	false
4. For the most part, my child likes to talk to me.	4. true	false
5. We almost never seem to agree.	5. true	false
6. My child usually listens to what I tell him/her.	6. true	false
7. At least three times a week, we get angry at each other.	7. true	false
8. My child says that I have no consideration of his/her feelings.	8. true	false
9. My child and I compromise during arguments.	9. true	false
10. My child often doesn't do what I ask.	10. true	false
11. The talks we have are frustrating.	11. true	false
12. My child often seems angry at me.	12. true	false
13. My child acts impatient when I talk.	13. true	false
14. In general, I don't think we get along very well.	14. true	false
15. My child almost never understands my side of an argument.	15. true	false
16. My child and I have big arguments about little things.	16. true	false
17. My child is defensive when I talk to him/her.	17. true	false
18. My child thinks my opinions don't count.	18. true	false
19. We argue a lot about rules.	19. true	false
20. My child tells me s/he thinks I am unfair.	20. true	false

Completed By: _____Date: _____

ISSUES CHECKLIST - PARENT

Office use only:
QI: _____
II: _____
WFI: _____

Below is a list of things that sometimes get talked about at home.

First go down **column A** for all 2 pages:

- Circle **YES** for the topics you and your teen have talked about at all during the last **TWO WEEKS**.
- Circle **NO** for the topics that have not come up during the past **TWO WEEKS**.

After you have finished go down **column B:**

- For **ONLY** those topics you circled **YES**, answer these two questions:
  - How many times during the last 2 weeks has it come up? (Give a number 1-14)
  - How intense are the discussions for each topic? (Circle a number)

A				B					
		YES/NO		# of Times?	Calm		A Little Angry		Angry
1.	Telephone Calls	YES	NO		1	2	3	4	5
2.	Time for going to bed	YES	NO		1	2	3	4	5
3.	Cleaning up bedroom	YES	NO		1	2	3	4	5
4.	Doing homework	YES	NO		1	2	3	4	5
5.	Putting away clothes	YES	NO		1	2	3	4	5
6.	Using the television	YES	NO		1	2	3	4	5
7.	Cleanliness (washing, showers, brushing teeth)	YES	NO		1	2	3	4	5
8.	Which clothes to wear	YES	NO		1	2	3	4	5
9.	How neat clothing looks	YES	NO		1	2	3	4	5
10.	Making too much noise at home	YES	NO		1	2	3	4	5
11.	Table manners	YES	NO		1	2	3	4	5
12.	Fighting with brothers and sisters	YES	NO		1	2	3	4	5
13.	Cursing	YES	NO		1	2	3	4	5
14.	How money is spent	YES	NO		1	2	3	4	5
15.	Picking books or movies	YES	NO		1	2	3	4	5
16.	Allowance	YES	NO		1	2	3	4	5
17.	Going places without parents (shopping, movies, etc.)	YES	NO		1	2	3	4	5
18.	Playing stereo or radio too loudly	YES	NO		1	2	3	4	5

A				B					
		YES/NO		# of Times?	Calm		A Little Angry		Angry
19.	Turning off lights in house	YES	NO		1	2	3	4	5
20.	Drugs	YES	NO		1	2	3	4	5
21.	Taking care of records, games, bikes, pets and other things	YES	NO		1	2	3	4	5
22.	Drinking beer or other liquor	YES	NO		1	2	3	4	5
23.	Buying records, games, toys and things	YES	NO		1	2	3	4	5
24.	Going on dates	YES	NO		1	2	3	4	5
25.	Who should be friends	YES	NO		1	2	3	4	5
26.	Selecting new clothes	YES	NO		1	2	3	4	5
27.	Sex	YES	NO		1	2	3	4	5
28.	Coming home on time	YES	NO		1	2	3	4	5
29.	Getting to school on time	YES	NO		1	2	3	4	5
30.	Getting low grades in school	YES	NO		1	2	3	4	5
31.	Getting in trouble at school	YES	NO		1	2	3	4	5
32.	Lying	YES	NO		1	2	3	4	5
33.	Helping out around the house	YES	NO		1	2	3	4	5
34.	Talking back to parents	YES	NO		1	2	3	4	5
35.	Getting up in the morning	YES	NO		1	2	3	4	5
36.	Bothering parents when they want to be left alone	YES	NO		1	2	3	4	5
37.	Bothering teenager when he/she wants to be left alone	YES	NO		1	2	3	4	5
38.	Putting feet on furniture	YES	NO		1	2	3	4	5
39.	Messing up the house	YES	NO		1	2	3	4	5
40.	What time to have meals	YES	NO		1	2	3	4	5
41.	How to spend free time	YES	NO		1	2	3	4	5
42.	Smoking	YES	NO		1	2	3	4	5
43.	Earning money away from the house	YES	NO		1	2	3	4	5
44.	What teenager eats	YES	NO		1	2	3	4	5

UCLA Parenting & Children's Friendship Program
INSURANCE INFORMATION FORM

We cannot guarantee our services will be covered by any particular health insurance program. Therefore, it is your responsibility to confirm your own coverage and if necessary obtain pre-authorization for our services. If your insurance company does not cover our program, we offer a self-pay fee of $559.20 for the initial intake appointment.

Please complete the form below. When we schedule your initial evaluation at UCLA, we will have our finance department verify your insurance coverage.

☐ **HEALTH INSURANCE (our services usually fall under behavioral or mental health)**

Insurance Provider: _____ ☐ HMO ☐ PPO ☐ POS
Subscriber/ Guarantor Name: _____
DOB of subscriber: _____ **Relationship of Subscriber to patient**:_____
Policy/Member ID/ Certificate #: _____
Group # (if applicable): _____
Subscriber's Employer: _____
Employer's Address: _____
_____
Employer's Phone #:_____
Phone # for customer service (mental/behavioral health): _____
Authorization # (if applicable*): _____
*Many managed care insurance providers require their customers to call the customer service number on their insurance card and get pre-authorization for services prior to an initial appointment. ***Please obtain an authorization number to see Cynthia Whitham, L.C.S.W. for an - outpatient initial evaluation at UCLA (CPT code 90791)***.
The CPT for outpatient group therapy is 90853. Our facility code is 95-4377221 – UCLA Practice Plan

☐ **SELF-PAY**

Self-pay fees:

- $559.20 for intake appointment
- Please call the office for current weekly self-pay fees.
- Guarantor name: _____ Relationship of guarantor to patient: _____
- DOB of guarantor: _____

*All fees may be subject to change without notice.