Fred Frankel, Ph.D. ABPP
Founder

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

Shilpa Baweja, Ph.D.
L.C.S.W.
Director

SEMEL
INSTITUTE
UCLA

Clinic Coordinator
Contact Information:

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

UCLA Children's Friendship 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**
- ☐ **Quality of Play Questionnaire**
- ☐ **SCARED-Parent**
- ☐ **SRS**
- ☐ **UCLA Children's Friendship Telephone Release**
- ☐ **Insurance Information Form**

When complete, you may return the packet to us:

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

Once we receive the packet, we will contact you to schedule the one-hour intake appointment with you and 30-minute intake appointment with your child for enrollment in an upcoming group.

Thank you for your time. We look forward to meeting both you and your child.
If you have any questions, please email our Clinic Coordinator at
socialskills@mednet.ucla.edu

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: ______________

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: _______

<u>**School History**</u>

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	**Age**	**Who Diagnosed?**	**Treatment Received?**
Please fill in the relevant diagnoses.			
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: ______________________________

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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
- ☐ Psychotic Disorder
- ☐ Depression
- ☐ Obsessive Compulsive Disorder
- ☐ Tourette/Other Tic Disorder
- ☐ Substance Abuse
- ☐ Intellectual Disability
- ☐ 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: ______________

Quality of Play Questionnaire

We would like information on your child's playmates. We **only** want to know about your child's playmates that you have invited over to your house **in order to play alone with your child.**

Do not consider children who only did homework together, or were over only as part of a group, party, or outing or only went to a movie together.

Please fill in the first name of the playmate that has played alone with your child at your house **most often in the past month**. If your child hasn't played with anyone like this for the past month, put the name of the child who **last** played with your child at your house and **you were around to see or hear what was happening**.

Playmate's name_________________________________

Please indicate below what you saw the last time they played together. **Circle one number in each row:**

How the children spent their time	Not at all	Just a little	Pretty much	Very much	
1. Chasing, running, hiding, climbing, sport, or physically active	0	1	2	3	QPQ01________
2. Cards or board games	0	1	2	3	QPQ02________
3. Imaginary or pretend games	0	1	2	3	QPQ03________
4. Arts/crafts/making things	0	1	2	3	QPQ04________
5. Talk	0	1	2	3	QPQ05________
6. Computer or Video games	0	1	2	3	QPQ06________
7. Watch TV or Videos	0	1	2	3	QPQ07 ________

What the children did during this visit:

They…	Not at all	Just a little	Pretty much	Very much	
8. played without each other	0	1	2	3	
9. didn't share a toy, game, etc	0	1	2	3	QPQ09________*
10. got upset at each other	0	1	2	3	QPQ10________*
11. argued with each other	0	1	2	3	QPQ11________*
12. criticized or teased each other	0	1	2	3	QPQ12________*
13. were bossy with each other	0	1	2	3	QPQ13________*
14. had brother or sister in to play	0	1	2	3	
15. had other children in to play	0	1	2	3	
16. needed a parent to solve problems	0	1	2	3	QPQ16________*
17. annoyed each other	0	1	2	3	QPQ17________*

Play at another child's house: Please try to recall the times your child was invited to **another** child's house as the **only** invited guest.

18. **Number of visits like this (to any child's house) in the last month _______**

Play at your house: Please try to recall the times you invited **another** child to your house as the **only** invited guest.

19. **Number of visits like this (by any child) in the last month _______**

QPQTOT ______

Child Name: ______________________________ Date: ______________________

Completed By: ☐ Mother ☐Father ☐Other: ______________

SCARED – Parent Version

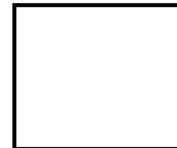
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, circle one number that corresponds to the response that seems to describe your child *for the last 3 months.* Please respond to all statements as well as you can, even if some do not seem to concern your child.

0 = Not True or Hardly Ever True 1 = Somewhat True or Sometimes True 2 = Very True or Often True

	0	1	2
1. My child doesn't like to be with people he/she doesn't know well.			
2. My child feels nervous with people he/she doesn't know well.			
3. It is hard for my child to talk with people he/she doesn't know well.			
4. My child feels shy with people he/she doesn't know well.			
5. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (e.g., read aloud, speak, play a game, play a sport).			
6. My child feels nervous when he/she is going to parties, dances or any place where there will be people that he/she doesn't know well.			
7. My child is shy.			

Child Name: ______________________________ Date: ____________________

Completed By: ☐ Mother ☐ Father ☐ Other: ______________



SRS

For each question, please check the box that best describes your child's behavior **over the past 6 months.**

1 = Not True **2 = Sometimes True** **3 = Often True** **4 = Almost Always True**

	1	2	3	4
1. Seems much more fidgety in social situations than when alone.				
2. Expressions on his or her face don't match what he or she is saying.				
3. Seems self-confident when interacting with others.				
4. When under stress, he or she shows rigid or inflexible patterns of behavior that seem odd.				
5. Doesn't recognize when others are trying to take advantage of him or her.				
6. Would rather be alone than with others.				
7. Is aware of what others are thinking or feeling.				
8. Behaves in ways that seem strange or bizarre.				
9. Clings to adults, seems too dependent on them.				
10. Takes things too literally and doesn't get the real meaning of a conversation.				
11. Has good self-confidence.				
12. Is able to communicate his or her feelings to others.				
13. Is awkward in turn-taking interactions with peers (for example, doesn't seem to understand the give-and-take of conversations).				
14. Is not well coordinated.				
15. Is able to understand the meaning of other people's tone of voice and facial expressions.				
16. Avoids eye contact or has unusual eye contact.				
17. Recognizes when something is unfair.				
18. Has difficulty making friends, even when trying his or her best.				
19. Gets frustrated trying to get ideas across in conversations.				
20. Shows unusual sensory interests (for example, mouthing or spinning objects) or strange ways of playing with toys.				
21. Is able to imitate others' actions.				
22. Plays appropriately with children his or her age.				
23. Does not join group activities unless told to do so.				
24. Has more difficulty than other children with changes in his or her routine.				
25. Doesn't seem to mind being out of step with or "not on the same wavelength" as others.				
26. Offers comfort to others when they are sad.				
27. Avoids starting social interactions with peers or adults.				
28. Thinks or talks about the same thing over and over.				
29. Is regarded by other children as odd or weird.				
30. Becomes upset in a situation with lots of things going on.				

	1	2	3	4
31. Can't get his or her mind off something one he or she starts thinking about it.				
32. Has good personal hygiene.				
33. Is socially awkward, even when he or she is trying to be polite.				
34. Avoids people who want to be emotionally close to him or her.				
35. Has trouble keeping up with the flow of a normal conversation.				
36. Has difficulty relating to adults.				
37. Has difficulty relating to peers.				
38. Responds appropriately to mood changes in others (for example, when a friend's or playmate's mood changes from happy to sad).				
39. Has an unusually narrow range of interests.				
40. Is imaginative, good at pretending (without losing touch with reality).				
41. Wanders aimlessly from one activity to another.				
42. Seems overly sensitive to sounds, textures, or smells.				
43. Separates easily from caregivers.				
44. Doesn't understand how events relate to one another (cause and effect) the way other children his or her age do.				
45. Focuses his or her attention to where others are looking or listening.				
46. Has overly serious facial expressions.				
47. Is too silly or laughs inappropriately.				
48. Has a sense of humor, understands jokes.				
49. Does extremely well at a few tasks, but does not do as well at most other tasks.				
50. Has repetitive, odd behaviors such as hand flapping or rocking.				
51. Has difficulty answering questions directly and ends up talking around the subject.				
52. Knows when he or she is talking too loud or making too much noise.				
53. Talks to people with an unusual tone of voice (for example, talks like a robot or like he or she is giving a lecture).				
54. Seems to react to people as if they are objects.				
55. Know when he or she is too close to someone or is invading someone's space.				
56. Walks in between two people who are talking.				
57. Gets teased a lot.				
58. Concentrates too much on parts of things rather than seeing the whole picture. For example, if asked to describe what happened in a story, he or she may talk only about the kind of clothes the characters were wearing.				
59. Is overly suspicious.				
60. Is emotionally distant, doesn't show his or her feelings.				
61. Is inflexible, has a hard time changing his or her mind.				
62. Gives unusual or illogical reasons for doing things.				
63. Touches others in an unusual way (for example he or she may touch someone just to make contact and then walk away without saying anything).				
64. Is too tense in social settings.				
65. Stares or gazes off into space.				

UCLA Children's Friendship Program

My child__________________________is currently attending the UCLA Children's Friendship Program to enhance appropriate peer social behavior. An integral aspect of this program is the c01mnunication with other children outside of the UCLA Clinic setting.

I hereby give permission for my child to exchange our phone number with other children in the group so they may contact each other during the week as directed by the group leader.

I understand that the children are involved in a learning process and may not inappropriately use the telephone.

I agree on behalf of myself and my child to hold harmless the Regents of the University of California, its UCLA facilities, employees, and agents from any injury or damage that arises or is alleged to arise from the disclosure of our telephone number.

____
Print: Parent/Guardian

______________________________ ________________
Signature: Parent/Guardian Date

____
Child's Home Phone Number

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 $683.00 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:

- $683.00 for intake appointment
- Please email socialskills@mednet.ucla.edu for current weekly self-pay fees.
- Guarantor name: ____________________ Relationship of guarantor to patient: __________
- DOB of guarantor: ______________

☐ **REGIONAL CENTER**

Please email socialskills@mednet.ucla.edu to discuss Regional Center proceedings.

*All fees may be subject to change without notice.