



# NEW HAVEN RESIDENTIAL TREATMENT CENTER APPLICATION PACKET

## ITEMS

Description of Services  
New Haven DVD  
Admission Information

## FORMS

**ALL FORMS MUST BE COMPLETED AND SIGNED PRIOR TO ADMISSION**

Admission Application  
Admission Information  
    Family History  
    Student Information – Behavioral / Social / Spiritual / Emotional / Educational  
    Educational  
    Medical History  
    Individual Treatment Plan Expectations



# NEW HAVEN RESIDENTIAL TREATMENT CENTER

## ADMISSION APPLICATION

A. STUDENT INFORMATION			
Student	Age	Date of Birth	SSN
Referred by		Phone number	Email
Name Preference – (nickname, middle name, etc.)		Current Grade in School	Current GPA
Height	Weight	Eye Color	Hair Color
Person completing application		Relationship to Student	
Distinguishing Features (birthmarks, scars, tattoos, piercings,)			
Student Lives With?			Custody Status?
Specific Events Leading to Decision to Place Daughter with New Haven			
Signature Parent / Guardian			Date
Signature Parent / Guardian			Date

## B. FAMILY INFORMATION

**PARENT(S)**    **BIOLOGICAL**    **ADOPTIVE**

<b>Father</b>		Date of Birth	Occupation	
Home Phone Number	Work Phone Number	Cell Phone Number	Involved with Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address				
Email Address	SSN	Highest Grade Completed	Yearly Income	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widower		If Remarried – Spouse Name		Years Married
Spouse's Email Address	Spouse's Work Phone Number	Spouse's Cell Phone Number	Spouse's SSN	

<b>Mother</b>		Date of Birth	Occupation	
Home Phone Number	Work Phone Number	Cell Phone Number	Involved with Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address				
Email Address	SSN	Highest Grade Completed	Yearly Income	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		If Remarried – Spouse Name		Years Married
Spouse's Email Address	Spouse's Work Phone Number	Spouse's Cell Phone Number	Spouse's SSN	

### OTHER LEGAL GUARDIAN(S)

<b>Name</b>		Date of Birth	Occupation	
Home Phone Number	Work Phone Number	Cell Phone Number	Involved with Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address				
Email Address	SSN	Highest Grade Completed	Yearly Income	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widower		If Remarried – Spouse Name		Years Married
Spouse's Email Address	Spouse's Work Phone Number	Spouse's Cell Phone Number	Spouse's SSN	

<b>Name</b>		Date of Birth	Occupation	
Home Phone Number	Work Phone Number	Cell Phone Number	Involved with Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address				
Email Address	SSN	Highest Grade Completed	Yearly Income	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		If Remarried – Spouse Name		Years Married
Spouse's Email Address	Spouse's Work Phone Number	Spouse's Cell Phone Number	Spouse's SSN	

**B. FAMILY INFORMATION (CONTINUED)**

**SIBLING(S)**

Name	Age	Relationship to Student	Living With?
Name	Age	Relationship to Student	Living With?
Name	Age	Relationship to Student	Living With?
Name	Age	Relationship to Student	Living With?
Name	Age	Relationship to Student	Living With?



# NEW HAVEN RESIDENTIAL TREATMENT CENTER

## ADMISSION INFORMATION

STUDENT INFORMATION
<b>FAMILY HISTORY</b>
List any significant medical, emotional, or drug use history with any family members (include extended family)
Please describe the pregnancy with your daughter (normal, complications, etc.)
Please describe the birthing process (normal, prolonged, breech, etc.)
Did your child achieve developmental tasks on time (walking, crawling, talking, etc.)?
Describe the overall personality of your daughter in the following three phases –
Birth to six (6) years of age –
Seven (7) to Twelve (12) years of age –
Thirteen (13) years of age to current age –

**FAMILY HISTORY continued**

Describe the relationship between your daughter and her biological father –

Describe the relationship between your daughter and her biological mother –

Describe the relationship between your daughter and her step or adoptive father (if applicable)

Describe the relationship between your daughter and her step or adoptive mother (if applicable)

Describe the relationship between your daughter and her siblings –

Describe the history of the marriage or marriage relationship(s) –

If there has been a divorce or separation, describe the history and your daughter's reaction. How old was she?

**FAMILY HISTORY continued**

Estimate the amount of time each week the following typically spend one on one with your daughter –

Biological Father –

Biological Mother –

Step / Adoptive Father –

Step / Adoptive Mother –

Estimate the amount of time each week your daughter has access to the following –

Biological Father –

Biological Mother –

Step / Adoptive Father –

Step / Adoptive Mother –

**TREATMENT HISTORY**

Has your daughter ever received counseling, psychological or psychiatric services?  Yes  No

If Yes, list counselor, outpatient therapy, family therapy, acute in-patient hospitalizations, etc.

Provider Name	Dates
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Diagnosis	Discharge Status
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Address	Phone Number
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Provider Name	Dates
---------------	-------

Diagnosis	Discharge Status
-----------	------------------

Address	Phone Number
---------	--------------

Provider Name	Dates
---------------	-------

Diagnosis	Discharge Status
-----------	------------------

Address	Phone Number
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Who is your daughter’s outpatient therapist after discharge from New Haven?

Name	Phone Number
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Describe any specific disorders your daughter has/had (depression, eating disorders, etc.)

BEHAVIORAL
Describe your daughter's strengths –
Describe your daughter's weaknesses –
Has your daughter demonstrated violence toward self, others, property, etc.?
Describe any violence, bizarre activity, gang affiliation, or cult activity –
Describe any run-away history (style, length, where, contact, home, friends, etc.)
Describe any substance abuse history (alcohol, street drugs, etc.). Include frequency and duration –
Describe any trauma your daughter has experienced (physical or sexual abuse, rape, violence, etc.)

**BEHAVIORAL continued**

Describe any juvenile judicial history (shoplifting, burglary, curfew violations, court action, etc.)

Does your daughter have any felony convictions or pending felonies?  Yes  No

If yes, please explain.

Does the court have legal / temporary custody of your daughter?  Yes  No

Is she court-ordered into treatment?  Yes  No

If Yes, presiding court / location –

Probation Officer	Phone Number
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Address

Special Instructions –

**Please identify any helpful strategies and/or techniques that have been utilized by your child for purposes of coping and/or de-escalation:**

**SOCIAL**

Is your daughter sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does she have a boyfriend? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Is your daughter generally respectful to authority?  Yes  No

If No, please explain –

How many very close friends does your daughter have?

Describe your daughter's general social skills (outgoing, less/more mature, mean to friends, socially isolated, etc.)

Describe your daughter's main peer group –

Describe a general history of her social life (especially if there have been recent changes)	
<b>SPIRITUAL</b>	
Does your daughter have a chosen religion preference? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, which religion?	
Does she believe in a higher power? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the family or your daughter involved in spiritual pursuits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please explain –	
<b>EMOTIONAL</b>	
Does your daughter have trouble expressing emotions? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Generally describe any emotional problems / concerns –	
<b>EDUCATIONAL</b>	
Describe your daughter’s school performance in three phases (grades, teacher relationship, classroom behavior)	
Kindergarten through 5 <sup>th</sup> Grade –	
6 <sup>th</sup> through 9 <sup>th</sup> Grade –	
9 <sup>th</sup> Grade through Current –	
Most recent school attended –	Current Grade

Counselor		Phone Number
Address		
Failed Classes / Grades		Repeated Classes / Grades
<b>EDUCATIONAL continued</b>		
Has your daughter ever been suspended / expelled? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please explain –		
Level of functioning (IQ)		
Favorite Classes –		
Least Favorite Classes –		
Hobbies / Special Interests –		
What do you perceive as your daughter's current academic needs?		
<b>MEDICAL HISTORY</b>		
Physician Name		Phone Number
Address		
Dentist Name		Phone Number
Address		
Has your daughter been treated for any chronic illness, fractures, surgery, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please provide the following (include dates, physician, diagnosis, medications, etc.)		
Physician		Phone Number
Date(s)	Diagnosis	Medication(s)
Physician		Phone Number
Date(s)	Diagnosis	Medication(s)
Physician		Phone Number
Date(s)	Diagnosis	Medication(s)
Is your daughter currently taking any medication(s) / prescriptions(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		

If Yes, please explain (name, prescribing physician, dosage, etc.)	
<b>MEDICAL HISTORY continued</b>	
Does your daughter have any other medical / physical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please explain –	
Does your daughter have / need any of the following?	
Allergies	Sexually Transmitted Disease
Special Needs (glasses, contacts, hearing aid, braces, etc.)	Hallucinations
Other	Other
Has your daughter attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please explain –	
Has your daughter ever had a serious illness or head injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please explain –	
Describe your daughter's general health –	
Date of last medical exam	Date of last eye exam
Date of last dental exam	Date of last hearing exam
Date of last tetanus inoculation	Date of last menstrual period
Does your daughter have any conditions, which would prevent her from participating in the daily academic program, recreational activities, physical education, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No	



INDIVIDUAL TREATMENT PLAN EXPECTATIONS

PARENT(S) / GUARDIAN(S)

What life goals do you desire in / for your daughter?

Expectations for involvement in assessment, treatment, and continuing care –

What is your expectation for your daughter upon discharge from New Haven?

**INDIVIDUAL TREATMENT PLAN EXPECTATIONS *continued***

Parent(s) or Guardian(s) - Please mark any symptom your daughter has displayed in the past year or any that may worry you. Some symptoms are listed twice – please mark it twice as the symptoms are grouped according to diagnosis and will assist New Haven in the diagnostic process.

<input type="checkbox"/> Depressed Mood most of day (indicated by daughter or by your observation) – feeling tearful or empty			
<input type="checkbox"/> Irritable Mood		<input type="checkbox"/> Diminished interest in pleasurable or goal oriented activity	
<input type="checkbox"/> Significant weight loss when not dieting		<input type="checkbox"/> Significant weight gain (5% change in a month)	
<input type="checkbox"/> Decrease in appetite	<input type="checkbox"/> Increase in appetite	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Hypersomnia
<input type="checkbox"/> Psychomotor Agitation	<input type="checkbox"/> Psychomotor Retardation	<input type="checkbox"/> Significant Fatigue	<input type="checkbox"/> Loss of Energy
<input type="checkbox"/> Feelings of Worthlessness	<input type="checkbox"/> Excessive or Inappropriate Guilt	<input type="checkbox"/> Diminished ability to think or concentrate	
<input type="checkbox"/> Indecisiveness	<input type="checkbox"/> Recurrent thoughts of Death	<input type="checkbox"/> Recurrent suicidal ideation	
<input type="checkbox"/> Suicide Plans	<input type="checkbox"/> Past suicide attempt	<input type="checkbox"/> Feelings of Hopelessness	
<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Inability to express herself to significant others	
<input type="checkbox"/> Feels Better When Something Good Happens		<input type="checkbox"/> Depression Worse in Morning	<input type="checkbox"/> Early Morning Awakening
<input type="checkbox"/> Long-standing Sensitivity to Interpersonal Rejection		<input type="checkbox"/> Heavy, Leaden Feelings in Arms or Legs	
<input type="checkbox"/> Period of abnormally elevated or irritable mood for more than one (1) week		<input type="checkbox"/> Increase in goal directed activity	
<input type="checkbox"/> Inflated Self-Esteem	<input type="checkbox"/> Pressured Speech	<input type="checkbox"/> Decreased need for sleep	<input type="checkbox"/> Grandiosity
<input type="checkbox"/> More talkative than usual	<input type="checkbox"/> Flight of Ideas	<input type="checkbox"/> Psychomotor Agitation	<input type="checkbox"/> Distractible
<input type="checkbox"/> Excessive involvement in activities with a high potential for painful consequences (shopping sprees, sexual indiscretion, high-risk activities, binges, etc.)			
<input type="checkbox"/> Pattern of Negative Behavior	<input type="checkbox"/> Hostile Behavior	<input type="checkbox"/> Defiant Behavior	<input type="checkbox"/> Resentful
<input type="checkbox"/> Deliberately annoys others	<input type="checkbox"/> Argues with adults	<input type="checkbox"/> Spiteful or Vindictive	<input type="checkbox"/> Angry
<input type="checkbox"/> Actively defies or refuses to comply with adult requests or rules		<input type="checkbox"/> Often loses temper with adults	
<input type="checkbox"/> Blames others for her mistakes or misbehavior	<input type="checkbox"/> Touchy or easily annoyed by others	<input type="checkbox"/> Sense of Entitlement	
<input type="checkbox"/> Dishonesty, shoplifting, running away from school, truant from school			
<input type="checkbox"/> Fails to give close attention to detail(s)		<input type="checkbox"/> Makes careless mistakes in schoolwork, work or other activities	
<input type="checkbox"/> Often forgetful in daily activities		<input type="checkbox"/> Often does not seem to listen when spoken to directly	
<input type="checkbox"/> Does not follow through with instruction(s)		<input type="checkbox"/> Difficulty sustaining attention in task or play activities	
<input type="checkbox"/> Difficulty organizing tasks and activities		<input type="checkbox"/> Avoids or dislikes engaging in tasks requiring sustained mental effort	
<input type="checkbox"/> Fails to finish schoolwork or chores ( not due to oppositional behavior or failure to understand)			
<input type="checkbox"/> Often leaves seat in classroom or in other situations in which remaining seated is expected			
<input type="checkbox"/> Often fidgets with hands or feet or squirms in seat		<input type="checkbox"/> Difficulty playing or engaging quietly in leisure activities	
<input type="checkbox"/> Talks excessively	<input type="checkbox"/> Often feels restless	<input type="checkbox"/> Difficulty waiting her turn	<input type="checkbox"/> Often Interrupts or Intrudes on Others
<input type="checkbox"/> Often 'on the go' or acts as if 'driven by a motor'		<input type="checkbox"/> Often blurts out answers before questions have been completed	
<input type="checkbox"/> Often loses things necessary for task or activities (assignments, books, pencils, etc.)			

**INDIVIDUAL TREATMENT PLAN EXPECTATIONS continued**

If your daughter has experienced or witnessed an event involving actual or threatened death, serious injury, or to the physical integrity of self or others, has she exhibited any of the following?

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Recurrent and intrusive distressing recollections of the event (images, thoughts or perceptions)                                  |  |   |  |
| <input type="checkbox"/> Her response to the experience involved intense fear, helplessness or horror  |  |   |  |
| <input type="checkbox"/> Recurrent distressing dreams of the event   |  | <input type="checkbox"/> Acting or feeling as if the traumatic event is recurring |  |
| <input type="checkbox"/> Intense psychological distress at exposure to internal/external cues that symbolize or resemble any aspect of the traumatic event |  |   |  |
| <input type="checkbox"/> Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event     |  |   |  |
| <input type="checkbox"/> Efforts to avoid thoughts, feelings, or conversations associated with the trauma  |  |   |  |
| <input type="checkbox"/> Efforts to avoid activities, places or people that arouse recollections of the trauma   |  |   |  |
| <input type="checkbox"/> Diminished interest or participation in significant activities  |  | <input type="checkbox"/> Inability to recall an important aspect of the trauma    |  |
| <input type="checkbox"/> Restricted range of moods   | <input type="checkbox"/> Sense of a foreshortened future | <input type="checkbox"/> Difficulty falling or staying asleep                     |  |
| <input type="checkbox"/> Feeling of detachment or estrangement from others   |  | <input type="checkbox"/> Irritability or outbursts of anger                       |  |
| <input type="checkbox"/> Difficulty concentrating  |  | <input type="checkbox"/> Hyper vigilance  | <input type="checkbox"/> Exaggerated startle response          |
|  |  |   |  |
| <input type="checkbox"/> Excessive anxiety and worry for at least six (6) months   |  | <input type="checkbox"/> Restlessness or feeling keyed up or on edge              |  |
| <input type="checkbox"/> Difficulty concentrating or mind going blank  |  | <input type="checkbox"/> Difficulty controlling the worry                         |  |
| <input type="checkbox"/> Irritability  | <input type="checkbox"/> Muscle Tension                  | <input type="checkbox"/> Being easily fatigued                                    | <input type="checkbox"/> Sleep Disturbance                     |
|  |  |   |  |
| <input type="checkbox"/> Discrete periods of intense fear or discomfort  |  | <input type="checkbox"/> Palpitations, pounding heart, or accelerated heart beat  |  |
| <input type="checkbox"/> Chest pain or discomfort  |  | <input type="checkbox"/> Numbness or tingling limbs                               | <input type="checkbox"/> Trembling or Shaking                  |
| <input type="checkbox"/> Sensations of shortness of breath or smothering   |  | <input type="checkbox"/> Feeling dizzy, unsteady, lightheaded, or faint           |  |
| <input type="checkbox"/> Sweating  | <input type="checkbox"/> Fear of Dying                   | <input type="checkbox"/> Feelings of choking                                      | <input type="checkbox"/> Chills or hot flushes                 |
| <input type="checkbox"/> Nausea or abdominal distress  |  | <input type="checkbox"/> De-realization or self detachment                        | <input type="checkbox"/> Fear of losing control or going crazy |
|  |  |   |  |
| <input type="checkbox"/> Fear of standing in lines   | <input type="checkbox"/> Fear of heights                 | <input type="checkbox"/> Fear of closed places                                    | <input type="checkbox"/> Fear of Crowds                        |
| <input type="checkbox"/> Anxiety about being in places that can be embarrassing  |  | <input type="checkbox"/> Fear of speaking in public                               |  |
| <input type="checkbox"/> Fear of being alone   | <input type="checkbox"/> Fear of leaving home            | <input type="checkbox"/> Fear of flying   | <input type="checkbox"/> Fear of animals                       |
|  |  |   |  |
| <input type="checkbox"/> Recurrent thoughts or impulses that cause marked anxiety or distress that are not about real life problems                        |  |   |  |
| <input type="checkbox"/> Attempts to deal with the thoughts with some other thought or action  |  | <input type="checkbox"/> Ritualistic behavior                                     |  |
| <input type="checkbox"/> Understands these thoughts are a product of her own mind  |  | <input type="checkbox"/> Washing hands over and over again                        |  |
| <input type="checkbox"/> Behaviors or mental acts aimed at preventing some dreaded event   |  | <input type="checkbox"/> Checking things over and over again                      |  |
| <input type="checkbox"/> Repetitive behaviors or mental acts she feels driven to perform in response to an obsession                                       |  |   |  |
| <input type="checkbox"/> Uncomfortable when things are not in perfect order (clothes, food on a plate, towels)   |  |   |  |

<b>INDIVIDUAL TREATMENT PLAN EXPECTATIONS <i>continued</i></b>		
<input type="checkbox"/> Use of any drug Cannabis (Marijuana), Amphetamines, Cocaine, Hallucinogens, Inhalants, Alcohol, Nicotine/Tobacco, other		
<input type="checkbox"/> TOLERANCE - needs increased amounts of the same substance to achieve desired effect		
<input type="checkbox"/> TOLERANCE - marked diminished effect with the same amount of the substance		
<input type="checkbox"/> WITHDRAWAL - classic withdrawal symptoms – OR – taking a similar substance to avoid withdrawal symptoms		
<input type="checkbox"/> The substance is taken in larger amounts or over a longer period of time than what she intended		
<input type="checkbox"/> Persistent desire or unsuccessful attempts to reduce usage	<input type="checkbox"/> Great amounts of time spent in drug related activities	
<input type="checkbox"/> Important parts of life are given up or reduced due to usage	<input type="checkbox"/> Continued use despite knowledge of harm to self and others	
<input type="checkbox"/> Recurrent use resulting in failure to fulfill a major role obligation (school, family, work, friends, etc.)		
<input type="checkbox"/> Use in physically hazardous situations (car, needles, etc.)	<input type="checkbox"/> Related legal problems (arrests, under-age use, etc.)	
<input type="checkbox"/> Continued use despite recurrent relationship problems (arguments, family stress, social problems, school problems)		
<input type="checkbox"/> Refusal to maintain body weight at or above a minimally normal weight for age and height		
<input type="checkbox"/> Intense fear of gaining weight or becoming fat	<input type="checkbox"/> Perceives self as much larger or fatter than she really is	
<input type="checkbox"/> (If she's had her first menstrual cycle), absence of at least three consecutive menstrual cycles.		
<input type="checkbox"/> regularly engages in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)		
<input type="checkbox"/> Denial of the seriousness of low body weight	<input type="checkbox"/> Self evaluation unduly influenced by weight / body shape	
<input type="checkbox"/> Binge eating episodes - Eating very large amounts of food (clearly more than most people would eat) in a discrete period of time		
<input type="checkbox"/> Sense of lack of control over eating	<input type="checkbox"/> Binge eating episodes are recurrent	
<input type="checkbox"/> Self-induced vomiting	<input type="checkbox"/> Misuse of laxatives	<input type="checkbox"/> Recent tooth decay
<input type="checkbox"/> Cuts on backs of hands	<input type="checkbox"/> Self evaluation unduly influenced by weight / body shape	
<input type="checkbox"/> Recurrent inappropriate compensatory behavior in order to prevent weight gain		
<input type="checkbox"/> History of physical complaints occurring over a long time	<input type="checkbox"/> Preoccupied with physical problems, sick often	
<input type="checkbox"/> Several discrete episodes of failure to resist aggressive impulses resulting in serious assaultive acts or destruction of property		
<input type="checkbox"/> Degree of aggressiveness expressed during episodes is grossly out of proportion to any precipitating stressors		
<input type="checkbox"/> Impairment in the use of multiple nonverbal behaviors (eye-to-eye gaze, facial expressions, body postures, gestures, etc.)		
<input type="checkbox"/> Failure to develop age appropriate peer relationships	<input type="checkbox"/> Lack of social or emotional reciprocity	
<input type="checkbox"/> Preoccupation with restricted patterns	<input type="checkbox"/> Preoccupation with parts of objects	
<input type="checkbox"/> Stereotyped and repetitive motor mannerisms	<input type="checkbox"/> Inflexible adherence to routines or rituals	
<input type="checkbox"/> Lack of spontaneous seeking to share enjoyment or interest		

<b>INDIVIDUAL TREATMENT PLAN EXPECTATIONS <i>continued</i></b>				
<input type="checkbox"/> Impaired communication		<input type="checkbox"/> Obvious lack of functionality		
<input type="checkbox"/> Overprotection	<input type="checkbox"/> Inadequate discipline	<input type="checkbox"/> Intense relationship		<input type="checkbox"/> Enmeshment
<input type="checkbox"/> Unresolved issues		<input type="checkbox"/> Lack of respect		<input type="checkbox"/> Out of control feelings
<input type="checkbox"/> Pattern of failing grades	<input type="checkbox"/> Underachievement	<input type="checkbox"/> Truancy		<input type="checkbox"/> Dropping out of school
<input type="checkbox"/> Physical Abuse of your Daughter			<input type="checkbox"/> Sexual Abuse of your Daughter	
<input type="checkbox"/> Non-compliance with out-patient therapy, medication, probation, in-patient treatment, etc.				
<input type="checkbox"/> IQ below 70	<input type="checkbox"/> IQ between 71-84	<input type="checkbox"/> IQ between 85-115	<input type="checkbox"/> IQ between 116-130	<input type="checkbox"/> IQ above 131
<input type="checkbox"/> Bereavement		<input type="checkbox"/> Recent abortion		<input type="checkbox"/> Recent miscarriage
<input type="checkbox"/> Recent loss of a loved one		<input type="checkbox"/> Recent suicide of a close friend		<input type="checkbox"/> Parents recently divorced
<input type="checkbox"/> Unstable relationships		<input type="checkbox"/> Unstable moods		<input type="checkbox"/> Highly impulsive
<input type="checkbox"/> Frantic efforts to avoid abandonment			<input type="checkbox"/> Unstable self-image or sense of self	
<input type="checkbox"/> Intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation				
<input type="checkbox"/> Impulsive in at least two (2) dangerous areas (spending, sex, substance abuse, reckless driving, binge eating, etc.)				
<input type="checkbox"/> Recurrent suicidal behavior, gestures, or threats			<input type="checkbox"/> Inappropriate and intense anger	
<input type="checkbox"/> Self - mutilating behavior		<input type="checkbox"/> Intensely reactive moods		<input type="checkbox"/> Chronic feelings of emptiness
<input type="checkbox"/> Difficulty controlling anger		<input type="checkbox"/> Stress related paranoid		<input type="checkbox"/> Dis-social symptoms
<input type="checkbox"/> Uncomfortable in situations where she is not the center of attention				
<input type="checkbox"/> Interaction with others is characterized by inappropriate sexually seductive or provocative behavior				
<input type="checkbox"/> High emotionality and attention seeking			<input type="checkbox"/> Rapidly shifting and shallow expression of emotion	
<input type="checkbox"/> Uses physical appearance to draw attention to self			<input type="checkbox"/> Speech is impressionistic and lacking in detail	
<input type="checkbox"/> Shows self-dramatization, theatricality, and exaggerated expression of emotion				
<input type="checkbox"/> Suggestible or easily influenced by others			<input type="checkbox"/> Considers relationships more intimate than they actually are	
<input type="checkbox"/> Good Physical Health		<input type="checkbox"/> Allergies		<input type="checkbox"/> Recent operation
<input type="checkbox"/> Sexually transmitted disease		<input type="checkbox"/> Broken bones		<input type="checkbox"/> Tooth decay

INDIVIDUAL TREATMENT PLAN EXPECTATIONS <i>continued</i>			
<input type="checkbox"/> Educational problems	<input type="checkbox"/> Change of residence	<input type="checkbox"/> Recent parental divorce	<input type="checkbox"/> Drug detoxification
<input type="checkbox"/> Problems with primary support group		<input type="checkbox"/> Recent break up with serious boy friend	
<input type="checkbox"/> Problems related to interaction with legal system or crime			
<input type="checkbox"/> Any other information regarding your daughter you think we should know –			