MAIA S. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
1489 CHAIN BRIDGE ROAD, SUITE 203
MCLEAN, VA 22101
703.447.6788

Forms and Interview Appointment:

Thank you for taking the time to complete these intake forms. Please fill them out and bring them to the first appointment. The Services Agreement and HIPAA documents are for your reference. Please note the last two pages of the packet include a series of questions that I would like for you to complete prior to the initial interview. Please email me your responses **1-2 days prior to our first appointment** so that I can guide our discussion most effectively. My email address is DrMDeubert@gmail.com. Additionally, please bring copies of any previous evaluations and, if applicable, relevant portions of the school record (e.g., transcripts, standardized test scores, teacher comments).

First Day of Testing:

It is important for the examinee to try and get a good night's sleep and to have a good breakfast prior to the testing session. Please make sure to pack a lunch, snacks, and beverages. Of note, it is important **not to drink anything caffeinated on either day of testing** (e.g., coffee, soda, energy drink). Also, please remember to bring a check for first half of the testing fee. For parents of young children, you may opt to stay for part of the time or the whole time depending on the comfort level of the child.

Medication:

For those who take medication for attention and concentration, please discuss with me before the first meeting whether or not to take it on the day of testing.

Directions to Office:

My office is located in the McLean Professional Park. There is a large, red sign at the entrance to the office complex. Please drive to the back of the complex, to the dead-end, and then turn right. Go to the top of the hill and park there. You will see the number to the building on the outside (1489). Walk up the path that is next to the building and go in the second door on the right (you will see a sign for "Chain Bridge Psychological Services" on the outside). My office is in the ground floor suite. In the waiting room, there is a light switch panel with the corresponding clinicians' names/offices. Please flip the light switch below "M Deubert" to the up position so that I know you have arrived and I will come out when the session is ready to begin.

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Client's Name: _____

Date of Birth: _____

Guarantor: _____

Address: _____

_____

_____

Email: _____

Phone #s: (Home)_____

(Work)_____

(Mobile)_____

(Other)_____

Emergency Contact: (Name) _____

(Phone #)_____

Pediatrician/GP Information:

Name of Physician:_____

Group Name: _____

Address: _____

_____

Phone #:_____

MAIA S. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
VIRGINIA LICENSE NO. 0810003490
MAIA S DEUBERT, LLC EIN. 20-8795418

SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL TESTING

A complete psychological evaluation is comprehensive and labor intensive. The face-to-face testing can take anywhere from 3 to 14 hours, depending on the type of evaluation and diagnostic issue at hand. The scoring, interpreting, and writing of the report are typically completed within four weeks of the last testing session. Once completed, we will meet for the feedback session during which time I will review the findings, provide you with a copy of the report, and answer any questions that you may have.

I evaluate various cognitive processes such as learning, memory, attention and concentration, and executive functioning. Additionally, I conduct assessments of the individual's emotional functioning, which includes (but is not limited to) how they cope with difficult situations, their view of the world, their sense of self, and the degree to which they experience symptoms of depression and/or anxiety. As with all psychological services, testing is only as helpful as the individual allows it to be. Therefore, the degree to which insights can be made depends on the individual's approach to the testing process.

CANCELLATIONS

If you are unable to attend one of the testing sessions as scheduled, you are required to provide at least **48 hours** notice. Otherwise, one additional hour will be charged to your overall bill. If the patient has a significant illness (fever, virus, vomiting, etc.), you will not be charged for cancelled appointments as long as you contact me within **two hours** of our scheduled meeting time.

PROFESSIONAL FEES

I am available for child, adolescent and adult evaluation and treatment, school consultation, supervision, and psychological testing. My fees are listed below:

Diagnostic Evaluation 60 mins:	$300.00
Individual/Family Therapy 60 mins:	$275.00
Individual/Family Therapy 45 mins:	$225.00
Individual/Family Therapy 30 mins:	$175.00
Forensic Services:	$600/hour
Psychological Testing:	$500 to $5000

In addition, I charge $275.00 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services may include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

BILLING & PAYMENT

Since it is can take up to 25 hours to complete an evaluation, you are expected to pay for half of the cost on the first day of testing. At the feedback session, during which time you will be provided with a copy of the testing report, you will be asked to pay for the remainder of the balance. After the evaluation is completed, you will receive a statement of professional services provided which you can submit to insurance for reimbursement.

You may choose to keep a credit card on file and be charged automatically at the close of the month. Please note that there is a 3.75% transaction fee that will be added on to the charge.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, **you (not your insurance company) are responsible for full payment of my fees.** It is very important that you find out exactly what testing services your insurance policy covers.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and brief substantiation of that diagnosis. Sometimes I am required to provide additional clinical information. This information is limited to the dates of treatment and a brief description of the services provided. This information will become part of the insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier. However, if revoked, I will continue to have the right to forward information necessary to process claims for services already provided.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am with a client, I will not answer the phone. If I do not answer, please leave a message on my voicemail and I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If I will be unavailable for an extended time, I will provide you in my outgoing voicemail with the name of a colleague to contact, if necessary. **In the event of a clinical emergency, if you are unable to reach me, call 911, or proceed to the nearest emergency room and ask for the psychologist or psychiatrist on call.**

It is acceptable to contact me via email to make scheduling changes or arrangements. My current email address is DrMDeubert@gmail.com. In addition, many parents of children and adolescent patients find it helpful to email me with relevant information (regarding noteworthy events or concerns) between sessions. Please note that email communication is almost always unidirectional, and that I will not usually respond to emails I receive. Please note that email is not a confidential form of communication, nor is it an appropriate medium for urgent or emergency messages. *In general, no advice, clinical information, or consultation will be provided via email.*

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health or mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in the Notice attached).

- Disclosures required by health insurance or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization or court order. If a subpoena is served to me with appropriate notices, I may have to release information in a sealed envelope to the clerk of the court issuing the subpoena. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of any mental health report.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I know or have reason to suspect that a child has been or is in immediate danger of being a mentally or physically abused or neglected child, the law requires that I file a report with the appropriate governmental agency, usually the Department of Social Services. Once such a report is filed, I may be required to provide additional information.

- If I have reason to suspect that an adult is abused, neglected, or exploited, the law requires that I report to the Department of Welfare or Social Services. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates a specific threat of immediate serious physical harm to himself/herself or an identifiable victim, and I believe he/she has the intent and ability to carry out the threat, I am required to take protective actions. These actions may include notifying the potential victim or his/her guardian, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PATIENT RIGHTS

You have certain rights with regard to your Clinical Record and disclosures of protected health information, These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MAIA S. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
VIRGINIA LICENSE NO. 0810003490
MAIA S DEUBERT, LLC EIN. 20-8795418

Notice of Privacy Practices of Your Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Any information I acquire about you while you are my client is safeguarded by law regulating mental health information.

Written Authorization

I may ask to use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes, but will only do so with your informed and written authorization. PHI refers to information in your health records that could identify you. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, again I will obtain a written authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. These are notes I have made about our conversation during a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage. The law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances: (a) if I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities; (b) I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglect, or exploitation; (c) if I receive a subpoena from the Virginia Board of Psychology because they are investigating my practice, I must disclose any PHI requested by the board; (d) if you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case; (e) if you communicate to me a specific threat of imminent harm against another individual, or if I believe that there is a clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm; (f) if I believe you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm; (g) if you file a worker's compensation claim, upon written request,

I will submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request. You also have the right to (a) request and receive confidential communications of PHI by means and locations we agree upon and (b) inspect or obtain a copy (or both) of Psychotherapy Notes, unless I believe the disclosure of the record will be injurious to your health. Upon your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes. You have the rights to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. However, I will discuss with you the details of the amendment process. You have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process. Finally you have the right to obtain a paper copy of the notice from me upon request.

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will notify you in writing.

If you have any questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me to discuss this matter. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to my attention at the above address. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

If you should have any questions about this notice, please do not hesitate to ask me.

MAIA S. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
VIRGINIA LICENSE NO. 0810003490
MAIA S DEUBERT, LLC EIN. 20-8795418

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE SERVICES AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM.

I have read, understand and agree to the structure as described in the Services Agreement.

Patient Name: _____

Signature: _____ **Date:** _____

* Adolescents may sign below *in addition* to their parent/ legal guardian's signature to signify that they have read and understand the above policies.

Signature of adolescent: _____ Date: _____

YOUR SIGNATURE BELOW INDICATES THAT YOU UNDERSTAND THAT CHAIN BRIDGE PSYCHOLOGICAL SERVICES, LLC AND ITS AFFILIATING CLINICIANS ARE NOT RESPONSIBLE FOR THE PRACTICE OF MAIA S. DEUBERT, PSY.D. AND THAT EACH CLINICIAN HAS HIS/HER INDIVIDUAL PRIVATE PRACTICE THAT IS SEPARATE FROM THE GROUP NAME.

Patient Name: _____

Signature: _____ **Date:** _____

Maia S. Deubert, Psy.D.

Licensed Clinical Psychologist
Virginia License No. 0810003490
Maia S Deubert, LLC EIN. 20-8795418

PROFESSIONAL FEES AND CONSENT FOR TREATMENT

PATIENT NAME: _____

RESPONSIBLE PARTY: _____

BILLING ADDRESS: _____

_____

FEES PER VISIT:	Diagnostic Evaluation 60 mins:	$300.00
	Individual/Family Therapy 60 mins:	$275.00
	Individual/Family Therapy 45 mins:	$225.00
	Individual/Family Therapy 30 mins:	$175.00
	Forensic Services:	$600/hour
	Psychological Testing:	$500 to $5000

SPECIAL PAY ARRANGEMENTS: _____

I hereby authorize Maia S. Deubert, Psy.D. to release information concerning my treatment to my insurance carrier in accordance with the Code of Virginia.

I acknowledge responsibility for this account and guarantee payment of all charges against this account. I understand that this account is my responsibility and not that of my insurance company. I have been informed that Dr. Maia Deubert does not participate with my insurance plan(s).

I agree to the above financial terms and consent to treatment for myself and/or child.

_____

SIGNATURE OF RESPONSIBLE PARTY DATE

MAIA S. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
VIRGINIA LICENSE NO. 0810003490
MAIA S DEUBERT, LLC EIN. 20-8795418

CREDIT CARD AUTHORIZATION

PATIENT NAME: _____

NAME ON CREDIT CARD: _____

BILLING ADDRESS OF CREDIT CARD
(No P.O. Boxes) _____

_____

CREDIT CARD NUMBER: _____

CREDIT CARD SECURITY NUMBER: _____
(The last 3 numbers are printed on the signature strip, or for American Express cards, 4-digit code printed on the front side of the card above the number)

CREDIT CARD EXPIRATION DATE: _____

I authorize Maia S Deubert, LLC to charge my credit card on a monthly basis for all outstanding balances for services rendered by Dr. Maia Deubert. I understand that I will be charged an additional 3.75% to cover the service fees for credit card use:

_____
SIGNATURE OF RESPONSIBLE PARTY DATE

MAIA S. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
1489 CHAIN BRIDGE ROAD, SUITE 203
MCLEAN, VA 22101
703 • 447 • 6788

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____

DOB: _____

I authorize: Maia Deubert, Psy.D.

_____ to exchange information with

_____ to release information to

_____ to receive information from

_____
NAME OF PERSON, ORGANIZATION OR INSTITUTION

_____
ADDRESS AND/OR PHONE NUMBER

The following information:

_____ Medical Records
_____ Psychiatric Records
_____ Psychological Evaluation
_____ Neuropsychological Evaluation
_____ Other information
_____ Behavioral Report
_____ Education/Academic Records
_____ Teacher's report
_____ Verbal Exchange

For the Purpose of: _____

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Release is valid for (circle one): **ONE YEAR** **TERMINATION OF TREATMENT**

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have already taken action in reliance on the authorization. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPPAA Privacy rule. (That is, once I have given -per your authorization- a copy of select clinical records to, for example your physician, I am not liable in case that the physician discloses it to someone else.)

Release Revoked: _____/_____/_____

INTAKE MEETING

Please type out the answers to the following questions and email them to me 1-2 days prior to the interview appointment (*DrMDeubert@gmail.com*). You do not need to answer every question, just the ones that provide helpful information for the evaluation being conducted.

1. Child's full name and date of birth.
2. What questions are you hoping to have answered from the evaluation process? What are your primary concerns?

FAMILY/DEVELOPMENT

3. Family. List immediate family members and indicate if they are living in or out of the home currently. Include family members' age, current grade level or highest degree earned, school/profession. Include any additional individuals residing in the home. If parents are separated/divorced or experience(d) significant marital conflict, please include information about when that occurred and the impact on the examinee. Please provide details about visitation and guardianship.
4. Language. English speaking home? Any other languages spoken by the family or child?
5. Pregnancy/birth. Full-term? Any complications before pregnant, during the pregnancy or delivery? Details – gestational week delivered, type of delivery, weight at birth. Breastfed?
6. Adoption. At what age did the adoption occur and any information known about birth parents and life experiences prior to adoption. Discuss adjustment to the adoptive home.
7. Developmental history. Please indicate if the following developmental milestones were early, late, or within normal limits. Please include additional information for anything that did not fall within the expected range:
   Expressive language (e.g., utterances, words, sentences)
   Physical Milestones (e.g., standing, crawling, walking)
   Social development (e.g., interactive play, making friends, keeping friends)
   Toilet training
   Fine motor skills (e.g., handwriting, cutting)
   Gross motor skills (e.g., balance, running, throwing)
8. Sensory. Any sensory sensitivities (e.g., textures, loud noises)? Picky eater? Does the s/he tend to engage in sensory seeking behaviors (e.g., spinning, very touchy)?
9. Vision and hearing. Has s/he ever been diagnosed with hearing or vision problems? If so, what are they? Glasses or contacts? History of ear infections? Tubes? Tonsils or adenoids removed? Hearing aid?
10. Temperament. How would you describe you or your child's temperament? What are his/her strengths and weaknesses?
11. Health. Current state of overall health? Any significant illnesses, conditions, injuries (including concussions), seizures or hospitalizations? Any allergies? History of headaches?
12. Medication. Please list all past and current medications taken. Please indicate who is prescribing any current medications.
13. Eating. Typical? Picky? Any concerns about eating disorder? Any digestive conditions (e.g., colitis)? Any recent changes in appetite? History of stomachaches?
14. Sleeping. How much sleep per night on average? Any difficulties falling asleep or staying asleep?

ACADEMIC

15. Hobbies. What does s/he enjoy doing during their free time? How does he/she spend time after school? During the summer? What after school activities do they participate in?
16. School history. Please list all school placements beginning in preschool through present day including dates. Indicate what their experiences were like at each school.
17. How do they get along with teachers? With other students?
18. Strengths and weaknesses. What are his/her academic strengths and weaknesses? Which subjects are most challenging for him/her? Which subjects come easiest? Any concerns in the following areas:
    Reading (comprehension, fluency/speed, decoding/sounding out words)
    Math (calculation, concept, fluency/speed)
    Writing (organization, execution, grammar, spelling, fluency/speed, handwriting)
    Oral language (listening comprehension, verbal expression)
    Attention
    Memory
19. Any difficulties completing tests within the designated time frame?
20. Does s/he have an IEP or 504 Plan? Grade at which the plan was put into effect? *Please bring a copy of current IEP or 504 Plan.*
21. Please describe his/her work habits? Where does s/he study? Do homework? Does s/he tend to have TV or social networking sites on while studying? How does s/he keep their work space? Room?
22. Does s/he like to read for pleasure? To draw?
23. Does s/he struggle to start tasks? Need prompting? Forget to turn in work that has been completed? Loses things? Procrastinates? Struggles to organize a long-term project?
24. Grades. What grades does s/he tend to receive? Has this been consistent or have his/her grades changed significantly? *Please bring copies of transcripts and standardized testing scores.*
25. Evaluations. Has s/he ever been evaluated before? *Please bring copies of any previous testing reports.*

SOCIAL/EMOTIONAL

26. Relationships with family. Please describe how s/he gets along with immediate family members.
27. Friendships. Is it difficult for him/her to make or keep friends? Do they tend to be his/her own age? History of being bullied or bullying?
28. Does s/he have a history of feeling highly anxious or depressed? Any self-harmful behaviors or feelings? Any obsessive or ritualistic behaviors? Please explain.
29. How does s/he tend to feel about himself/herself? Any preoccupations with concerns about body or image?
30. Family history? Is there a family history of emotional difficulties (e.g., depression, anxiety), learning problems (e.g., dyslexia), attention deficit (ADHD), or substance abuse (e.g., alcoholism, drug use)? Please explain. Include immediate and extended family.
31. Diagnoses. Has s/he been diagnosed with a learning, attention, or psychiatric disorder? If so, by whom and when.
32. Support services. Has s/he ever participated in psychotherapy, speech and language therapy, occupational therapy or any other support service? Please list providers and dates seen. Were the services found to be helpful?

33. Any other concerns or considerations that would be helpful for the examiner to know and understand?