Laurie Ferguson, Psy.D.
Licensed Clinical Psychologist, Director
Spark Psychological Services
Laurie Ferguson, Psychologist, Inc.
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Information Regarding Office Policies and Fees
Welcome to the practice! Please let me know if you have any questions!

COVID19 Notice: To keep everyone healthy, all appointments are conducted via confidential, HIPAA-secure teletherapy (Zoom). This may limit the effectiveness of therapy or assessment, and additional in-person therapy or assessment may be needed, if desired, once in-person sessions can resume in order to fully benefit from treatment or assessment.

Cancellation Policy: Appointments are made for you only (I do not "double book" appointments). Please call or email with at least 24-hour notice to reschedule or cancel an appointment. Special circumstances sometimes occur where 24-hour notice may not be possible. To keep all our patients healthy, please reschedule your appointment if you are ill. **If illness or special circumstances do not apply, you will be billed for a missed session.** If you are more than 15 minutes late, you will need to reschedule and you will be billed for the missed session. If too many sessions are missed, or if this appointment policy is being abused, termination of services may occur.

Your Appointment, Fees and Insurance: Dr. Ferguson is an out-of-network provider for your insurance. You are responsible for covering the fee at the time of service. You will be provided a Super Bill to submit to your insurance. Contact the insurance company prior to your appointment to verify any out-of-network benefits. Personal checks, cash, credit and debit cards, and Health Care Savings Account credit/debit cards are accepted.

In shared child custody arrangements, the parent bringing the child for treatment is responsible for payment. In shared custody arrangements, both parents must sign this form and consent for treatment.

For TCRC, Social Security, Social Services, School/College clients: An assessment by Dr. Ferguson is no guarantee of eligibility or services, which are at the sole discretion of the agency/organization. Assessment results could result in an increase or decrease of services or denial of eligibility, even if you already are eligible.

Dr. Ferguson does not accept Medicare, and her services are not reimbursable by Medicare. If you are a Medicare client or are Medicare-eligible, you must advise Dr. Ferguson. You must complete a separate contract mandated by Medicare prior to your appointment if you have Medicare or are Medicare-eligible.

Fee Schedule (with CPT codes): *fees are subject to change without notice*
Intake Appointment and/or Diagnostic Interview (90791), 60 minutes, $250
Psychological Testing (96130, 96131, 9613, 96137), 60 minutes, $175
Individual Therapy (90834), or Family Therapy (90846 / 90847), 45-50 minutes, $140 / (90837), 60 minutes, $150
Expert Witness Services or any court-related services, 60 minutes, $500 ($2,000 retainer required)
Brief phone call or email to change appointments, no charge
All other phone calls, emails, reports, and meetings attended are pro-rated for actual time spent by Dr. Ferguson

Late Payments: Payment is due at the time of service. There is a $35 fee for returned checks. A late fee of $25 per month is applied to past due accounts. Unpaid account balances over 30 days may be forwarded to collections and termination from the practice may occur.

What can I expect in therapy or testing? What do I tell my family member about the appointment? You know yourself the best, and you have the right to set your own goals and pace. Dr. Ferguson will inform you whether your goals are compatible with the type of therapy or testing that she provides. How long therapy or

testing takes will depend on your goals, symptom severity, and other factors. Therapy and testing are ways to know more about your learning style, emotions, thoughts, and behaviors, so that you can succeed at school, work, and in relationships. Difficult topics are discussed and some people experience an increase in depression, anxiety, unsafe behavior, or even suicide. It is very important that you share this with Dr. Ferguson so that she can help you. For testing clients, you have a right to receive a report of Dr. Ferguson's findings in understandable language. You have a right to disagree with Dr. Ferguson's recommendations or diagnoses. Dr. Ferguson welcomes your questions and feedback, positive or negative, and this can improve the effectiveness of the therapy or accuracy of the assessment. You have a right to terminate therapy at any time, although it is always helpful to discuss this with Dr. Ferguson so that she can give you referrals if needed.

Privacy and Confidentiality: Your privacy is very important to Dr. Ferguson. As this is a small community, we may occasionally see each other outside of our appointment. In order to protect your privacy, it is up to you if you would like to say hello or communicate in any way. I do not participate in fundraising or business endeavors of my clients. Your Personal Health Information (PHI) is protected by the Health Insurance Portability and Accountability Act (HIPAA: www.hhs.gov.). Your private information is never shared without your written authorization, or as permitted by law, including but not limited to the following:

If child or elder abuse or neglect occurs, or if a client is a danger to him- or herself or others, Dr. Ferguson is required by law to disclose this information and client contact information to the proper authorities.

In any judicial matters, confidentiality ends when a judge issues a court order for my records or if you bring a lawsuit or licensing board complaint against Dr. Ferguson.

Minor clients: Only parents/guardians with legal custody for health care decisions have access to a minor's records, regardless of who is paying for the session. Dr. Ferguson is legally prevented from releasing information to parents without the minor's consent, including information regarding pregnancy, drug or alcohol use, contraceptive use, sexually transmitted diseases, or medical history.

Contacting You: You will be asked in the Client Intake Form how you would like to be contacted (email, phone) for confidential messages. All information and appointment requests need to be communicated in voicemail or email. Dr. Ferguson cannot respond by text. Use of email means that you accept the risk of electronic communication. There is no guarantee that information in an email or attached to an email remains private. This includes but is not limited to encrypted information, "secure" email services such as Gmail, or cloud-storage services such as Drop-Box.

Social Media: To help protect your confidentiality and preserve therapeutic boundaries, I do not "friend," follow, or search clients online. If you happen to receive a "friend" request from me, it is an error (please contact me to let me know). Posting a review of my services is your right, but to protect your confidentiality, I will not respond online. I welcome any comments about our work and hope we can communicate in person. I maintain two professional media services (Twitter and a Facebook page), which you are welcome to follow for psychology-related articles and information. Following my professional media accounts is not an endorsement of my services.

Emergency Information: Dr. Ferguson does not provide emergency services. If you are experiencing a life threatening emergency, call 911 or go to your nearest emergency room. Mobile Crisis can be called for non-life threatening services 24 hours, 7 days per week at 800-838-1381. The SLO Hotline is also available 24 days, 7 days per week for resources and suicide prevention at 800-783-0607.

I have received and understand the above Information regarding Policies and Fees.

Printed name of patient	Signature of patient (only needed if age 18+)	Date
Printed name of parent/guardian	Signature of parent/guardian	Date

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Client Information ***(the Client is the person coming for therapy or assessment)***

A. Client's full legal name: _____ Today's date: _____

What name do you prefer to be called? _____ Date of birth: _____

Age: _____ Gender: _____ Pronouns: _____ Who referred you? _____

Home street address: _____ City: _____

State: _____ Zip: _____ Ethnicity / Religion: _____

Profession: _____ Employer: _____ City: _____

B. If Client is a minor (under age 18) or a conserved adult:
Is there a legal custody agreement for health care decisions? ❑ Yes ❑ No Is the client a conserved adult? ❑ Yes ❑ No

Parent / Guardian's Name: _____

Address, if different than client's: _____

Employer: _____ Occupation: _____

Additional Parent / Guardian's Name: _____

Address, if different than client's: _____

Employer: _____ Occupation: _____

C. Contacting you: Check the YES box if it is ok to leave confidential information. Check the NO box and only Dr. Ferguson's name and phone number will be left in messages. By checking "Yes," you agree to accept the risks of electronic communication that is not guaranteed secure.

Is it ok to leave confidential information?

Client or Parent's Home Phone: _____ ❑ Yes ❑ No

Client or Parent's Cell: _____ ❑ Yes ❑ No

Alternate Cell: _____ ❑ Yes ❑ No

Email: _____ ❑ Yes ❑ No

If you are here for an assessment, choose the way(s) you would like your report sent to you:
❑ **Email** ❑ **Regular Mail** ❑ **Fax:** _____

Client Information (p. 2)
Client Name:_____

C. Current or Last School Attended: _____ Grade: _____

City: _____ ❑ Received GED ❑ Graduated High School year: _____

Has the Client ever had any of the following: ❑ 504 Plan ❑ IEP ❑ SST ❑ Special Education
❑ Psychoeducational or Psychological Testing ❑ Occupational Therapy ❑ Physical Therapy
❑ Speech/Language Eval/Services ❑ Neurology Eval/MRI/EEG/EKG ❑ Audiologist Exam
❑ Ophthalmologist Exam ❑ Other: _____

F. Current Medical Concerns & Medications (include natural supplements):

_____
_____
_____

Physician/Pediatrician's name: _____ City: _____

G. Therapies, past and current:

Provider Name: Purpose: Dates:

_____
_____
_____
_____

H. Who Lives With The Client?:
Cient's Marital Status: ❑ Single ❑ Married ❑ Live-in Partner ❑ Divorced ❑ Separated ❑ Widowed

Family Members (Name / Relationship / Age / Does this person live with the client full-time?)
Example: John Smith / Son / 15 years old / Lives with me weekends and some holidays
_____
_____
_____

I. What are your main concerns?_____
_____
_____
_____
_____

J. What are your goal(s) for therapy / assessment?_____
_____
_____
_____
_____

Client's (or Parent's) Signature: _____ Date:_____

This is a strictly confidential patient medical record. Redisclosure or transfer withouyt signed informed consent is expressly prohibited by law.

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SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

This information is very helpful in the treatment and/or evaluation of the client.
This information may be included in a written report, unless you advise Dr. Ferguson otherwise.
Any information shared with Dr. Ferguson, either written or verbal, may be subject to court subpoena, therefore, there are limits to confidentiality. Discuss any confidentiality concerns with Dr. Ferguson.

I. GENERAL INFORMATION: *The client is the person coming in for assessment or treatment.*

Client's full legal name_____ DOB_____ Age_____
Client prefers to be called _____ Gender _____ Pronouns _____
Primary Language(s) at home:_____

MAIN locations (city, state) that the client has lived:
1. Birthplace _____ Lived here until age: _____
2. _____ Lived here until age: _____
3. _____ Lived here until age: _____
4. _____ Lived here until age: _____

Have there been any significant changes in the client's home, career or relationships? (marriage, deaths, births, address changes, family separations/divorce, money problems, etc.)_____
_____
_____

Client's strengths and interests:_____
_____
_____
_____

For clients who are minors:
Parent: _____Occupation:_____
Parent: _____Occupation:_____
Are parents currently: □ married □ divorced □ separated □ never married
• Who has *legal custody for health care decisions*? (this is different than physical custody; please provide court order if applicable): _____
• If separated or divorced, how do you feel your child/teen has adjusted to the separation/divorce?_____
_____
Are there any other adults who have a ***significant*** part in raising your child/teen? Who?_____
_____

II. HEALTH AND DEVELOPMENT:

A. Pregnancy and Birth of client's biological mother:

The client's relationship to legal guardian(s): □ biological □ adopted □ foster □ other: _____
Were fertility treatments utilized for this pregnancy? Please describe: _____
_____
Biological mother's age at birth? _____ Did mother receive routine medical prenatal care? □Yes □ No
When did prenatal care start? _____Please specify any medications used during pregnancy / reason used: _____
During pregnancy was there any use of: □ nicotine/cigarettes □ marijuana □ illegal drugs □ other: _____
Child was born at City/State: _____ □ home □ hospital/birthing center Name: _____
_____ Pregnancy lasted _____weeks / months
Child's birth weight: _____pounds _____ounces APGAR score at 1 minute____ at 5 minutes_____ □ unknown

Please check the conditions below that describe the health of the child and mother during…

Mother's pregnancy

- □ No complications
- □ Diabetes
- □ Injury
- □ Hypertension
- □ Excessive bleeding
- □ Emotional stress
- □ Other problem (specify)

Child's Delivery

- □ Normal
- □ Induced labor
- □ C-section
- □ Breech birth
- □ Very long labor (>12 hours)
- □ Other problem (specify):

Child's Condition at Birth

- □ Normal
- □ Breathing problem
- □ Jaundice
- □ Birth injury/defect
- □ Newborn ICU
- □ Other problem (specify)

Describe concerns with pregnancy/labor/delivery/baby's condition at birth: _____
_____
_____
_____

Behavior as an infant and toddler (up to 3 years of age): Were any of the following a significant concern?

- □ Did not enjoy cuddling
- □ Was not easily calmed by being held
- □ Difficult to comfort
- □ Colicky
- □ Excessive irritability
- □ Diminished sleep
- □ Frequent head banging
- □ Spinning, rocking, or hand flapping
- □ Poor eye contact
- □ Did not turn towards caregivers
- □ Did not respond to name
- □ Did not respond to speech of caregivers
- □ Difficult nursing
- □ Difficulty transitioning to baby food or table food

Describe concerns and temperament as a newborn (happy, "easy," "colicky," etc.):_____
_____
_____
_____
_____
_____

B. Development

Please indicate the age when the client achieved the following milestones. Estimates are acceptable:

Age sat up without help:_____
Age crawled: _____
Age walked alone: _____
Age spoke first words: _____
Age spoke short phrases: _____
Age spoke in sentences:_____
Age bladder trained for day:_____
Age fully bowel trained:_____
Age stayed dry all night: _____

Did or does the client have more difficulty than peers the same age:

Past Month	When Younger		Past Month	When Younger	
□	□	Throwing or catching a ball	□	□	Knowing left and right
□	□	Putting on shoes (velcro closure)	□	□	Holding a crayon or pencil
□	□	Tying shoe laces	□	□	Accidentally dropping things
□	□	Dressing self	□	□	Knowing where his/her body is in space
□	□	Buttoning and zipping	□	□	Clumsy or trouble with balance
□	□	Running	□	□	Likes wrestling, rough play
□	□	Jumping	□	□	Avoids heights (play structure, stairs, etc.)
□	□	Riding a tricycle or bike	□	□	Avoids swings
□	□	Toileting accidents	□	□	Trouble telling time more than same-age peers
□	□	Feeling when needs to go to the bathroom	□	□	Motor skills aren't even / symmetrical
□	□	Spins, rocks, paces, or headbanging (circle)	□	□	Repeats words or phrases, or "echoes" others
□	□	Other repetitive motor movements	□	□	Uses phrases from tv/movies excessively
□	□	Articulation trouble or hard to understand	□	□	"Black and white" or literal thinking
□	□	Won't talk about his/her day	□	□	Trouble understanding humor or sarcasm
□	□	When upset, has a lot of trouble communicating	□	□	Trouble following a conversation
□	□	Trouble with eye contact (not just when upset)	□	□	Communicates best with adults or family
□	□	Does not pick up on social cues	□	□	Often turns conversation to favorite topics
□	□	Does not seem to understand body language	□	□	Rarely shares interests or accomplishments
□	□	Has trouble following multi-step directions	□	□	Difficulty using pronouns (he, she, we, they, I)
□	□	Frequently argues or debates the meaning of words	□	□	Mutism (difficulty or "refusal" to speak)

Any other concerns with communication skills, motor skills, or development: _____

_____

_____

_____

C. Health

How is the client's health now? □ Excellent □ Good □ Fair □ Poor When was last check-up? _____
Are immunizations up to date? □Yes □ No Is there an alternative immunization schedule? □Yes □ No
Any concerns with growth/weight? □Yes □ No Describe: _____
Does the client use: □ Nicotine □ Alcohol □ Marijuana □ Vape □ Other drugs Describe/How often: _____

_____

Has the client ever:

Received Early Intervention Services? □Yes □ No Regional Center Services? □Yes □ No
Been identified as having a mental health diagnosis? □Yes □ No Describe: _____

_____

Received psychological counseling? □Yes □ No Describe: _____
Received speech, occupational therapy, physical therapy, vision therapy, etc.)? □Yes □ No Describe: _____

_____

_____

Received private tutoring (i.e., Kumon, Lindamood-Bell, etc.)? □Yes □ No Describe: _____

_____

Has <u>the client</u> had any of the following? (There is space later to discuss family history.) Please check all that apply for the client and include details and age of onset:

□ Headache or Migraines _____
□ Hit head or concussion _____
□ Seizures _____
□ Blackouts or fainting _____
□ Surgery _____

_____

□ Hospitalization (overnight) _____

_____

□ ER visit(s) _____

_____

□ Ear Infections_____
□ Allergies to foods, medications or seasonal allergies _____

_____

□ Asthma _____
□ Vocal Cord Dysfunction (VCD) _____
□ Vision Problem (wears glasses, etc.) _____
□ Hearing Problems (uses hearing aid, etc.) _____
□ Constipation or Diarrhea _____
□ Other Gastrointestinal Problems _____
□ Thyroid Condition _____
□ Heart Condition _____
□ Acne or Skin Conditions _____
□ Hormone Therapy_____
□ Physical, Sexual, or Emotional Abuse _____
□ Poverty, Homelessness, Food Insecurity or Neglect_____
□ Other concern (please describe) _____
□ Is there any health care, surgery, or procedure that is planned for the future or that the client needs/wants but has not been able to access for any reason? _____
Any additional information to share? _____

_____

_____

D. Family History:

1. These questions are about the BIOLOGICAL FAMILY MEMBERS (not the client): Write which ***biological*** family member (parent, sibling, aunt/uncle, grandparent, cousin, etc.):

□ Learning Difficulties _____
□ Formally diagnosed with Dyslexia / Reading Disorder _____
□ Formally diagnosed with Learning Disorder in math _____
□ Formally diagnosed with Learning Disorder in writing _____
□ Attention problems _____
□ Hyperactivity _____
□ Formally diagnosed with ADD or ADHD _____
□ Speech or Language problem _____
□ Diagnosed or suspected (circle) Autism _____
□ Diagnosed or suspected (circle) Asperger's _____
□ Intellectual Disability or Cognitive Delay (used to be termed "Mental Retardation") _____
□ Depression _____
□ Anxiety or Panic (circle) _____
□ Obsessive Compulsive symptoms _____
□ Hoarding _____
□ Mood Swings _____
□ Formally diagnosed with Bipolar Disorder _____
□ Excessive anger or rage _____
□ Schizophrenia _____
□ Delusions or thought disorder _____
□ Drug problem _____
□ Alcohol problem _____
□ Hospitalization for danger to self or others (suicide, self-harm, etc.) _____
□ Hospitalization for drug/alcohol use or addiction _____
□ Hospitalization for other mental health concern _____
□ Other concern (please describe): _____
_____

Highest education level achieved by biological mother: □ some high school □ GED □ high school grad □ some college □ 4-year college degree □ master's degree □ doctorate degree □ trade school □ other: _____

Highest education level achieved by biological father: □ some high school □ GED □ high school grad □ some college □ 4-year college degree □ master's degree □ doctorate degree □ trade school □ other: _____

2. Does the client's family or household (biological or non-biological) have any history of the following:
□ Physical Abuse _____
□ Sexual Abuse _____
□ Neglect _____
□ Domestic Violence _____
□ Other Trauma _____
□ Jail/prison _____
□ Probation _____
□ DUI or Revoked driver's license _____
□ Other concern (please describe): _____
_____

III. BEHAVIOR:

A. Please check below the behaviors that describe the client:

Past Month	Up to age 5 or 6 years old	
□	□	Fidgets, has a hard time staying seated
□	□	Has difficulty waiting for his/her turn
□	□	Talks excessively, interrupts often
□	□	Daydreams or poor concentration
□	□	Poor eye contact
□	□	Often loses things
□	□	Very disorganized
□	□	Difficulty making decisions
□	□	Finding things is difficult for him/her
□	□	Difficulty initiating or completing tasks
□	□	Difficulty following instructions
□	□	Trouble with time management
□	□	Needs lots of prompts to do things
□	□	Disorganized
□	□	Impulsive
□	□	Hyperactive, "driven by a motor"
□	□	Often argumentative
□	□	Blames others for own mistakes
□	□	Often actively defiant to adults or rules
□	□	Immature compared to peers
□	□	Has been teased or bulled by others
□	□	Teases or bullies others
□	□	Lies or steals (circle)
□	□	Physically aggressive
□	□	Sets fires or fascinated by fire
□	□	Cruel toward animals
□	□	Engages in dangerous activities
□	□	Wanders off or elopes (runs away)
□	□	Doesn't have age typical stranger danger
□	□	Problems with social skills
□	□	Does not have enough friends
□	□	Trouble playing creatively or using "pretend"
□	□	Transitions are difficult
□	□	Does not like changes or new routines
□	□	Avoids new activities or foods
□	□	Uses electronics too much

Past Month	Up to age 5 or 6 years old	
□	□	Often depressed
□	□	Often irritable or frustrated
□	□	Mood swings
□	□	Explosive temper
□	□	Cries easily or frequently
□	□	Feeling of worthlessness or low self-esteem
□	□	Does not want to spend time w/ family, friends (circle)
□	□	Suicidal thoughts or actions (circle)
□	□	Has hurt self on purpose (cutting, scratching)
□	□	Sleeping too little or too much (circle)
□	□	Low energy/fatigue
□	□	Exercises too little or too much (circle)
□	□	Poor appetite, picky eating, or overeating (circle)
□	□	Lots of stomach aches or headaches
□	□	Feels stressed out or overwhelmed
□	□	Anxious or worried
□	□	Panic attacks
□	□	Specific fears
□	□	Excessive separation difficulties
□	□	Frequently asks to stay home from school
□	□	Saying the same thing over and over
□	□	Obsessions (can't stop thinking about something)
□	□	Compulsions (can't stop doing something)
□	□	Excessive interest in certain topics/activities
□	□	Unusual interests or fascinations
□	□	Interests are too limited
□	□	Does not like large groups of people
□	□	Overly sensitive to sound
□	□	Overly sensitive to touch, texture, clothes
□	□	Overly sensitive to light
□	□	Overly sensitive to certain tastes/food textures
□	□	Gets too close to others or in to people's "space"
□	□	Clothing bothers him/her excessively
□	□	Excessively low or high pain tolerance (circle)
□	□	Sensory seeking (touch, sound, etc.)
□		(For adults) Sexual problems or concerns

B. Tell me more about the client: *write n/a if not applicable to the client*

Describe the client's personality/temperament:_____

_____

How does the client get along with family members? _____

_____

Describe the client's peer relationships:_____

_____

Tell me about the client's self-esteem: _____

_____

Does the client ask for help when needed and speak up about their needs? _____

_____

Is the client dating or interested in dating? _____

How does the client identify in terms of gender identity and sexual orientation? _____

_____

Does the client have questions about sexuality, puberty, gender identity or expression, or sexual orientation? ___

_____

What responsibilities/chores does the client have at home? _____

_____

How does the client respond to limits/rules?_____

_____

What time does the client go to sleep? _____am/pm Wake up?____ am/pm □ Sleep times are very inconsistent

Any sleep problems currently? □ Trouble falling asleep □ Waking up too early and can't get back to sleep □ Nightmares □ Sleepwalking □ Night terrors □ Restless sleep □ Tired even after sleeping "enough" hours

C. Independent, Adaptive Living Skills: Please check below all skills that **the client can do independently (without excessive reminders or excessive support for the client's age):**

- □ Dressing or undressing
- □ Showering, bathing, wash face, brush teeth
- □ Getting/fixing a simple snack
- □ Understands concept of stranger danger
- □ Bathing, dressing, grooming
- □ Grocery Shopping
- □ Cooking a whole meal
- □ Cleaning the kitchen or bathroom
- □ Doing a load of laundry
- □ Attend college, trade school, or training
- □ Live in a dorm or with roommates
- □ Live on his/her own
- □ Drives a car (or is learning to drive)
- □ Using public transportation for a long trip
- □ Applying for a credit card
- □ Applying for a job and interviewing
- □ Has some marketable job skills
- □ Quick learner
- □ Hard worker
- □ Putting on clothes appropriate to the weather
- □ Brushing hair, grooming
- □ Keeping room clean, putting away toys/belongings
- □ Completing chores or responsibilities
- □ Stays w/ caregiver in public (does not wander off)
- □ Understands how money works and how to save
- □ Ride a bus, walk or bike in the community
- □ Babysitting, yardwork or other suitable teen job
- □ Comfortable talking with adults
- □ Understands social media risks
- □ Can make own doctor or other appointments
- □ Can open own savings or checking account
- □ Can keep to a budget and not overspend
- □ Understands how marketing influences buying choices
- □ Understands how to avoid possible dangerous situations
- □ Is not easily taken advantage of
- □ Knows how to choose friends
- □ Has good coping skills, is resilient
- □ Can resolve disagreements w/ peers or co-workers

IV. Educational History

How does / did the client feel about school? _____

Does / did the client feel or talk about being "bored" at school? _____

How motivated is / was the client is to learn in school? _____

How much of a struggle is / was homework? □ Not a struggle □ Sometimes a struggle □ Often struggles

Name of school attended and briefly describe client's academic and/or behavioral performance:

Preschool/Daycare _____

_____

Elementary School _____

_____

Middle School _____

_____

High School _____

_____

College _____

_____

For current students: Have there been excessive absences or tardies in the last year? □ Yes □ No

Have there been behavior problems at school? □ Yes □ No _____

Any other problems or challenges at school? _____

Are there services/supports you would like the school/college to provide: □ additional time on tests □ quiet room for tests □ help with organization or study skills □ note taking help □ aide in the classroom (K-12)

Other: _____

V. Work History

Current Employer: _____ Position Title: _____

Length of time at current job: _____ Does the client enjoy the job? □ Yes □ No

How motivated is the client is to meet the job responsibilities? _____

Is work difficult for the client? □ Not a struggle □ Sometimes a struggle □ Often struggles Why? _____

_____

Has the client experienced discrimination on the job? □ Yes □ No Describe: _____

_____

Are there accommodations you would like the employer to provide: □ work from home □ modified schedule □ time to sit down □ breaks □ clearer instructions □ visual schedule Other: _____

_____

Is the client paid adequately? □ Yes □ No Does the client wish to change jobs? □ Yes □ No

Does the job change require going back to school or getting more training? □ Yes □ No

List any skills that the client needs to develop in order to be more successful at work: _____

_____

VII. Legal History: Has the client ever been involved in: □ lawsuit □ jail / prison □ probation □ small claims □ worker's compensation □ victim of crime □ Other: _____

Does the client anticipate being party to a lawsuit in the future? □ Yes □ No Describe: _____

VII. Anything Else You Would Like Dr. Ferguson to know? (please add additional pages as needed)

Person completing this form: Relationship to Client: □ Self □ Parent □ Guardian □ Conservator □ Other: _____

_____

Signature **Name** **Date**