

NEBRASKA MENTAL HEALTH CENTERS - Confidential Intake Form

<u>Name (First, Middle Initial, Last):</u>		Gender	Birthdate (mm/dd/yyyy)
		M F	
Street Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	
Social Security Number:	Marital Status:	Email Address:	
	S M W D		
Employer:	Full-time Part-time	Employer Address:	
Education Level (highest grade completed):	Student Now?	School:	
	Yes No		
Have you (patient) had previous counseling?	If yes, please tell us when and with whom:		
Yes No			
Emergency Contact (name, relationship, phone):		Initial here for permission to contact in case of emergency: _____	
How did you hear about us:			

Parent / Legal Guardian Information (for patients under 19yrs of age, elderly, mentally disabled, etc)

<u>Parent/Guardian Name (First, Middle Initial, Last):</u>		Relationship to Patient:	
Street Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
<u>Parent/Guardian Name (First, Middle Initial, Last):</u>		Relationship to Patient:	
Street Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	

Insurance Plan Information

<u>Primary Plan Name:</u>	Phone #:	Policy #:	Group #:
Policy Holder Name:		Birthdate (mm/dd/yyyy):	Social Security Number:
Policy Holder's Employer:		Relationship to patient:	
<u>Secondary Plan Name:</u>	Phone #:	Policy #:	Group #:
Policy Holder Name:		Birthdate (mm/dd/yyyy):	Social Security Number:
Policy Holder's Employer:		Relationship to patient:	



Patient Rights:

1. To receive quality, considerate, and respectful care.
2. To receive treatment without regard to age, race, color, sex or sexual orientation, religion, marital status, national origin, economic status or source of payment;
3. To be treated with respect and recognition of your dignity and right to privacy.
4. To receive information about services, staff, and hours of operation.
5. To receive a clear explanation of their condition and treatment options.
6. To be informed and to participate in the decisions about your treatment.
7. Information in a language they can understand.
8. To be provided a way in which to make a complaint or a grievance about services without discrimination or reprisal, and get a timely answer.
9. To have treatment and other member information kept private. Only where permitted by law will records be released without members' permission.
10. To have access to your medical records as permitted by Nebraska State law.
11. To have your psychiatric/mental health advance directive followed, should you have one. Check one below.
 - I have a psychiatric/mental health advance directive.
 - I want information about having a psychiatric/mental health advance directive developed
 - I do not want to have a psychiatric/mental health advance directive developed.
12. To be provided an on-call crisis line manned by clinical personnel to assist patients after normal business hours. Call the Emergency Assistance On-Call Crisis Line at 402-483-6990 and leave a voice message with his/her name and phone number. The on-call clinician returns calls as clinically necessary.

_____ Patient/Guardian Initials

Permission to Observe Sessions and Discuss Case Information

We would also like to inform you that as a group practice and training facility for a Psychology Internship and Residency Programs, professionals work together to consult on patient care issues. It is possible your material could be used in teaching, supervision, and consultation with other therapists or, on occasion, an intern or a supervisor may observe your session. Your therapist will, on these occasions, ask prior to the beginning of the session if someone can join for observation and/or provide assistance. You may decline at that time. All professionals within NMHC are bound by confidentiality agreements and HIPAA regulations.

_____ Patient/Guardian Initials

CONSENT FOR TREATMENT

I hereby consent to mental healthcare to be provided by Nebraska Mental Health Centers. This includes assessment and treatment procedures as appropriate. I understand that treatment options will be discussed with me and that I have a right to participate in decisions about treatment.

Patient Name: _____ Patient Signature: _____

Parent/Guardian Name _____ Parent/Guardian Signature: _____

Date: _____ Staff Initials _____



Financial Policy and Patient Responsibility

Patient Responsibilities

- Provide a photo ID for your confidential patient chart (16 years and older).
- Provide NMHC with your current insurance and policy holder information.
- Know their insurance policy. Patients should be aware of their benefit coverage including which providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and costs share information such as deductibles, co-insurance, and co-pays. If you are not familiar with your plan coverage for mental health services, we recommend you contact your carrier directly.
- Pay their co-pay amount at the time of service.
- Pay for their visit in full at the time of service if a self-pay patient.
- Pay any Medicare deductible and co-insurance amounts not covered by their supplemental insurance.
- Promptly pay any patient responsibility indicated by their insurance carrier. A late charge of 1.5% per month on unpaid patient balances will be added to accounts not paid within 90 days of receipt of insurance payment.
- In the case of a divorce, the custodial parent is responsible for all payments. NMHC is not involved in disagreements between the parties in a divorce situation.
- Inform the front office of any change of personal information (e.g., phone #, address, insurance information)
- Keep all appointments. If needing to cancel an appointment, provide office notification at least 24 hours in advance. Any No Show or Late Cancel appointments may be charged as follows:
 - First Time – No Charge
 - Second Time – Half price of the Session scheduled.
 - Third Time – Full Price of the Session scheduled.

NMHC will bill your insurance company in a timely manner, be as accurate as possible with our billing procedures, and will efficiently answer any billing questions you may have. We will send you a monthly statement so that you know the amount you are responsible to pay. Payment is due upon receipt of the monthly billing statement.

Account balance past 30 days must be paid prior to the next visit. If you cannot pay, other options may be discussed. Please speak to the accounts manager. If your account balance remains past due after 90 days, we will notify you that without a response from you, we may use a collection agency or our attorneys to obtain payment in full.

Financial Policy Acknowledgement

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, check or credit card. I agree that if my account is referred to a collection agency or attorney I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

Patient Name: _____ Signature: _____ Date _____

Patient's Guardian Name: _____ Signature: _____ Date: _____

NMHC Staff Signature: _____ Date: _____



Nebraska Mental Health Centers

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Authorization to Exchange Confidential Information with Medical Primary Care Provider

Patient Name: _____

Date of Birth: _____

The Purpose of the Authorization: To release behavioral health evaluation and/or treatment information to the Medical Primary Care Provider listed below to ensure quality and coordination of care and to request applicable medical/health information in accordance with the Federal and State statutory requirements concerning confidentiality of records

_____ I hereby authorize that confidential information be exchanged with my Medical Primary Care Provider listed below.

Doctor Name: _____

Doctor Phone Number: _____

Doctor Fax Number: _____

_____ I decline to authorize the exchange of confidential information with my Medical Primary Care Provider.

_____ I do not have a Medical Primary Care Provider.

Signature of Patient: _____

Date: _____

OR

Signature of Responsible Party: _____

Date: _____

Name of Responsible Party: _____

NMHC Staff Signature: _____

Date: _____

Important Rights and Other Required Statements You Should Know:

- You can revoke this authorization at any time by writing to the providers named above. If you revoke this authorization it will not apply to the information that has already been released.
- The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by Federal or State privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment or treatment for services. This authorization is completely voluntary.
- You have a right to a copy of this authorization once you have signed it.
- A photocopy or fax of this release is as good as the original. NMHC will not condition treatment, payment, enrollment, or eligibility for benefits on this authorization. NMHC notifies you of the potential that this information, once forwarded to the other party, could be re-disclosed and no longer protected by the rule.

Jill Zlomke McPherson, MA, LIMHP, Executive Director

Dr. Lee C. Zlomke, Clinical Director

4545 South 86th Street • Lincoln, NE 68526

Phone: 402-483-6990 or 1-888-210-8064 • Fax: 402-483-7045

Visit us online at www.nmhc-clinics.com

Nebraska Mental Health Centers

Consent for Use/Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Nebraska Mental Health Centers (NMHC) for the purpose of diagnosing or providing treatment to me, obtain payment for my health care bills, or to conduct health care operations of NMHC. I understand that diagnosis or treatment of me by NMHC may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my health care provider, a health care professional, a health plan, my employer, or a healthcare clearinghouse. This protected health information related to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the following rights with regard to my protected health information:

- Right to request restrictions on certain uses and disclosures of PHI. However, NMHC is not required to agree to a restriction you request.
- Right to receive confidential communications by alternative means and at alternative locations.
- Right to inspect and copy PHI and psychotherapy notes in NMHC mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. NMHC may deny your access to PHI under certain circumstances, but in all cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- Right to amend PHI for as long as the PHI is maintained in the record. NMHC may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to a paper copy of the notice from NMHC upon request.

I understand I have a right to review NMHC's Notice of Privacy Practices prior to signing this document. A copy of the NMHC's Notice of Privacy Practices is available in the waiting room. A copy of the afore-mentioned documents will also be provided to me upon my request. The Notice of Privacy Practices describes the types of uses and disclosures of my "protected health information" (PHI) that will occur in my treatment, payment of my bills, or the performance of healthcare operation of NMHC. NMHC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I have the right to revoke this consent in writing, at any time, except to the extent that NMHC has taken action in reliance on this consent.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____

NMHC Staff Signature: _____ Date: _____



Nebraska Mental Health Centers

Intake Questionnaire

Family/Self Psycho-social History

Have you and/or anyone in your birth family experienced or been diagnosed with the following? Check all that apply.

Self Family

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Retardation |
| <input type="checkbox"/> | <input type="checkbox"/> | Speech or Communication Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Attention-Deficit/Hyperactivity Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning Problems/Disabilities |
| <input type="checkbox"/> | <input type="checkbox"/> | Pervasive Developmental Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism Spectrum Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety Disorders (Panic, Phobias, Social Anxiety) |
| <input type="checkbox"/> | <input type="checkbox"/> | Post-Traumatic Stress |
| <input type="checkbox"/> | <input type="checkbox"/> | Obsessive-Compulsive Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Manic-Depression/Bipolar Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Personality Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Schizophrenia or other Psychosis |

Self Family

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures or other Neurological Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Genetic Disorder (e.g. Down Syndrome) |
| <input type="checkbox"/> | <input type="checkbox"/> | Dementia |
| <input type="checkbox"/> | <input type="checkbox"/> | Neglect |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Domestic violence |
| <input type="checkbox"/> | <input type="checkbox"/> | Legal problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Financial problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol/Substance Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Serious illness |
| <input type="checkbox"/> | <input type="checkbox"/> | Accident or injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent/Multiple moves |
| <input type="checkbox"/> | <input type="checkbox"/> | Homelessness |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Current Psychological Difficulties

Please check any that apply to you at this time

- | | |
|--------------------------|---|
| <input type="checkbox"/> | Generalized Anxiety |
| <input type="checkbox"/> | Specific fears/phobias |
| <input type="checkbox"/> | Panic Attacks |
| <input type="checkbox"/> | Obsessive thinking/repetitive behaviors |
| <input type="checkbox"/> | Sadness/Depression |
| <input type="checkbox"/> | Frequent crying |
| <input type="checkbox"/> | Loss of energy |
| <input type="checkbox"/> | Loss of pleasure in life |
| <input type="checkbox"/> | Trouble waking up |
| <input type="checkbox"/> | Fatigue/tiredness during the day |
| <input type="checkbox"/> | Nightmares/Night terrors |
| <input type="checkbox"/> | Memory problems |
| <input type="checkbox"/> | Paranoia |
| <input type="checkbox"/> | Problems with attention/concentration |

- | | |
|--------------------------|---------------------------------|
| <input type="checkbox"/> | Racing thoughts |
| <input type="checkbox"/> | Problems making/keeping friends |
| <input type="checkbox"/> | Problems controlling temper |
| <input type="checkbox"/> | Relationship/Marriage problems |
| <input type="checkbox"/> | Problems with intimacy |
| <input type="checkbox"/> | Problems with job |
| <input type="checkbox"/> | Alcohol/drug use/abuse |
| <input type="checkbox"/> | Financial problems |
| <input type="checkbox"/> | Legal situation |
| <input type="checkbox"/> | Mood swings |
| <input type="checkbox"/> | Hallucinations |
| <input type="checkbox"/> | Frequent body complaints |
| <input type="checkbox"/> | Body image issues |
| <input type="checkbox"/> | Other: _____ |

Have you ever or are you currently contemplating suicide?

- No Yes (Currently) Yes (Past)

Has anyone close to you (family/friends) ever attempted/committed suicide?

- Yes No

Have you ever or are you currently contemplating harming another person?

- No Yes (Currently) Yes (Past)

Health and Social Information

How is your health at present? (Select one)

- Poor
- Unsatisfactory
- Good
- Very Good

Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, diabetes, etc.)

How many times per week do you exercise?

- 1 or less
- 2
- 3
- 4 or more

Rate the overall level of stress in your life.

- Very Low
- Low
- None
- High
- Very High

List any sources of stress in your life: _____

Are you having any problems with your sleep habits?

- Yes
- No

If yes, check where applicable:

- Sleeping too little
- Sleeping too much
- Poor quality sleep
- Disturbing dreams
- Other: _____

Have you ever or are you currently engaging in self-harm?

- No
- Yes (Currently)
- Yes (Past)

Are you having any difficulty with appetite or eating habits?

- Yes
- No

If yes, check where applicable:

- Eating less
- Eating more
- Binging
- Restricting

Have you experienced significant weight change in the last 2 months?

- Yes (gain)
- Yes (loss)
- No

Are you currently in a relationship?

- Yes
- No

If yes, please list status: _____

Number of marriages: _____

Number of divorces: _____

If widowed, your age at death of spouse: _____

Do you have children?

- Yes
- No

If yes please list below:

Medical Information

Do you now have, or have you had in the past, any of the following?

Now Past

- | | | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Concussion/Loss of Consciousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Digestive Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Abortion (how many) |
| <input type="checkbox"/> | <input type="checkbox"/> | Serious Accident |

Now Past

- | | | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Immune System Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy (how many) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |

Now Past

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Fatigue Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Miscarriage (how many) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

List all medications you take, including prescription, psychotropics, over-the-counter, vitamins, drops, and topicals

List medications to which you are allergic

List any operations/medical procedures and the dates they took place

List any other hospitalizations and/or major injuries

Legal history

Have you ever been the victim of a crime?

- Yes
 No

Have you ever been convicted of a misdemeanor or felony?

- Yes
 No

Substances History

Please indicate substances currently used (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Usage	Amount	Frequency	Age (of first use)
Caffeine	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Alcohol	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Tobacco	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Marijuana	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Ecstasy	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Cocaine/Crack	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Heroin	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Methamphetamines	<input type="checkbox"/> Current <input type="checkbox"/> Past			
PCP/LSD/Mushrooms	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Painkillers	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Steroids	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Tranquilizers	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Sleeping pills	<input type="checkbox"/> Current <input type="checkbox"/> Past			
Diet pills	<input type="checkbox"/> Current <input type="checkbox"/> Past			

Have you ever believed your substance use was a problem for you?

- Yes
 No

Has anyone ever told you they believed your substance use was a problem?

- Yes
 No

Have you ever had withdrawal symptoms when trying to stop using any substances?

- Yes
 No

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?

- Yes
 No

If yes, please describe: _____

Have you ever participated in drug/alcohol treatment?

- Yes
 No

If yes please list type, length, dates, and age at the time you received these services: _____

Do you currently or have you ever attended Alcoholics or Narcotics Anonymous?

- Yes
 No

If yes, please list length of time sober and number of meetings you attend per week: _____

TIMBERLAWN CHILD FUNCTIONING SCALE

Name of Patient: _____ Date: _____

Name of Rater: _____

Relationship of Rater to Patient: _____

Age: _____ Sex: M F Grade: _____

Status: _____ Inpatient
_____ Outpatient
_____ Other

Type of Rating: _____ Intake
_____ Discharge
_____ Follow-Up
_____ Other

Please rate the child on the following scales from your direct observation and background knowledge of his/her present functioning. Read each scale carefully and evaluate independently of the others. Flexibility in rating is provided by mid-points which are not specifically defined. To complete the form, circle the number which best describes the child on the range of behavior or functioning for every scale.

A. LIKABILITY

- 1 Others have strongly positive feelings for the child
- 2
- 3 Others have moderately positive feelings for the child
- 4
- 5 Neutral
- 6
- 7 Others have moderately negatives for the child
- 8
- 9 Others have strongly negative feelings for the child

B. LANGUAGE

- 1 Exceptional mastery of language and expressive verbal skills
- 2
- 3 Appropriate speech and language skills for age
- 4
- 5 Clear difficulty in expression for age; needs to be asked to repeat things often
- 6
- 7 Extremely limited expressive skills; poor intelligibility or difficult to understand
- 8
- 9 Mute or near mute; makes unintelligible sounds rather than saying words; gives a few simple, often repeated phrases; socially unusual or peculiar language

C. THINKING/BEHAVIOR

- 1 Superior degree of logical orderly thinking and goal-directed behavior
- 2
- 3 Logical and organized thinking for age, and conventional behavior
- 4
- 5 Mild confusion under stress or some unusual or strange behavior
- 6
- 7 Unusual thoughts, confused reasoning, or frankly odd or repetitive/ritualistic behavior; strange fantasies or beliefs
- 8
- 9 Incoherent, disorganized thinking; does not know where he/she is; holds onto peculiar or untrue beliefs; sees or hears things that are not there; bizarre or stereotyped/repetitive movements; rocking, whirling, head banging, arm flapping

D. ATTENTION SPAN/ACTIVITY LEVEL

- 1 Superior attention span, direction of activity or task-focus for age
- 2
- 3 Average attention span or activity level; able to concentrate, sit still and focus attention as well as others his/her age
- 4
- 5 Mildly shortened attention span; mild but noticeable problem with activity level; slightly distracted by minor things; restless and fidgety
- 6
- 7 Moderate problem with attention span and activity level; frequently distracted by minor things with difficulty staying on topic or task; frequently gets up, moves fast, or shows impulsive motion
- 8
- 9 Severe problem with attention span and activity level; distracted by unimportant things to point of interrupting thoughts or actions to a significant degree; almost constant driven behavior

E. EDUCATIONAL PERFORMANCE

- 1 Excellent school performance
- 2
- 3 Average school performance
- 4
- 5 Poor school performance
- 6
- 7 Some school failure
- 8
- 9 Chronic school failure resulting in increasingly lowered achievement or inability to attend school

F. INDUSTRY AND COMPETENCE

- 1 Superior motivation, ability to accomplish goals or productivity
- 2
- 3 Average motivation and accomplishment; gets satisfaction from accomplishments
- 4
- 5 Infrequently starts tasks on his/her own, but gets things done with some encouragement
- 6
- 7 Passive attempts at tasks (goes through motions, but doesn't really try); quits easily even with support; gets little satisfaction from tasks
- 8
- 9 Rarely attempts tasks; need constant one-to-one attention to get things done; must have external direction and frequent praise or rewards; may be unable to accomplish anything, even with support; gets no satisfaction from accomplishments

G. IMPULSE CONTROL

- 1 Superior ability to tolerate frustration, delay gratification, and manage self-control
- 2
- 3 Average self-control for age; some capacity to delay gratification; responds to limit-setting
- 4
- 5 Weak control of impulses; reacts without thinking, but regains control with help
- 6
- 7 Clearly impulsive; easily frustrated and acts on frustration with immediate outbursts; unpredictable behavior with minor stress
- 8
- 9 Almost no capacity to delay gratification; consistently impulsive or out of control with little or no restraint of behavior

H. PERSONAL HYGIENE/SELF-HELP SKILLS

- 1 Superior personal hygiene and self-sufficiency in personal health care
- 2
- 3 Average grooming and self-care for age
- 4
- 5 Poor eating and grooming habits
- 6
- 7 Very limited self-care, always looks messy, poor eating and toilet habits with frequent accidents
- 8
- 9 No attempt to care for self, offensive appearance, no bladder or bowel control, needs constant attention to hygiene

I. SEXUALITY

- 1 Superior sexual adjustment in terms of identity and behavior
- 2
- 3 Average interest in and anxiety over sex for age
- 4
- 5 Excessive curiosity or noticeable avoidance of sexual topics
- 6
- 7 Conflicted and/or very anxious in dealing with sex, frequently inappropriate sexual behavior or gestures; lack of usual respect in social situations
- 8
- 9 Complete denial or avoidance of sex; major sexual acting-out, such as exposing self or overt seduction

J. ACCEPTANCE OF RULES

- 1 Superior acceptance of, or adjustment to rules and limits; high degree of adaptive social conscience
- 2
- 3 Average response for age to rules and limits
- 4
- 5 Active opposition to rules and resistance to limits; avoidance or manipulation of rules; lacks concern for others
- 6
- 7 Serious conflict with authority; rebellious or hostile refusal to cooperate; frequent violation of rules such as fire-setting, hurting others, cruel behavior
- 8
- 9 Pattern of dangerous defiance or illegal rule breaking; lack of concern or social conscience regarding hurting others

K. SOCIAL RELATEDNESS

- 1 Superior social interaction; able to form very close, warm, trusting, and stable relationships
- 2
- 3 Average dependence and independence for age, relates warmly; able to trust, relate warmly, and show feelings for others; forms lasting relationships
- 4
- 5 Has trouble fitting in with others; teases or is teased by others; pushes children around or lacks interest in other children; is clinging, demanding or resentful of authority
- 6
- 7 Conflicted, shallow, or short-lived relationships; frequent quarrels or fights with peers; isolated from peers; controlling; minimal attachment; extreme clinging; constant demand for attention
- 8
- 9 Almost no meaningful relationships with peers; withdrawn; mistrusting; dangerous fights with others; severe non-relatedness

L. ADAPTABILITY TO STRESS

- 1 Superior flexibility or adaptability in responding to stress
- 2
- 3 Average capacity to handle common stresses for age with brief setbacks
- 4
- 5 Easily upset or greater than expected setbacks for age in response to everyday stress (episodic bedwetting, some defiance, withdrawal, or anxiety)
- 6
- 7 Falls apart quickly under common stresses with marked setbacks to infant-like behaviors (thumb-sucking, withdrawal, panic, serious defiance, baby-talk, bedwetting and/or soiling)
- 8
- 9 Profound setbacks under common stress with loss of touch with reality, infant-like behavior, unusual, disorganized thinking, bizarre behavior, panic states, bedwetting, or soiling



Nebraska Mental Health Centers

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ADHD DIAGNOSTIC PARENT RATING SCALE

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

Date of Birth: _____ Age: _____ Grade: _____

Circle the number on the scale that corresponds to how you would rate your child's behavior.

0= Never 1=Occasionally 2=Often 3=Very Often

- | | | | | |
|---|---|---|---|---|
| 1. Does not pay attention to details or makes careless mistakes, for example homework | 0 | 1 | 2 | 3 |
| 2. Has difficulty attending to what needs to be done | 0 | 1 | 2 | 3 |
| 3. Does not seem to listen when spoken to directly | 0 | 1 | 2 | 3 |
| 4. Does not follow through when given directions and fails to finish things | 0 | 1 | 2 | 3 |
| 5. Has difficulty organizing tasks and activities | 0 | 1 | 2 | 3 |
| 6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort | 0 | 1 | 2 | 3 |
| 7. Loses things needed for tasks or activities (assignments, pencils, books) | 0 | 1 | 2 | 3 |
| 8. Is easily distracted by noises or other things | 0 | 1 | 2 | 3 |
| 9. Is forgetful in daily activities | 0 | 1 | 2 | 3 |
| 10. Fidgets with hands or feet or squirms in seat | 0 | 1 | 2 | 3 |
| 11. Leaves seat when he is supposed to stay in seat | 0 | 1 | 2 | 3 |
| 12. Runs about or climbs too much when he is supposed to stay seated | 0 | 1 | 2 | 3 |
| 13. Has difficulty playing or starting quiet games | 0 | 1 | 2 | 3 |
| 14. Is "on the go" or often acts as if "driven by a motor" | 0 | 1 | 2 | 3 |
| 15. Talks too much | 0 | 1 | 2 | 3 |
| 16. Blurts out answers before questions have been completed | 0 | 1 | 2 | 3 |
| 17. Has difficulty waiting his/her turn | 0 | 1 | 2 | 3 |
| 18. Interrupts or bothers others when they are talking or playing games | 0 | 1 | 2 | 3 |