Vortex Psychiatry & TMS Clinic

Said A. Ibrahimi, M.D.
www.VortexPsychiatry.com

You have an appointment with one of our doctors.

If you need to cancel this appointment, please give us 3-day notice. Canceling with less notice will subject you to an appointment change fee of $75. This must be paid before a change in this appointment can be made. We schedule 60 minutes for this appointment and last-minute cancellation keeps us from serving others who are waiting to see your doctor.

We kindly ask that you do not cancel this appointment without appropriate notice.

It is very important that you fill out and bring these forms with you. There is a fair amount of information needed and it may take a while to fill out all this information. If you have any other information about past evaluations, please bring a copy for the doctor.

The charge for the initial evaluation is $510. This includes an office charge of $50 which is not billable to your insurance. It is required in addition to your copay if you have one. A credit card on file is required for all new patients.

Please be sure that the physician you are seeing is a provider for your insurance. We do not guarantee coverage if your insurance considers the physician out of network. A credit card is required to guarantee payment and will be needed on your first visit. We are unable to see you without a credit card on file. We also charge an administrative fee of $50 once per year.

For child evaluation, please ask a teacher who knows your child best to fill out the Teacher questionnaire in your packet. The teacher can either give the form back to you or mail it to us directly. If your child is young, please bring a game, toy or books. A caretaker while parents are talking to the doctor may also be appropriate.

Thank you.

Said A. Ibrahimi, M.D.

Please fill out the intake packet before your appointment. Please also bring copies of all past testing, psychiatric or psychological treatment records, school/college records and psychiatric inpatient records/discharge summaries, if applicable.

About the evaluation
There are no standard psychological or laboratory tests by which one can make a psychiatric diagnosis. The diagnosis is made by listening to the presenting concerns, going over the records, looking into family and patient's history, conducting interviews with the patient, the family, and others, if necessary.

The initial evaluation will help you determine
What may be the underlying reason for the problems? Are there any psychological, medical, neurological, or genetic problems underlying the condition? Do the problems present a psychiatric disorder or a variant of normal behavior? What can be done to address the problems and what will happen if we do nothing?

The initial evaluation takes approximately one hour, sometimes longer, and consists of:

1. Patient and family interview
2. Discussion of findings and presentation of diagnostic impression
3. Treatment recommendations

The evaluation will give you a good understanding of what's going on. There are many ways to deal with the problems. Many patients and families are uncomfortable about psychiatric medications. We want you to know that medications are not always recommended and often are not even appropriate. The decision about the medication depends on the nature and severity of the problems, the patient's age, associated issues, but ultimately, on the best available treatment option.

If a medication is prescribed, you will be scheduled for follow-up appointments in one week to one month's time, depending on the problems and the prescribed medication(s).

We look forward to seeing you and hope that we can be of service.

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PATIENT INFORMATION- Minor

Date: _____

Patient Name: _____ Patient Age: _____Date of Birth: _____

Best contact phone number: _____ Email: _____

Address: _____City: _____State: _____ Zip: _____

Marital Status: _____ Gender: _____

Occupation**: (Circle one) Student Unemployed Employed**

Patient Guardian Name _____

Patient Guardian Best Contact Phone Number:

Main Phone_____2nd phone _____

Email address _____

Do you have legal custody of this child? YES NO

Address: _____City: _____State: _____ Zip: _____

Marital Status: _____ Gender: _____

Occupation**: (Circle one) Student Unemployed Employed**

INSURANCE INFORMATION:

Guarantor Name: _____Date of Birth: _____

Primary Insurance: _____

Insurance identification number_____ Policy, Group, or Local _____

Insurance Provider Phone Number: _____

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Financial Responsibility Form

Date_____

Patient's Name (please print) _____

Responsible Person's Name _____

Date of Birth_____SSN_____

If using insurance, are you the Insured?_____

Address _____

City_____State, Zip _____

Phone_____Cell_____

Employer Name _____

Employer Address _____

I will be responsible for all bills for this patient, no matter who brings the patient to the office, such as when brought by caretakers, grandparents, stepparents, ex-spouse etc., as long as the services provided are for the benefit of the patient. I understand that if my Insurance plan refuses to cover services given to me by this office, I will be responsible for the charges.

I will provide a current credit card on file. I allow the office to charge fees not covered by the insurance such as for lack of coverage, yearly admin charge, deductibles, unpaid copays, and no-show charges. A statement of such charges will be sent to you.

I agree to pay all bills as presented and all reasonable fees associated at the time with the with collection of such charges including fees for bounced checks, rush Rx, copays, phone consultation charges not covered by insurance, same day cancellation and no-show fees, request for copy of records, school form filling etc. per schedule of fees attached currently in force.

Signature_____ Date _____

Relationship to patient (if other than patient): _____

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Dear Patients,

This letter is to inform you of our updated billing practice regarding receiving patient payments. Effective January 2015, we now require a credit or debit card to be on file with our office for full patient payment of services at each appointment.

Why the change? There are several reasons for this change. With the changing environment in healthcare, in particular the Affordable Care Act and High Deductible Health Plans (HDHPs) more responsibility of payment is being placed on the patient. We need to be sure that patient balances are paid in a timely manner. To do this, we need to ensure we have a guarantee of payment on file in our office.

What is a Deductible and How Does It Affect Me? An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay. For example, if your policy has a $2,000 deductible, you must pay the first $2,000 of medical expenses before the insurance company begins to pay for any services. This works just like the deductible for your car insurance or homeowner's insurance policy does.

When do I have to pay for services? Any time you receive medical care, you will be expected to pay in full for your services until your deductible is met. If you have a very large deductible, called a high- deductible insurance plan, you may have to pay out of pocket for most of your primary care services.

How will I know when my deductible has been met? You can call your insurance company at any time to check on how much of your deductible has been met and some insurance companies have this information available online. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay if the amount went to your deductible when they send you an Explanation of Benefits (EOB.)

How will I know how much you are going to charge me? You will receive a letter in the mail (or e-mail) from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits (EOB.) This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay.

Then what? We receive the same Explanation of Benefits (EOB) that you do. Most Insurances will send your EOB prior to us receiving our copy. It arrives about 10-20 days after your appointment has been billed. We look at each EOB carefully and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a statement for in the mail. All patients with commercial insurance are required to keep a credit or debit card on file. If you do not wish to keep a card on file, we will expect an estimated payment at the time of service. For example, if your commercial insurance requires $190.00 to be paid for standard service and your deductible is not met, you will be expected to pay the $190.00 via check or credit card before you are seen, but this will not include ancillary charges that may arise out of your visit. Once we receive the Explanation of Benefits (EOB) on your visit, we will send a statement if your patient responsibility is higher than the originally collected amount or you will have a credit on your account if your patient responsibility is lower than the originally collected amount. Once we receive the insurance EOB for your visit, we will charge the credit card on file the exact amount as per the EOB that is stated to be patient responsibility. Once charged, we will email you a receipt of payment.

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Credit Card Payment Authorization

In order to coordinate coverage of services for patients, we require patients to provide us with a valid credit card which we will charge following office visits for amounts owed for co-payments, deductibles, and co-insurance by patients for services rendered by your physician. In the event a patient misses or cancels an appointment without two business days' notice, Vortex Psychiatry will charge the appropriate fee pursuant to our cancellation policy to the cardholder's credit card. Vortex Psychiatry will not charge the cardholder's credit card more than $460.00 in a single transaction.

I_____[name of cardholder] hereby authorize Vortex Psychiatry to keep my credit card information provided below on file and charge my credit card following office visits, from the first date of service, for any amounts owed for services rendered to _____[name of patient if cardholder is parent/guardian]/me which are not covered by insurance, including co-pays, deductibles, and co-insurance. In addition, I authorize Vortex Psychiatry to charge my credit card fees for missed or cancelled appointments by the patient/me. I understand that I may elect receive receipts via mail or email for any amounts charged to my credit card by Vortex Psychiatry for services rendered to the patient/me. I further understand that such amounts charged to my credit card will appear on my credit card statement.

I understand that this authorization is valid for one (1) year from the date written below unless I cancel this authorization by providing written notice to Vortex Psychiatry.

Patient:_____Cardholder Name:_____

Cardholder Billing Address_____

City_____State_____Zip_____

Email: _____

(To receive receipts after card has been charged)

_____ _____ _____

_____Digits of Credit Card

_____Expiration Date Security Code_____

Circle one : VISA MASTER CARD DISCOVER AMERICAN EXPRESS HSA

Cardholder/ Account Holder Signature:_____Date:_____

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Consent to Release and Exchange Information

If you have seen other professionals regarding this problem and would like us to co-ordinate with them, please provide us this consent.

For young patients, his or her pediatrician must be added.

Patients First Name_____ **Last Name**_____ **Is Patient over 18 years old?** _____

If no, Guardian's Name _____

I am requesting you to provide all pertinent medical information about the patient listed above to Said A. Ibrahimi, Vortex Psychiatry. This information may be in electronic from such as a PDF file sent via email ***(vortexpsychiatry@outlook.com)*** *Fax or by hard copy mailed to above address.*

I am giving my consent to both parties to share and exchange information as appropriate for the care of the patient.

Professional / Specialty /Family _____

Business Name_____

Address_____ **City**_____ **State, Zip**_____

Phone_____ **Email**_____

Professional / Specialty /Family_____

Business Name_____

Address_____ **City**_____ **State, Zip**_____

Phone_____ **Email**_____

Professional / Specialty /Family_____

Business Name_____

Address_____ **City**_____ **State, Zip**_____

Phone_____ **Email**_____

Signature of Patient (if over 18 years of age)_____

Signature of Guardian_____ **Date** _____

Office Policies and HIPAA Policy Acknowledgement

- Our HIPAA policy is posted on our website: www.VortexPsychiatry.com.com. Please be sure to read it.

- The office staff is available to answer your call from 8:00 a.m. 5:00pm. Monday thru Friday, and we are available by email as well: VortexPsychiatry@outlook.com

- We use an electronic reminder service for your upcoming appointment. The reminders will come via email.

- A $50 admin fee is charged yearly for all accounts. This fee is not billable to insurance and needs to be paid on your first visit of the year.

- We charge $205 for all changes and cancellation of appointments with less than 2 business-day notice. There are no exceptions for this (including sickness, work travel etc.) This is a typical policy for psychiatric offices where a considerable time is set aside with no double booking.

- You may email us about yourself or the patient if you wish. Please clearly indicate the patient name and the doctor to whom your communication is directed. The doctors review the emails daily in most cases. If it is urgent, please call the office instead of emailing. Standard emails are not hack-proof but are considered HIPPA compliant.

- Refills are done using electronics means. This is secure and avoids errors. **Please do not call the office for refills.**

- Most Rx refills require regular follow-up as suggested by the doctor. Rx refill requests must be made in writing via website or email.

- For medication refills (Schedule II medications) we require a 7-day notice. Other medications require a 3-day notice. Urgent refill requests, with less than 3-day notice, will be charged a $10.00 rush fee.

Signature & Date:

_____

If you will be using your medical insurance to pay for visits to this office….

- Insurance coverage is for a particular doctor and not the office.
- If your insurance changes, let us know immediately. Transactions older than 90 days cannot be billed to insurance.
- If you have any other insurance plan, please send the superbill given to you by the office to your company. They will reimburse you directly based on your deductible and out of network coverage.
- We require a credit card on file for timely payment of amount due to this office for all unpaid charges.
- <u>We do not verify or guarantee your coverage. This is your responsibility.</u>
- If you are seen by the doctors and your insurance deems the charges not covered, you are responsible for them.
- Please check with your insurance as to what your deductible is. During the first quarter of the year, you are expected to pay the contracted rate at the time of service. We require full payment of agreed upon rate at time of visit if you have not met your deductible.
- Phone consultations over 10 minutes are charged. Your insurance most likely will not over these.
- Some services such as phone consultations with other providers, review of records, no- show charges, cancellation fees, form filling, reports etc. are often NOT a reimbursable expense. If these services are used or requested by you, you are responsible for their charge.
- If after billing your insurance company we find that you do not have coverage, have not met the deductible, or for any other reason, the amount due will be charged to your credit card on file after 30 days.
- Please call your insurance and make certain that you are covered for seeing this office, the doctor with whom you have the appointment and understand clearly your deductibles and your coverage. For purposes of meeting your deductible, please be advised that typical charges from this office may be app. $1500 per year.

Insured's Signature & Date _____

Please read carefully and sign. This is a required form if you want us to bill your insurance.

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Contract for Controlled Substances

Controlled substance medications (i.e., benzodiazepines and stimulants) are very useful. However, they have potential for misuse and therefore are controlled by local, state, and federal authorities. Because my provider is prescribing such medications for me, I agree to the following conditions:

1) I am responsible for the controlled substance medications prescribed to me. If my prescriptions and/or medication are misplaced, stolen, or if "I run out early", I understand that this medication will not be replaced regardless of the circumstances.

2) I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from Vortex Psychiatry. Besides being illegal to do so, it may endanger my health. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves the concomitant use of non-prescription or illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

3) I am aware that all requests for prescriptions must be in writing during business hours.
    a. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. Renewals are based upon keeping scheduled appointments.
    b. Refills will not be made as an "emergency". No controlled medications can be ordered when the office is closed. I understand the importance of following my treatment plan as directed by my physician and agree to keep my scheduled appointments.

4) I understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as: failure in taking medications as prescribed, utilizing other illicit drugs, obtaining similar medications from others, or abuse of controlled medications, I may be subject to dismissal from this practice.

5) I understand that the main treatment goal is to improve my ability to function. I am being given potent medication to help me reach that goal and agree to help myself by following better health habits. I understand that using illicit drugs will negatively impact my progress. Continued use of illegal or illicit substances after warning can be cause for termination of medical care and reporting to authorities.

I have read this contract and fully understand its content and the consequences of violating this contract. By signing below, I accept the above treatment agreement.

Patient or Guardian Signature:_____Date: _____

Message to our patients about the Arbitration Agreement

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates, and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both healthcare providers and their courts. Arbitration agreements between patients and physicians have long been recognized and approved by the State of California. By signing this agreement, yon are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both the patients and physicians. This is because the time it takes to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of a trial and the publicity which may accompany judicial proceeding.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We are all caring doctors and do our utmost to be responsive. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Physician's or Authorized Representative's Signature (Date)

_____

Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____

Patient's or Patient Representative's Signature (Date)

By: _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

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Schedule of Fees

(As of July 2022 - Subject to change)

Fee	Charge	Notes
New Eval appointments	**$460**	**Approx. 1 hour**
Yearly admin charge	**$50**	**Payable at first visit of the year- not covered by insurance. Is in addition to your copay.**
Regular follow-ups	**$205**	**App. 15-to 30 mins.**
Longer follow-ups Check	**$320**	**App. 30 to 40 mins or complex**
Cancelled/no show appointment	**$75- $205**	**Less than 48-hour notice.**
Rush Rx Refill	**$10**	**Less than 48- hour to fill Rx**
Copy of Records	**$30**	**See website for more details**
Letters/Forms	**$50 -$150**	**Personal letters/Forms for schools, lawyers, psychologists, airlines, others**

Patient Signature: _____ Date: _____

Family History Questionnaire

Date _____

_____
Patient Name

_____
This form completed by:

Pt's Date of Birth_____Age_____M____F_____Height_____Wt._____

Referred
by_____

List your questions and concerns:
_____
_____
_____
_____
_____
_____
_____
_____

Family Information

Child lives with

Parent 1_____Age _____

Education (highest degree) _____

Occupation _____

Parent 2_____Age _____

Education (highest degree) _____

Occupation _____

	Biological	Step	Adoptive	Foster	Not at home
Parent 1	( )	( )	( )	( )	( )
Parent 2	( )	( )	( )	( )	( )

The parents are Married_____ Separated_____Single_____ Divorced _____

Custody arrangement, if applies

_____

Biological parents, if different from above

Parent 1_____Age _____

Education (highest degree) _____

Occupation _____

Parent 2_____Age _____

Education (highest degree) _____

Occupation _____

Brothers (indicate if half or step)

Name_____Age_____

Name_____Age_____

Name_____Age_____

Sisters (indicate if half or step)

Name_____Age_____

Name_____Age_____

Name_____Age_____

Who else lives at home?

Name_____Age_____

Relationship_____Occupation_____

Name_____Age_____

Relationship_____Occupation_____

List major psychiatric disorder (depression, anxiety, OCD, schizophrenia, ADHD, alcohol or drug abuse, psychiatric hospitalizations; also include suicide, homicide, and major legal offences) in close members of the family biologically related to the patient.

Relation_____Age _____

Problem_____

Relation_____Age _____

Problem_____

Relation_____Age _____

Problem_____

Relation_____Age _____

Problem_____

Information about school

Name_____Grade _____

Type of Class _____

City_____Phone(s) _____

Teacher(s) name(s)

_____

School History (Specify behavioral and academic problems, repeated grade, comments)

Age, Grade	**School**	**Comment**

Past Medical History

Patient's Primary Care Physician:_____

Phone _____

Address _____

Other Physicians and Therapists currently involved in your care

Name_____specialty _____

Phone _____

Address _____

Name_____specialty _____

Phone _____

Address _____

Neonatal History (list all significant issues related to pregnancy, birth, and immediate post-partum period, including prematurity, forceps delivery, meconium, birth trauma, jaundice, colic, etc.)

_____

_____

_____

Medical (list any significant illnesses, surgeries, and hospitalizations (incl. head injuries, seizures, vision or hearing loss, etc.)

Age	Event

Medication and Treatment History

Past medications List, in chronological order, all **psychiatric** medications the patient took in the past. If the list is long, print it separately and bring it to your appointment.

Age	Medication	Dosage	Comment

Current medications List ALL medications (including prescriptions, OTC, vitamins, herbal, topical, etc.)

Name	Dosage	Schedule	Comment

List any non-medication treatment the patient has undergone

Treatment	Professional	When/How long	Currently receiving this treatment? (y/n)

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CHILD AND ADOLESCENT RATING SCALE (PCC-CARS)

Name_____Age_____DOB _____
first *last*

Major concerns (*check all that apply):*

- ☐ Attention
- ☐ Behavior
- ☐ Academic
- ☐ Social

☐ Others (please specify):

Please rate the behaviors: **0 – Never (None) 1 – Sometimes (Mild) 2 – Often/Always (Severe)** *(circle the most appropriate number)*

Block I				Block II			
0	1	2	Easily distracted from task	0	1	2	Argues with parent, adults
0	1	2	Difficulties focusing, can't start	0	1	2	Refuses rules
0	1	2	Poor attention to details, careless mistakes	0	1	2	Loses temper, gets angry, screams
0	1	2	Forgetful, loses personal things	0	1	2	Feelings are easily hurt, gets frustrated
0	1	2	Poor planning, wastes time,	0	1	2	Gives up easily
0	1	2	Daydreaming, in his/her thoughts				
0	1	2	Shifts from one activity to another				
0	1	2	Can't wait for his/her turn	0	1	2	Deliberately vandalized property
0	1	2	Leaves work unfinished	0	1	2	Lies, "cons" to get what (s)he wants
0	1	2	Acts before thinking, interrupts	0	1	2	Bullies, intimidates others
0	1	2	Fidgets and squirms	0	1	2	Have stolen from a store, others
0	1	2	Talks excessively, can't stop	0	1	2	Got into fights, used a weapon
0	1	2	Moves constantly, can't sit still	0	1	2	Physically cruel to people & animals
0	1	2	Likes sameness, routine, no changes	0	1	2	Callous, feels no guilt
0	1	2	Extremely stubborn	0	1	2	Smokes, drinks, drugs
0	1	2	Transitions are difficult	0	1	2	Truant from school
0	1	2	Very sensitive (to loud noise, tags, smells)	0	1	2	Has been arrested, committed an illegal act
0	1	2	Perfectionist, works slow				

Block III

Tics are involuntary, rapid, repetitive, purposeless movements or vocalizations

0 1 2 Eye blinking
0 1 2 Facial movements
0 1 2 Head or body jerking
0 1 2 Nervous coughs, grunts, snorts
0 1 2 Bites nails, cracks knuckles, picks skin
0 1 2 Chews on cloths

Obsessions are recurrent, unpleasant thoughts
Compulsions are behaviors to stop obsessions or other anxious thoughts.

0 1 2 Can't get mind of certain thoughts
0 1 2 Fears that might do something bad
0 1 2 Concerned about order and neatness
0 1 2 Stores things, can't discard them
0 1 2 Repeats certain acts over and over

Block IV

0 1 2 Always worries about everything
0 1 2 Always tense, needs lots of reassurances
0 1 2 Very shy and timid, clingy
0 1 2 Extremely self-conscious (worries what others are thinking/saying about him/her)
0 1 2 Easily embarrassed and sensitive to criticism
0 1 2 Had panic attacks in the past
0 1 2 Excessive fear of dark, heights, bees, etc.
0 1 2 Had separation problems as a child
0 1 2 Nervous stomach, headaches
0 1 2 Family history of anxiety, panic, and social phobia
0 1 2 Excessive tiredness, daytime sleepiness

Block V

0 1 2 Irritable, touchy, grouchy, easily angry
0 1 2 Unhappy most of the day, most days
0 1 2 Cries easily, has sad thoughts
0 1 2 Talks about dying, sad themes in play
0 1 2 Talks about wanting to die
0 1 2 Feels things will never get better
0 1 2 Does <u>not</u> enjoy anything anymore
0 1 2 Major changes in sleep and appetite
0 1 2 Feels worthless, inferior (e.g. I am stupid)
0 1 2 Feels guilty, too hard on self
0 1 2 Feels that be better off dead
0 1 2 Harmed self (cutting, scratching, burning)
0 1 2 Mood changes quickly, drastically
0 1 2 Episodes of being talkative, pressure to talk
0 1 2 Periods of extreme energy alternating with periods of excessive tiredness and quiet
0 1 2 Brags, shows off, reckless
0 1 2 Goes through uncontrollable rages
0 1 2 Early preoccupation with sex
0 1 2 Family history of depression or bipolar disorder

Block VI

0 1 2 Talks to self, hears what others can't hear
0 1 2 Feels others are out to get him/her
0 1 2 Strange, bizarre, odd behavior, talk
0 1 2 Believes in reading minds
0 1 2 Has strange, bizarre ideas

Block VII

0 1 2 Bedwetting
0 1 2 Soils underwear
0 1 2 Sleeps too much, always tired
0 1 2 Hard time falling asleep
0 1 2 Sleepwalking, -talking, night terrors

Block VIII

0 1 2 Socially awkward, misses social cues
0 1 2 Does <u>not</u> look in the eyes
0 1 2 Prefers playing alone, refuses group activities
0 1 2 Bullies, provokes fights, teases others

Block IX

0 1 2 School work is hard, confusing
0 1 2 Behind in reading, math
0 1 2 Had to repeat a grade or was held back
0 1 2 Homework takes all night to finish

<u>Additional Comments</u>:

For office use

Vortex Psychiatry & TMS Clinic
Said A. Ibrahimi, M.D.
www.VortexPsychiatry.com

School Performance and Achievement (to be completed by teacher)

Dear Teacher,

Thank you for taking time to fill this questionnaire for:

Name_____Date _____

Your input is most valuable to us in the assessment of student's learning and social needs. Please return this completed for to the parent(s) or main it back to us at the above address. It will be shared with the family upon request.

Student's Name_____Grade_____

School Name_____

Address: _____

Phone _____

Type of Classroom/Services (reg., SDC, RSP, etc.) _____

Briefly describe student's academic work habits

_____

_____

_____

Student's response to classroom rules, instructions

_____

_____

_____

Briefly describe interactions with other students, school friends

_____

_____

Academic Achievement (Current Level of daily achievement in class)

Subject	Grade/Comment

Comments

_____

_____

_____

_____

Most Recent Achievement Tests

Name of the test Score/Comments

_____ _____

_____ _____

_____ _____

_____ _____

Additional tests performed in school (IEP, Speech, and Language, etc.)

Name of the test	Score/Comments

What concerns you most about this student?

Student's strengths

Student's deficits

Additional comments

Form Completed by Name _____Title _____

Teacher's Rating Form

Teacher Name: _____Date:_____

	Not at all	A little	Pretty much	Very Much
Unfocused, inattentive, easily distracted				
Work is unfinished, poorly organized				
Daydreams, in the fog				
Impulsive, cuts into lines, interrupts				
Fidgety and squirmy				
Argumentative, uncooperative, defiant				
Bothers or teases others, starts fights				
Excitable and anxious, worries a lot				
Tics, nervous habits, repetitive behavior				
Irritable, angry				
Unhappy, moody (mood changes quickly)				
Loses temper, yells, cries				
Poor social skills, socially inappropriate				
Odd behavior, mannerism, movements				

Comments and Noteworthy recent events

_____

_____

_____