Fred Frankel, Ph.D. ABPP
Founder

Cynthia Whitham, L.C.S.W.
Director

Robert Myatt, Ph.D.
Associate Director

SEMEL INSTITUTE UCLA

Clinic Coordinator Contact Information:

310-825-0142 ph
310-206-4446 fax
www.semel.ucla.edu/socialskills
socialskills@mednet.ucla.edu

UCLA Children's Friendship Program

Enclosed you will find a number of forms that will help us to determine the appropriateness of our program for you and your child. Filling out these forms is equivalent to a one hour interview at no cost to you. It is important that you complete each questionnaire before you return them.

Please return your packet promptly as enrollment is limited to each group!

- ☐ **Child Background Form**
- ☐ **SNAP-IV Rating Scale**
- ☐ **Quality of Play Questionnaire**
- ☐ **WING**
- ☐ **UCLA Children's Friendship Telephone Release**
- ☐ **Insurance Information Form**

When complete, you may return the packet to us:

1. Mail to: UCLA Children's Friendship Program, 760 Westwood Plaza, Rm 27-384 Los Angeles, CA 90095, Mail Code 175919
2. Fax to 310-206-4446 (please email socialskills@mednet.ucla.edu to confirm we received the fax)

Once we receive the packet, we will contact you to schedule a one hour intake appointment with you and your child for enrollment in an upcoming group.

Thank you for your time. We look forward to meeting both you and your child.
If you have any questions, please call our Clinic Coordinator at **310-825-0142**.

STEWART & LYNDA RESNICK
NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Child and Adolescent Psychiatry Clinic
Background Information Sheet

Patient Identification

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

Child's Age: _____ Child's Gender: _____

Birth Date: ___ /____ /_____ Place of Birth: _____

Child's Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic/Latino ☐ Asian/Pacific Islander ☐ Native American
☐ Other: _____

Language Spoken at Home: ☐ English ☐ Other: _____

Child's Home Address: _____

_____

***Please indicate the best phone number to contact**

Parent/Guardian 1:

Name: _____ Home: (___) _____ Cell: (___) _____ Email: _____

Relationship to Child: _____ Age: _____ Occupation: _____

Parent/Guardian 2:

Name: _____ Home: (___) _____ Cell: (___) _____ Email: _____

Relationship to Child: _____ Age: _____ Occupation: _____

Other (if applicable, i.e. biological parent, step parent):

Name: _____ Home: (___) _____ Cell: (___) _____ Email: _____

Relationship to Child: _____ Age: _____ Occupation: _____

The child lives with:

☐ Both Biological/Adoptive Parents
☐ Single Parent: Please note: ☐ Mother or ☐ Father
☐ Mother and step-father
☐ Father and step-mother
☐ Equal time with separated/divorced parents
☐ Other: _____

Current marital status of biological parents:

Married ☐ How long: _____
Separated ☐ How long: _____
Divorced ☐ How long: _____
Other ☐ Describe: _____

If parents separated/divorced, who has legal custody in terms of physical/mental healthcare? _____

Is child legally adopted? ☐ No ☐ Yes If yes, age at adoption: _____

STEWART & LYNDA RESNICK
NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Patient Identification

Parents' education (highest level completed): **Parent 1** **Parent 2**

1. Some school but less than completion of high school ☐ ☐
2. Up to high school diploma or equivalent (GED) ☐ ☐
3. Technical/trade school or some college ☐ ☐
4. College graduate or equivalent (B.A., B.S.) ☐ ☐
5. Post graduate/Professional degree (M.A., Ph.D., M.D., J.D.) ☐ ☐

Child's siblings (list names and ages)
Full brothers: _____
Full sisters: _____
Half/step siblings: _____

Child's Current School: ☐ Public ☐ Private ☐ Homeschooled ☐ Not in School ☐ Other: _____
Name of School: _____
Address: _____
Phone: (___) _____ Teacher: _____ Grade: _____
If completing during summer break, please indicate grade level for **next academic year*

How many years at current school: _____

School History

Has your child:	Currently	In the Past
1. Had an Individualized Education Plan (IEP)?	☐	☐
2. Had a 504 or other accommodations?	☐	☐
3. Attended resource, remedial, or special education classes?	☐	☐
4. Ever repeated or failed a grade?	☐	☐
5. Had difficulty making/keeping friends?	☐	☐
6. Had behavioral problems in school?	☐	☐
7. Been suspended or expelled from school?	☐	☐

What is your child's current school performance:
☐ Failing ☐ Below Average ☐ Average ☐ Above Average

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NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Patient Identification

Developmental History

When did your child:

Say his/her first words: _____
Put two or more words together: _____
Take his/her first steps: _____
First become toilet trained: _____

Child Mental Health History *Please fill in the relevant diagnoses.*	**Age**	**Who Diagnosed?**	**Treatment Received?**
Obsessive Compulsive Disorder	____	_____	_____
Tourette's/Other Tic Disorder	____	_____	_____
Anxiety Disorder	____	_____	_____
Attention Deficit Hyperactivity Disorder	____	_____	_____
Depression	____	_____	_____
Bipolar Disorder	____	_____	_____
Eating Disorder	____	_____	_____
Autism Spectrum Disorder	____	_____	_____
Mental Retardation	____	_____	_____
Posttraumatic Stress Disorder	____	_____	_____
Psychotic Disorder	____	_____	_____
Substance Abuse	____	_____	_____
Learning Disorder	____	_____	_____
Oppositional Defiant Disorder	____	_____	_____
Other: _____	____	_____	_____

Has your child ever had thoughts of wanting to hurt himself/herself? ☐ Yes ☐ No

Medical History (type and date):

Allergies: _____

Significant illnesses: _____

Significant injuries: _____

Significant operations/medical procedures/hospitalizations: _____

STEWART & LYNDA RESNICK
NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Patient Identification

Child Medication History

Medication	Start Date	End Date (if applicable)	Current/Final Dose	How Effective? Any Side Effects?

Child History of Psychiatric Hospitalizations: ☐ No ☐ Yes
If yes, please describe:

Hospital	Admission Date	Discharge Date

Has your child ever had legal problems? ☐ No ☐ Yes, please describe: _____

Family History of psychiatric / emotional problems:

- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Autism Spectrum Disorder
- ☐ Posttraumatic Stress
- ☐ Learning Disorder
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Eating Disorder
- ☐ Mental Retardation
- ☐ Psychotic Disorder
- ☐ Depression
- ☐ Obsessive Compulsive Disorder
- ☐ Tourette/Other Tic Disorder
- ☐ Substance Abuse
- ☐ Other: _____

STEWART & LYNDA RESNICK
NEUROPSYCHIATRIC HOSPITAL
& BEHAVIORAL HEALTH SERVICES AT UCLA

Patient Identification

Child's Pediatrician/Primary Care Physician

Name: _____

Address: _____

_____

Phone: _____

Does your child have any other doctors or clinicians?

Name: _____

Address: _____

_____

Phone: _____

Discipline: ☐ Psychiatrist ☐ Psychologist ☐ Neurologist ☐ Other: _____

Name: _____

Address: _____

_____

Phone: _____

Discipline: ☐ Psychiatrist ☐ Psychologist ☐ Neurologist ☐ Other: _____

_____ _____

(Signature of Patient, Parent or Legal Guardian) (Date and Time signed)

_____

(Printed Name)

Child Name: _____ Date:_____

Completed By: ☐ Mother ☐Father ☐Other: _____

Please rate your child's behavior below. Please note: If your child is currently taking medication please answer the questions below according to your child's behavior when they are off the medication.

SNAP-IV RATING SCALE

James M. Swanson, Ph.D

Check the column which best describes this child:	Not at All	Just a Little	Pretty Much	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities	☐	☐	☐	☐
2. Often has difficulty sustaining attention in tasks or play activities	☐	☐	☐	☐
3. Often does not seem to listen when spoken to directly	☐	☐	☐	☐
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)	☐	☐	☐	☐
5. Often has difficulty organizing tasks and activities	☐	☐	☐	☐
6. Often avoids, dislikes, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework)	☐	☐	☐	☐
7. Often loses things necessary for tasks or activities (e.g., school assignments, pencils, books, tools, or toys)	☐	☐	☐	☐
8. Is often easily distracted by extraneous stimuli	☐	☐	☐	☐
9. Often forgetful in daily activities	☐	☐	☐	☐
10. Often fidgets with hands or feet, squirms in seat	☐	☐	☐	☐
11. Often leaves seat in classroom or in other situations in which remaining seated is expected	☐	☐	☐	☐
12. Often runs about or climbs excessively in situations where it is inappropriate	☐	☐	☐	☐
13. Often has difficulty playing or engaging in leisure activities quietly	☐	☐	☐	☐
14. Is always "on the go" or acts if "driven by a motor"	☐	☐	☐	☐
15. Often talks excessively	☐	☐	☐	☐
16. Often blurts out answers to questions before the questions have been completed	☐	☐	☐	☐
17. Often has difficulty awaiting turn	☐	☐	☐	☐
18. Often interrupts or intrudes on others (e.g., butts into other's conversations or games)	☐	☐	☐	☐
1. Often loses temper	☐	☐	☐	☐
2. Often argues with adults	☐	☐	☐	☐
3. Often actively defies or refuses adult requests or rules	☐	☐	☐	☐
4. Often deliberately does things that annoy other people	☐	☐	☐	☐
5. Often blames others for his or her mistakes or misbehavior	☐	☐	☐	☐
6. Often touchy or easily annoyed by others	☐	☐	☐	☐
7. Is often angry and resentful	☐	☐	☐	☐
8. Is often spiteful or vindictive	☐	☐	☐	☐

Office Use Only:			
Total item ratings =	_____/9	_____/9	_____/8
Avg rating per item =	_____	_____	_____

Child Name: _____ Date:_____

Completed By: ☐ Mother ☐Father ☐Other: _____

Quality of Play Questionnaire

We would like information on your child's playmates. We **only** want to know about your child's playmates that you have invited over to your house **in order to play alone with your child.**

Do not consider children who only did homework together, or were over only as part of a group, party, or outing or only went to a movie together.

Please fill in the first name of the playmate that has played alone with your child at your house **most often in the past month**. If your child hasn't played with anyone like this for the past month, put the name of the child who **last** played with your child at your house and **you were around to see or hear what was happening**.

Playmate's name_____

Please indicate below what you saw the last time they played together. <u>Circle one number in each row:</u>

How the children spent their time	Not at all	Just a little	Pretty much	Very much	
1. Chasing, running, hiding, climbing, sport, or physically active	0	1	2	3	QPQ01 _____
2. Cards or board games	0	1	2	3	QPQ02 _____
3. Imaginary or pretend games	0	1	2	3	QPQ03 _____
4. Arts/crafts/making things	0	1	2	3	QPQ04 _____
5. Talk	0	1	2	3	QPQ05 _____
6. Computer or Video games	0	1	2	3	QPQ06 _____
7. Watch TV or Videos	0	1	2	3	QPQ07 _____

<u>What the children did during this visit:</u>

They…	Not at all	Just a little	Pretty much	Very much	
8. played without each other	0	1	2	3	
9. didn't share a toy, game, etc	0	1	2	3	QPQ09 _____*
10. got upset at each other	0	1	2	3	QPQ10 _____*
11. argued with each other	0	1	2	3	QPQ11 _____*
12. criticized or teased each other	0	1	2	3	QPQ12 _____*
13. were bossy with each other	0	1	2	3	QPQ13 _____*
14. had brother or sister in to play	0	1	2	3	
15. had other children in to play	0	1	2	3	
16. needed a parent to solve problems	0	1	2	3	QPQ16 _____*
17. annoyed each other	0	1	2	3	QPQ17 _____*

Play at <u>another child's house</u>: Please try to recall the times your child was invited to **another** child's house as the **only** invited guest.

18. **Number of visits like this (to any child's house) in the last month _____**

Play at <u>your house</u>: Please try to recall the times you invited **another** child to your house as the **only** invited guest.

19. **Number of visits like this (by any child) in the last month _____**

QPQTOT _____

Child Name: _____ Date:_____

Completed By: ☐ Mother ☐Father ☐Other: _____

WING

This child stands out as different from other children of his/her age in the following way:

	NO	SOMEWHAT	YES
1. Is old-fashioned or precocious.	☐	☐	☐
2. Is regarded as an " eccentric professor" by the other children.	☐	☐	☐
3. Lives somewhat in a world of his/ her own with restricted idiosyncratic intellectual interests.	☐	☐	☐
4. Accumulates facts on certain subjects (good rote memory) but does not really understand the meaning.	☐	☐	☐
5. Has a literal understanding of ambiguous and metaphorical language.	☐	☐	☐
6. Has a deviant style of communication with a formal, fussy, old-fashioned or " robot like" language	☐	☐	☐
7. Invents idiosyncratic words and expressions	☐	☐	☐
8. Has a different voice or speech.	☐	☐	☐
9. Expresses sounds involuntarily; clears throat, grunts, smacks, cries or screams.	☐	☐	☐
10. Is surprisingly good at some things and surprisingly poor at others.	☐	☐	☐
11. Uses language freely but fails to make adjustment to fit social contexts or the needs of different listeners.	☐	☐	☐
12. Lacks empathy	☐	☐	☐
13. Makes naïve and embarrassing remarks.	☐	☐	☐
14. Has a deviant style of gaze.	☐	☐	☐
15. Wishes to be sociable but fails to make relationships with peers.	☐	☐	☐
16. Can be with other children but only on his/her terms.	☐	☐	☐
17. Lacks best friend.	☐	☐	☐
18. Lacks common sense.	☐	☐	☐
19. Is poor at games; no idea of cooperating in a team, scores " own goals"	☐	☐	☐
20. Has clumsy, ill coordinated, ungainly, awkward movements or gestures.	☐	☐	☐
21. Has involuntary face or body movements.	☐	☐	☐
22. Has difficulties in completing simple daily activities because of compulsory repetition of certain actions or thoughts.	☐	☐	☐
23. Has special routine; insists on no change	☐	☐	☐
24. Shows idiosyncratic attachment to objects.	☐	☐	☐
25. Is bullied by other children.	☐	☐	☐
26. Has markedly unusual facial expression.	☐	☐	☐
27. Has markedly unusual posture.	☐	☐	☐

UCLA Children's Friendship Program

My child _____is currently attending the UCLA Children's Friendship Program to enhance appropriate peer social behavior. An integral aspect of this program is the communication with other children outside of the UCLA Clinic setting.

I herby give permission for my child to exchange our phone number with other children in the group so they may contact each other during the week as directed by the group leader.

I understand that the children are involved in a learning process and may not inappropriately use the telephone.

I agree on behalf of myself and my child to hold harmless the Regents of the University of California, its UCLA facilities, employees, and agents from any injury or damage that arises or is alleged to arise from the disclosure of our telephone number.

_____
Print: Parent/Guardian

_____ _____
Signature: Parent/Guardian Date

_____
Child's Home Phone Number

UCLA Parenting & Children's Friendship Program
INSURANCE INFORMATION FORM

We cannot guarantee our services will be covered by any particular health insurance program. Therefore, it is your responsibility to confirm your own coverage and if necessary obtain pre-authorization for our services. If your insurance company does not cover our program, we offer a self-pay fee of $559.20 for the initial intake appointment.

Please complete the form below. When we schedule your initial evaluation at UCLA, we will have our finance department verify your insurance coverage.

☐ **HEALTH INSURANCE (our services usually fall under behavioral or mental health)**

Insurance Provider: _____ ☐ HMO ☐ PPO ☐ POS
Subscriber/ Guarantor Name: _____
DOB of subscriber: _____ **Relationship of Subscriber to patient**:_____
Policy/Member ID/ Certificate #: _____
Group # (if applicable): _____
Subscriber's Employer: _____
Employer's Address: _____
_____
Employer's Phone #:_____
Phone # for customer service (mental/behavioral health): _____
Authorization # (if applicable*): _____
*Many managed care insurance providers require their customers to call the customer service number on their insurance card and get pre-authorization for services prior to an initial appointment. ***Please obtain an authorization number to see Cynthia Whitham, L.C.S.W. for an - outpatient initial evaluation at UCLA (CPT code 90791)***.
The CPT for outpatient group therapy is 90853. Our facility code is 95-4377221 – UCLA Practice Plan

☐ **SELF-PAY**

Self-pay fees:
- $559.20 for intake appointment
- Please call the office for current weekly self-pay fees.
- Guarantor name: _____ Relationship of guarantor to patient: _____
- DOB of guarantor: _____

☐ **REGIONAL CENTER**

Please call the office to discuss Regional Center proceedings.

*All fees may be subject to change without notice.