

# Registration

© 010211 Norton A. Roitman, MD  
filled out by applicant, parent, guardian or completed by assistant

**Applicant** \_\_\_\_\_ age \_\_\_\_\_ sex \_\_\_\_\_ birth date \_\_\_\_\_

address \_\_\_\_\_ city, state, zip \_\_\_\_\_

phones: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_ email \_\_\_\_\_

best time to call at home \_\_\_\_\_ work \_\_\_\_\_ days off (circle) Su M T W Th F S

*check your preferences:*  any contact is fine  do not call at home;  do not call at work;  do not leave messages;  do not fax

employer/school \_\_\_\_\_ job/grade \_\_\_\_\_

street address \_\_\_\_\_ city, state, zip \_\_\_\_\_

referred by \_\_\_\_\_ personal physician \_\_\_\_\_

**Primary contact** \_\_\_\_\_ relationship \_\_\_\_\_

address  check if same as above: \_\_\_\_\_ city, state, zip \_\_\_\_\_

phones: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_ email \_\_\_\_\_

best time to call at home \_\_\_\_\_ work \_\_\_\_\_ days off (circle) Su M T W Th F S

*check your preferences:*  any contact is fine  do not call at home;  do not call at work;  do not leave messages;  do not fax

employer/school \_\_\_\_\_ job/grade \_\_\_\_\_

street address \_\_\_\_\_ city, state, zip \_\_\_\_\_

**Secondary contact** \_\_\_\_\_ relationship \_\_\_\_\_

address  check if same as above: \_\_\_\_\_ city, state, zip \_\_\_\_\_

phones: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_ email \_\_\_\_\_

best time to call at home \_\_\_\_\_ work \_\_\_\_\_ days off (circle) Su M T W Th F S

*check your preferences:*  any contact is fine  do not call at home;  do not call at work;  do not leave messages;  do not fax

employer/school \_\_\_\_\_ job/grade \_\_\_\_\_

street address \_\_\_\_\_ city, state, zip \_\_\_\_\_

I request initial consultative services for myself, my family, my client and/or my dependent.

If applying for a minor, I certify that I have the legal right to obtain of consultation, evaluation and/or treatment.

Permission for services and release of information can be revoked at any time.

I understand that this initial consultation does not initiate a doctor/patient relationship and may result in a referral, report, discharge or consultation with a third party.

I understand that I am responsible for the charges incurred for these services unless a specific payor (person, third party or agency) arranged for payment in advance.

Please specify payor:  myself  \_\_\_\_\_.

Responsible party \_\_\_\_\_ date \_\_\_\_\_

**Applicant** \_\_\_\_\_ Age \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Filled out by  parent  other \_\_\_\_\_ clinician \_\_\_\_\_

Use the lines below each section or the back of the page to explain your answers. Although some questions may be difficult to answer in the space provided, do your best to be brief and to the point. During the interview you can ask questions, explain your answers, discuss whatever you like.

**This interview is used for children of all ages. For questions that are not appropriate for his age, just write in NA.**

**1. What is the purpose of his evaluation? What problems do you think he has?**

Problem list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. When did these problems start? \_\_\_\_\_ How long do you think it will take to take care of them? \_\_\_\_\_

3. What do you think caused them? \_\_\_\_\_

**Treatment**

**4. Did he have counseling for ADD/ADHD, emotional or behavioral problems?**  yes  no

Age	Where	Who treated him	What for	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**5. Did he take medication in the past?**  yes  no (List current medications on page 4, past meds below)

If so	What kind	What for	How much/how often	Doctor	He took it for (how long)	Until when
Example:	Ritalin	concentration/attention	15 mgs/ 2 times a day	Jones	2 years	until 6 month ago
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**6. Was he hospitalized for these or other problems?**  yes  no If so, how many times? \_\_\_\_\_

Age	Where	His doctor	What for (diagnosis, if any)	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Did he have any BAD REACTIONS to medications?  no  yes \_\_\_\_\_

Was treatment helpful?  yes  no  sort of Explain: \_\_\_\_\_

**7. Placements** Other than treatment centers, list the places he lived when he did not stay with his mother or father.

age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____
age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____
age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____
age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____
age ___ to ___	<input type="checkbox"/> relative _____	<input type="checkbox"/> foster/group home _____	<input type="checkbox"/> shelter/detention _____	<input type="checkbox"/> other _____

## Growing up

8. Did he have any MEDICAL problems  at birth  birth to age 3  3 to 5  5 to 12  12 to 18?  no

Please explain: (put recent and current conditions on page 4) \_\_\_\_\_

9. Did he have DELAYS or problems with:  don't know

- crawling/walking  coordination  eating \_\_\_\_\_
- ear infections  growing  weaning \_\_\_\_\_
- learning to talk  toileting  attention \_\_\_\_\_
- staying alone  playing  learning \_\_\_\_\_

10. What words fit his PERSONALITY best:  social  leader  loner  joiner  fearful  temperamental  self-absorbed  
 shy  careful  serious  scattered  fighter  withdrawn  impulsive  aggressive  thoughtless  gothic  stoner  
 rigid  fearless  angry  fun  easy going  defiant  weird  studious  other \_\_\_\_\_

11. Did he have trouble GETTING ALONG \_\_\_\_\_  no

with  other kids  brothers/sisters  parents \_\_\_\_\_

teachers  other authority figures? \_\_\_\_\_

starting in  preschool  KG  grade \_\_\_\_\_

Any past trouble with the law?  no  yes \_\_\_\_\_

vandalism/theft  fires  drugs  truant \_\_\_\_\_

hurt animals  gang activity  violence \_\_\_\_\_

12. Did he WORRY about  leaving home  going to school  safety/health  being around people?  no  
When worried, did he have  stomach pains  trouble sleeping  nightmares  panic attacks? Other: \_\_\_\_\_  no

Did he ever try to harm himself? Explain: \_\_\_\_\_  no

13. Did he undergo TRAUMA such as  DEATHS, illness or losses  parents DIVORCED  witness ABUSE?  no

Was he abused, mistreated or abandoned?  yes  no Explain this section below

How was he PUNISHED?  NA \_\_\_\_\_

timed out  grounded  points \_\_\_\_\_

natural consequences  belted \_\_\_\_\_

lectured  chores  other \_\_\_\_\_

Was he  poorly accepted or \_\_\_\_\_

rejected by his parents \_\_\_\_\_

raised by foster parents? \_\_\_\_\_

Did his parents lose control? \_\_\_\_\_

Did either use drugs or alcohol? \_\_\_\_\_

Were they in trouble with the law? \_\_\_\_\_

## Everyday life

14. School \_\_\_\_\_  none. What grade is he in? \_\_\_\_\_ What grade should he be in? \_\_\_\_\_  
 Learning disability  NA  yes:  reading  math  written language  verbal  receptive  expressive  processing  speech Other \_\_\_\_\_  
 Special classes:  none  resource  self-contained  other: \_\_\_\_\_ Was he  RPC'd  Suspended  Expelled  Special schooled: \_\_\_\_\_
- Give some idea of his range of grades last year  As  Bs  Cs  Ds  Fs. Is this different than before?  yes  no  
 When did this change? \_\_\_\_\_ Why? \_\_\_\_\_
15. Does he do chores or work  NA?  yes  no What does he do? \_\_\_\_\_
16. Does he follow any religion or spiritual practice? \_\_\_\_\_  none
17. Problems and stress. Check all areas of concern.
- |  |   |  |   |   |   |  |                                |
|--|---|--|---|---|---|--|--------------------------------|
| <input type="checkbox"/> <b>PERSONAL</b>     | <input type="checkbox"/> self-control   | <input type="checkbox"/> motivation        | <input type="checkbox"/> concentration  | <input type="checkbox"/> fatigue          | <input type="checkbox"/> mood             | <input type="checkbox"/> organization            | <input type="checkbox"/> grief |
|  | <input type="checkbox"/> family illness | <input type="checkbox"/> health            | <input type="checkbox"/> accident       | <input type="checkbox"/> adoption         | <input type="checkbox"/> parenting        | <input type="checkbox"/> home/household/move(s)  |                                |
| <input type="checkbox"/> <b>RELATIONSHIP</b> | <input type="checkbox"/> friend(s)      | <input type="checkbox"/> roommate          | <input type="checkbox"/> girl/boyfriend | <input type="checkbox"/> coach/tutor      | <input type="checkbox"/> teacher          | <input type="checkbox"/> plays with younger kids |                                |
| <input type="checkbox"/> <b>FAMILY</b>       | <input type="checkbox"/> fighting       | <input type="checkbox"/> conflicts/divorce | <input type="checkbox"/> custody        | <input type="checkbox"/> sibling problems | <input type="checkbox"/> parents          | <input type="checkbox"/> other relatives         |                                |
| <input type="checkbox"/> <b>SCHOOL</b>       | <input type="checkbox"/> performance    | <input type="checkbox"/> concentration     | <input type="checkbox"/> behavioral     | <input type="checkbox"/> disability       | <input type="checkbox"/> accommodation    | <input type="checkbox"/> conflicts               |                                |
| <input type="checkbox"/> <b>HABIT</b>        | <input type="checkbox"/> alcohol/drug   | <input type="checkbox"/> gambling          | <input type="checkbox"/> sexual         | <input type="checkbox"/> obsession        | <input type="checkbox"/> impulsivity      | <input type="checkbox"/> other behavioral        |                                |
| <input type="checkbox"/> <b>LEGAL</b>        | <input type="checkbox"/> probation      | <input type="checkbox"/> parental fitness  | <input type="checkbox"/> competency     | <input type="checkbox"/> drug/alcohol     | <input type="checkbox"/> community safety | <input type="checkbox"/> criminal allegation     |                                |

18. Explain how he copes with stress: \_\_\_\_\_

How well do you think he is doing?  poorly  could be better  varies  very well  in denial

19. What are his strengths and interests?  reading  writing  music (what kind) \_\_\_\_\_  play sports (which one) \_\_\_\_\_  
 faith/prayer  community/church  building/mechanics/computer  chores  shopping  collections  video/computer games  plays instrument  
 movies/TV  art/photo  travel  friends/social  blogs/chat/online  gamble  journal  design /fashion  coach/volunteer  other: \_\_\_\_\_

## Family

20. Did he go through divorce?  yes  no Was it difficult?  yes  no Is it still?  yes  no  
 Are/were there problems with  legal custody  physical custody  visitation  alimony/child support  parental differences  abuse allegations  
 Explain: \_\_\_\_\_

21. Have any of his blood relatives had EMOTIONAL, BEHAVIORAL or ADDICTION problems?  yes  no  
 addiction  drugs  alcohol  learning disability  ADHD  Manic depression/bipolar  depression  anxiety  panic  autism  
 obsessive/compulsions  psychosis/schizophrenia  diagnosis unknown  needed medication  hospitalized  other: \_\_\_\_\_

### 22. List his family members living in his home(s). Use an "[s]" in the box to indicate step-relative.

Example SUSAN SAMPLER . age 15 . mom dad sister brother  \_\_\_\_\_ -->  Lives with him  other home her father

Name \_\_\_\_\_ . age \_\_\_\_ . mom dad sister brother  \_\_\_\_\_ -->  Lives w/him  other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . mom dad sister brother  \_\_\_\_\_ -->  Lives w/him  other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . mom dad sister brother  \_\_\_\_\_ -->  Lives w/him  other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . mom dad sister brother  \_\_\_\_\_ -->  Lives w/him  other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . mom dad sister brother  \_\_\_\_\_ -->  Lives w/him  other home \_\_\_\_\_

His visitation schedule is  NA: \_\_\_\_\_



## Drug and Alcohol Profile

Check here if this section is  Not Applicable

Has anyone told him they were concerned about his drug or alcohol use?  yes  no  
 Does it annoy him when others tell him how they feel about his drinking or use?  yes  no  
 Has he ever felt guilty about drinking?  yes  no  
 Did he ever drink to get the day started when he first woke up (had an eye-opener)?  yes  no

Has he ever: had a seizure while withdrawing from alcohol or drugs?  yes  no  
 hallucinated, had shakes, anxiety, agitation or physical craving after stopping?  yes  no  
 gone to two or more, or switched doctors to get more prescriptions?  yes  no

Has he ever lost memory due to alcohol or drugs?  temporarily  permanently  Ever blacked out?  
 Ever overdose  on purpose?  by accident?  go to the hospital?  stomach pumped?  admitted overnight?  
 If he no longer drink or use drugs, why did he stop? \_\_\_\_\_

Ever go to  AA  NA  CA  ACOA  Al-anon  Ever have a sponsor?  Is he familiar with the 12 steps?

## Check all the substances he has tried and circle his favorites.

When did he start?

	Age	How much and how often do/did he use? Cost per week.	Did he stop?	When
<input checked="" type="checkbox"/> EXAMPLE (weed)	10	One or two blunts every day. \$50 to \$300 per week	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	2 months ago
<input type="checkbox"/> alcohol	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> weed/marijuana	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> crystal meth/speed	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> cocaine/ crack	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> XTC/ecstasy/MDMA/X	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> heroin	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> mushrooms/peyote	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> LSD/ PCP	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> GHB/ DXM/ K	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> sherm	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> Xanax/Valium/Ativan	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> barbiturates	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> other prescriptions	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> huffing paint, glue, etc.	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> other _____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> I mixed them as follows _____				

Did he get into legal or other trouble in any way due to his substance use? Please explain:

List any other addiction he might have. \_\_\_\_\_

# CHILD Psych Symptoms Checklist –(Boy)

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Son's Name \_\_\_\_\_

Date \_\_\_\_\_

Filled out by \_\_\_\_\_

Relationship \_\_\_\_\_

*This questionnaire defines your son's problem areas. Many of these questions may not apply to him. Some may sound strange, or be inappropriate but please do your best. You can ask questions and explain your answers during the interview.*

**Check** NOW, PAST, or N/A (Not Applicable/appropriate) for each line as it applies to your son NOW, in the past only, both or neither.

For example:

**NOW PAST N/A**

- Does your son like to watch television?  
   Does your son drive carefully?  
   Does your son have allergies?  
   Does your son wet his bed?

**If your son has DEPRESSION, please describe what it is like for him:** (If not, check  here, and move on to page 2)

**NOW PAST N/A**

- Does his depression or sadness COME AND GO frequently?  
   Do his moods come OUT of the BLUE?  
   Is his depression triggered by things that HAPPEN?  
   Does he stay depressed for 2 WEEKS or more with little if any relief?

When he is depressed, does he:

**NOW PAST N/A**

- ... lose his ENERGY?  
   ... have a "WHATEVER" attitude *only* when he is depressed?  
   ... lose INTEREST in everything? ...  slow down ...  become RESTLESS?  
   ... lose his APPETITE? ...  LOSE weight ...  GAIN weight?  
  
   Does he have trouble FALLING ASLEEP?  
   ... wake up in the  MIDDLE of the night, or  EARLY in the morning?  wake up IN A PANIC?  
   ... need a lot of NAP TIME?  
   Does your son wake GASPING for breath?  SNORE?

During periods of depression, does your son:

**NOW PAST N/A**

- ... get very ANGRY AT HIMSELF? ...  all the time? ...  only when very depressed?  
   ... feel GUILTY for things that are not his fault?  
   ... STAY ALONE ...  MOPE around?  
   ... have trouble THINKING or CONCENTRATING?  
   ... CRY easily ...  seem DESPERATE?

If your son has thoughts about hurting himself:

**NOW PAST N/A**

- Do you have reason to believe he has INJURED HIMSELF on purpose?  
   Do you think he has THOUGHTS about taking his life?  
   Do you think that he has PLANS to do it?  
   Has he ever TRIED to end his life?

Do you think he has any such thoughts or plans NOW?

# CHILD Psych Symptoms Checklist –(Boy)

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Is your son ever ON EDGE (anxiety or panic) to an extreme? (If not, check [ ] here, and move on to the next section.)

**NOW PAST N/A**

- Do his nerves effect EVERY PART of his life?
- Does he have sudden ATTACKS ... MINUTES or ...  HOURS that go away quickly?
- ...does he stay nervous for a ... FEW DAYS, or ... is it  ALWAYS THERE?
- Does your son complain about FEELINGS IN HIS BODY when he gets upset, such as...
- PAINS in his ... CHEST, ... HEAD or ... STOMACH?
- When nervous, does your son have trouble BREATHING?
- ... complain that his ... HEART POUNDS? ... LOSES FEELING in his hands, head or feet?
- Does your son look SHAKY, SWEATY, FLUSHED or DIZZY when he gets nervous?
- Does your son AVOID PEOPLE or ... THINGS? \_\_\_\_\_
- Does he have extreme NIGHTMARES? For instance
- Does he talk about memories that are so real, it's like he is actually LIVING them?
- Does he ever seem to be OUT OF TOUCH like he is OUTSIDE OF HIS BODY as though he is watching a movie of his life instead of living it?

Does your son have abnormal MOVEMENTS of his face or other parts of his body?

(If not, check [ ] here, and move on to the next section below.)

**NOW PAST N/A**

- Does he get movements or irritations in his THROAT or MOUTH such as throat clearing or sniffing?
- Do his hands SHAKE a lot of the time?
- Do other parts of your his body JERK uncontrollably?
- Does this happen only when he is nervous?
- Does it happen at BEDTIME when he is trying to fall asleep?
- Does your son call out FOUL LANGUAGE out of the blue as though he has no control?
- Does your son have severe HEADACHES?
- Has he ever ... BLACKED-OUT ...  had FITS ...  FAINTED ...  SEIZURE(S)?
- Has your son WET or SOILED his clothes? ...  DURING BLACKOUTS?

Does your son have:

**NOW PAST N/A**

- THOUGHTS that just WON'T GO AWAY?
- ... the need to DO THINGS OVER AND OVER almost unable to stop?
- ... uncontrollable urges such as CHECKING his body, locking the door over and over again, washing, counting, or having to have everything ...  "JUST SO"?
- If your son tries to control these, does it seem to be extremely UNCOMFORTABLE for him?

Does your son take things very SERIOUSLY to the point that he performs:

- RITUALS, ROUTINES or HABITS that don't make sense?
- Would you or others describe your son as RIGID?
- Do you ever think that your son's "trying to be PERFECT" gets out of hand?

Does your son

**NOW PAST N/A**

- BINGE eat or PURGE food?
- Use LAXATIVES or make himself VOMIT?
- Does your son think he or he is over-weight whiles others see him as just fine?

## CHILD Psych Symptoms Checklist –(Boy)

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Has he done things OUT OF CHARACTER such as:

**NOW PAST N/A**

- Gone SEVERAL NIGHTS WITH LITTLE IF ANY SLEEP?  
   SPENT a lot? ...  GAVE away THINGS he treasured?  
   Shown a lot of ...  ENERGY? Acted exceptionally ...  STRONG or...  SMART?  
   Treated OTHERS POORLY, acted RUDE, HOSTILE or ARGUMENTATIVE out of character?  
   Did your son feel SHAME or regret LATER about unusual things he did?  
   Has his SEXUAL DRIVE or behavior ever been a concern to you?  
   Does he get very, very focused on HORROR films, PAIN or REVENGE?  
   Did your son show signs of EXTREME JEALOUSY?  
   Do these characteristics come and go together in episodes?  
   Are they part of his EVERYDAY behavior?  
   Do you think these out of character reactions are due only to drug use?  
   Is your son showing these characteristics now?

Did your son ever say that BIZARRE things were happening, such as:

**NOW PAST N/A**

- VOICES whispering, talking, calling his name or swearing at him?  
   SMELLING things no one else does?  
   ... heard or saw THINGS or PEOPLE that no one else does?  
   ... lost his sense of DIRECTION ...  MEMORY?  
   Has your son ever said that things looked like they were breathing, shrinking or growing?

Has he:

**NOW PAST N/A**

- stopped TAKING CARE of himself?  
   become ill at ease WITH PEOPLE?  
   ... lost his SENSE OF HUMOR?  
   ... said that the RADIO or T.V. was TALKING to him?  
   ... said his THOUGHTS WERE BEING READ or CONTROLLED?  
   Does he have thoughts or beliefs that are IRRATIONAL and hard to follow, understand or believe  
(aside from those other kids his age might have)?  
   Do you think ALCOHOL or DRUGS were responsible for these reactions?

Would you use any of the following terms to describe your son's USUAL behavior?

- |                                  |                                     |   |   |  |
|----------------------------------|-------------------------------------|---|---|--|
| <input type="checkbox"/> Selfish | <input type="checkbox"/> Steals     | <input type="checkbox"/> Inattentive    | <input type="checkbox"/> Stubborn           | <input type="checkbox"/> Hurts animals         |
| <input type="checkbox"/> Fidgety | <input type="checkbox"/> Sets fires | <input type="checkbox"/> Destructive    | <input type="checkbox"/> Anti-authority     | <input type="checkbox"/> Lacks conscience      |
| <input type="checkbox"/> Lies    | <input type="checkbox"/> Fights     | <input type="checkbox"/> Restless       | <input type="checkbox"/> Distractible       | <input type="checkbox"/> Insensitive to pain   |
| <input type="checkbox"/> Willful | <input type="checkbox"/> Argues     | <input type="checkbox"/> Irresponsible  | <input type="checkbox"/> Calls out in class | <input type="checkbox"/> Can't wait turn       |
| <input type="checkbox"/> Bullies | <input type="checkbox"/> Cheats     | <input type="checkbox"/> Disrespectful  | <input type="checkbox"/> Short attention    | <input type="checkbox"/> Acts without thinking |
| <input type="checkbox"/> Hateful | <input type="checkbox"/> Whines     | <input type="checkbox"/> Demanding      | <input type="checkbox"/> Takes risks        | <input type="checkbox"/> Uncaring about others |
| <input type="checkbox"/> Abusive | <input type="checkbox"/> Defiant    | <input type="checkbox"/> Out of control | <input type="checkbox"/> Manipulative       | <input type="checkbox"/> Other:                |

Describe any illegal or other activities not covered elsewhere that you are concerned about below or on the back.

# Release of information

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Filled out by applicant, parent or guardian, completed by assistant.

Today's date \_\_\_\_\_

**Applicant** \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize Dr. Roitman and his staff to (check all that are applicable):

- exchange information with:
  - only request information from:
  - only release information to:

Name \_\_\_\_\_ Title \_\_\_\_\_

Street \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ fax \_\_\_\_\_ cell \_\_\_\_\_ **Initial** \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Street \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ fax \_\_\_\_\_ cell \_\_\_\_\_ **Initial** \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Street \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ fax \_\_\_\_\_ cell \_\_\_\_\_ **Initial** \_\_\_\_\_

NORTON A. ROITMAN, MD  
2340 PASEO DEL PRADO #D 307  
LAS VEGAS, NEVADA 89102

Phone 702-222-1812 Fax 702-222-1786 eMail: NRoitmanMD@gmail.com

The purpose of this release of information is to

- Coordinate treatment with other providers
- Verify attendance
- Evaluate status
- Obtain assistance
- Other \_\_\_\_\_

I release Norton A. Roitman, MD and his staff from any legal liability resulting from the release of this information with the understanding that reasonable professional safeguards will be taken. Unless otherwise specified, release authorization will expire in one year. Release of information is subject to revocation at any time.

Responsible party \_\_\_\_\_ Staff \_\_\_\_\_