

Life Development Resources, P.A.

Date _____ Therapist _____ DX Code _____

Patient Information

Patient Name (Print) _____ Date of Birth _____

Street Address _____ Home Phone _____
 City _____ State _____ ZIP _____ Work Phone _____
 Okay to Leave Message? ___ Yes ___ No

Soc Sec # _____ Cell Phone _____

Emergency Contact _____ Emergency Phone _____

Sex: ___ M ___ F Age _____ Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Other

Employer _____ Occupation _____

Referred by _____

Primary Insurance

Primary Insurance Company _____ Phone _____

Ins Claims Address _____ City _____ State _____ Zip _____

Policy/ID _____ Group/Plan ID _____

For Health Partners Only: Policy Holder's ID _____

Name of Policyholder _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Soc Sec # _____ Employer _____ Date of Birth _____

Secondary Insurance

Secondary Insurance Company _____ Phone _____

Ins Claims Address _____ City _____ State _____ Zip _____

Policy/ID _____ Group/Plan ID _____

Name of Policyholder _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Soc Sec # _____ Employer _____ Date of Birth _____

Responsible Party

Name _____ Relationship _____

Address _____ Phone _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the healthcare provider to release all necessary information to A.C.E. Billing, Inc, to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____

LIFE DEVELOPMENT RESOURCES, P.A.

10591 165th St. W., Lakeville, MN 55044

Ph: (952) 898-1133 Fax: (952) 435-6797

ADOLESCENT PSYCHOLOGICAL INTAKE (Age 12-18) (To be filled out by adolescent)

Your Name: _____

Therapist Name: _____

Date of Birth: _____

Date of Intake: _____

1. Presenting Problems and Symptoms

- ◆ What are the main reasons for coming to therapy? _____

- ◆ How long has this been a problem for you? _____

THIS SPACE RESERVED FOR THERAPIST

2. Social / Family History

Personal

- ◆ Who do you live with? _____
- ◆ Your Age: _____
- ◆ Where were you born? _____
- ◆ Ethnicity: _____
- ◆ Sex: ___ male ___ female
- ◆ Do you have a history of any of the following types of abuse?

	<u>When</u>	<u>By Whom</u>
Physical	_____	_____
Sexual	_____	_____
Emotional	_____	_____
Neglect	_____	_____
- ◆ Any other type of victimization such as bullying? ___no ___yes: _____
- ◆ Have there been any other adults or children living in the home either past or present? ___no ___yes: _____

Peer Relationships

- ◆ Do you seek friendships with peers? _____
- ◆ Are you sought by peers for friendship? _____
- ◆ Are your friends primarily your age? ____ If no, are they generally younger? ____ Older? ____
- ◆ Describe briefly any problems you may have with peers _____

- ◆ Describe briefly the strengths you may have with peers _____

- ◆ All adolescents exhibit, to some degree, the kinds of behavior listed below. Check those that you believe you exhibit to an excessive or exaggerated degree when compared to other adolescents your age.
 - Hyperactivity (high activity level) _____
 - Short attention span _____
 - Impulsivity (poor self-control) _____
 - Low frustration threshold _____
 - Temper outbursts _____
 - Interrupting frequently _____
 - Ignoring requests when spoken to _____
 - Sudden outbursts of physical abuse directed at others _____
 - Act like you are driven by a motor _____
 - Heedless to danger _____
 - Excessive number of accidents _____
 - Poor memory _____
 - More active than siblings _____

Interests and Accomplishments

- ◆ What are your main hobbies and interests? _____

- ◆ What are your areas of greatest accomplishment? _____

- ◆ What do you enjoy doing most? _____

- ◆ What do you dislike doing most? _____

Employment (if applicable)

- ◆ Where do you work? _____
- ◆ What do you do? _____
- ◆ How long have you been there? _____ How many hours per week do you work? _____
- ◆ Any significant work-related problems or difficulties? _____

Legal Issues

- ◆ History of legal issues ____ no ____ yes: _____
- ◆ Arrests ____ no ____ yes: _____
- ◆ Convictions ____ no ____ yes: _____

◆ DWI ___ no ___ yes: _____

◆ Current legal issues? ___ no ___ yes: _____

Religious / Spiritual

◆ Do you have a current religious affiliation? ___ no ___ yes: _____

◆ Name of church you attend or belong to: _____

◆ How important is your religion and/or spirituality to you? _____

◆ Were you raised with a religious background? ___ no ___ yes: _____

◆ Do you have spiritual concerns? ___ no ___ yes: _____

THIS SPACE RESERVED FOR THERAPIST (Social/Family)

3. Medical History

◆ Have you gained or lost weight in the past year? ___ no ___ yes: _____ lbs.

◆ Present Height _____ Present Weight _____

◆ Has your appetite increased or decreased during the past year? ___ no ___ yes: _____

◆ Do you generally eat healthy? ___ no ___ yes

◆ How much exercise do you get per week and what kind of exercise do you do? _____

◆ Do you use a hearing aid or have difficulties hearing? ___ no ___ yes

◆ Do you have any problems walking or getting around? ___ no ___ yes

◆ Do you have any problems with shakes, tics, or tremors? ___ no ___ yes

◆ Do you have any problems with vision? ___ no ___ yes

- ◆ Do you feel like anyone is out to get you? ___ no ___ yes: _____
- ◆ Sleep
 - ◆ Are you having any difficulties sleeping? ___ no ___ yes: _____
 - ◆ How many hours of sleep do you get per night? _____
 - ◆ Do you have nightmares? ___ no ___ yes: _____
 - ◆ Insomnia? ___ no ___ yes: _____
 - ◆ Do you wake too early in the A.M.? ___ no ___ yes: _____
 - ◆ Do you wake up frequently during the night? ___ no ___ yes: _____
- ◆ Have you ever tried to kill yourself? ___ no ___ yes: _____
- ◆ Do you currently feel like killing yourself? ___ no ___ yes: _____
- ◆ Have you ever done things to hurt yourself on purpose? (cutting, hitting, burning ,etc.)
___ no ___ yes: _____
- ◆ Do you currently feel like killing someone else? ___ no ___ yes: _____
- ◆ What makes you angry? _____
- ◆ What do you do when you get angry? _____

Drug and Alcohol Issues

- ◆ Have you ever had a chemical dependency evaluation? ___ no ___ yes
When? _____ Where? _____
- ◆ Have you ever had chemical dependency treatment?
When? _____ Where? _____
- ◆ Do you attend AA or NA? ___ no ___ yes: _____
- ◆ Have you ever had a blackout? ___ no ___ yes: _____
- ◆ Have you used more than one **chemical** at the same time in order to get high? ___no ___yes
- ◆ Do you **avoid** family activities so you can use? ___no ___yes
- ◆ Do you have a **group** of friends who use? ___no ___yes
- ◆ Do you use to improve your **emotions** such as when you feel sad or depressed? ___no ___yes
- ◆ Do you smoke cigarettes? ___no ___yes: How often? _____ How much? _____
- ◆ Caffeine use? ___ cups of coffee per day ___ cans of pop per day (with caffeine) ___ other _____
- ◆ Check off the substances you have used/tried and indicate how much & how often used **in the past month**
 - ___Alcohol ___LSD ___Cocaine ___Mushrooms ___Marijuana
 - ___Ecstasy ___Crack ___Speed ___Crank ___Meth
 - ___Heroin ___Inhalants – gas, glue, etc. ___Nicotine
 - ___Prescription Drugs (used without prescription) What? _____
 - ___Pain medications other than aspirin, Tylenol, etc. What? _____
 - ___Sleeping medications What? _____
 - ___Other (Name) _____

SYMPTOM CHECKLIST – (To Be Filled Out By Adolescent)

Please mark all of the symptoms that currently apply to you. If there are symptoms that you have also experienced in the past, please indicate these.

<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>	<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>
___	___	Parent/sibling problems	___	___	Racing thoughts
___	___	Relationship problems	___	___	Distractible
___	___	Difficulties with family	___	___	Excessive energy
___	___	Step-family problems	___	___	Overspending
___	___	Divorce issues	___	___	Anxiety
___	___	Difficulties with friends	___	___	Panic attacks
___	___	School problems	___	___	Fears of being outside the home alone
___	___	Work problems	___	___	Fears of being in a crowd or standing in line
___	___	Serious physical illness (in yourself)	___	___	Phobia
___	___	Serious physical illness (in someone else)	___	___	Fears of social situations
___	___	Death of family member	___	___	Obsessive thoughts
___	___	Death of friend	___	___	Compulsive behaviors
___	___	Depressed mood	___	___	Behavior to undo things
___	___	Loss of interest in activities	___	___	Physical abuse to others
___	___	Withdrawn/isolation	___	___	Physical abuse by others
___	___	Weight loss	___	___	Verbal abuse to others
___	___	Weight gain	___	___	Verbal abuse by others
___	___	Increase in appetite	___	___	Sexual abuse to others
___	___	Decrease in appetite	___	___	Sexual abuse by others
___	___	Sleep difficulties	___	___	Intrusive memories
___	___	Feeling restless or agitated	___	___	Recurrent distressing dreams
___	___	Fatigue or loss of energy	___	___	Recurrent flashbacks
___	___	Feeling worthless	___	___	Easily startled
___	___	Feeling guilty	___	___	Difficulties controlling worry
___	___	Feeling hopeless	___	___	Restlessness
___	___	Feeling ashamed	___	___	Feeling keyed up or on edge
___	___	Low self-esteem	___	___	Mind going blank
___	___	Trouble with concentration	___	___	Episodes of lost time
___	___	Trouble with memory	___	___	Episodes of unexplainable actions
___	___	Attention problems	___	___	Excessive fantasy or daydreaming
___	___	Confusion	___	___	Difficulty trusting others
___	___	Trouble making decisions	___	___	Avoidance of conflict
___	___	Suicidal thoughts	___	___	Shy/uneasy around others
___	___	Suicidal urges	___	___	Muscle tension
___	___	Suicidal plan	___	___	Headaches
___	___	Self-injury (e.g. burning, cutting)	___	___	Stomach aches
___	___	Crying spells	___	___	Motor or vocal tic
___	___	Anger	___	___	Overeating
___	___	Irritability	___	___	Not eating enough
___	___	Loss of temper/outbursts	___	___	Starving self to lose weight
___	___	Mood swings	___	___	Dissatisfaction with appearance
___	___	Inflated self-esteem or grandiosity	___	___	Gambling
___	___	Decreased need for sleep (e.g. feel rested after only 3 hours of sleep)	___	___	Overuse of Computer or Internet
___	___	More talkative than usual	___	___	Alcohol Abuse
___	___		___	___	Drug Abuse

<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>
_____	_____	Hold grudges, unforgiving
_____	_____	Sexual problems
_____	_____	Low sexual interest
_____	_____	Sexual orientation concerns
_____	_____	Lack close friends
_____	_____	Unusual thoughts or perceptions
_____	_____	Stealing
_____	_____	Breaking the law
_____	_____	Impulsive
_____	_____	Physical Fights
_____	_____	Aggressive/Violent behavior
_____	_____	Fears of abandonment
_____	_____	Difficulties with identity
_____	_____	Chronic feelings of emptiness
_____	_____	Need to be center of attention
_____	_____	Require excessive admiration
_____	_____	Believe others are envious of you
_____	_____	Arrogant
_____	_____	Avoid school/work due to fear of criticism
_____	_____	Fear of failure
_____	_____	Unwilling to get involved in things unless certain of being liked
_____	_____	Feel socially inferior
_____	_____	Reluctant to take risks due to embarrassment
_____	_____	Need to be liked by others
_____	_____	Need to please others
_____	_____	Difficulty saying "no"
_____	_____	Feel uncomfortable when alone
_____	_____	Difficulty making decisions
_____	_____	Fear of disapproval
_____	_____	Very occupied with details, lists, order
_____	_____	Perfectionism
_____	_____	Difficulties throwing things away
_____	_____	Hoard things
_____	_____	Rigid
_____	_____	Stubborn
_____	_____	Excessive devotion to work
_____	_____	Often fail to give close attention to details or make careless mistakes in schoolwork, work, or other activities
_____	_____	Often have difficulty sustaining attention in tasks or activities
_____	_____	Often do not seem to listen when spoken to directly
_____	_____	Often do not follow through on instructions & fail to finish schoolwork, chores, or duties in the workplace
_____	_____	Often have difficulty organizing tasks and activities

<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>
_____	_____	Often avoid, dislike, or are reluctant to engage in tasks that require sustained mental effort (such as homework)
_____	_____	Often lose things necessary for tasks or activities (e.g. assignments, pencils, books, or tools)
_____	_____	Often easily distracted by extraneous stimuli
_____	_____	Often forgetful in daily activities
_____	_____	Often fidget with hands or feet or squirm in seat
_____	_____	Often leave seat in classroom or in other situations in which remaining seated is expected
_____	_____	Often feel restless
_____	_____	Often have difficulty engaging in leisure activities quietly
_____	_____	Often "on the go" or act as if "driven by a motor"
_____	_____	Often talk excessively
_____	_____	Often blurt out answers before questions have been completed
_____	_____	Often have difficulty awaiting turn
_____	_____	Often interrupt or intrude on others (e.g. butt into conversations or games)
_____	_____	Other symptoms not listed:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any other concerns that you would like to alert me of or elaborate on at this time? (Please feel free to discuss concerns in person. This form is intended to help to obtain a great deal of information in a short period of time. It is not intended to replace important discussions with you.)

TO BE FILLED OUT BY PARENT(S)

1. Social / Family History

Family

◆ Child's Parents

Father's Name: _____ Age: _____ Living ___ Deceased ___

Occupation: _____ Where does he live? _____

Mother's Name: _____ Age: _____ Living ___ Deceased ___

Occupation: _____ Where does she live? _____

◆ Child's brothers and/or sisters or step-siblings (list names, ages, occupations & where they live)

◆ Mother: Age _____ Age at time of pregnancy with patient _____

Number of Previous Pregnancies _____ Number of Spontaneous Abortions (Miscarriages) _____

Number of Induced Abortions _____

Infertility Problems (specify) _____

School: Highest Grade Completed _____

Learning Difficulties (specify) _____

Behavioral Difficulties (specify) _____

Medical Problems (specify) _____

Have any of your biological relatives (not including patient and siblings) ever had problems similar to those of your child?

If so, describe. _____

◆ Father: Age _____

School: Highest Grade Completed _____

Learning Difficulties (specify) _____

Behavioral Difficulties (specify) _____

Medical Problems (specify) _____

Have any of your biological relatives (not including patient and siblings) ever had problems similar to those of your child?

If so, describe. _____

Does anyone in your family (parents, siblings, children, grandparents, etc.) have problems or previously have problems with depression, anxiety, confusion, drug or alcohol abuse, or other mental health issues?

Education

◆ Name of child's current school: _____ Current grade _____

◆ Rate your child's school experiences related to academic learning: Good _____ Average _____ Poor _____

◆ To the best of your knowledge, at what grade level is your child functioning: Reading _____ Spelling _____ Arithmetic _____

◆ Has your child ever had to repeat a grade? If so, when _____

◆ Present Class Placement: Mainstream _____ Special Class (if so, specify) _____

- ◆ Academic Issues ___ no ___ yes: _____

- ◆ Kinds of special therapy or remedial work your child is currently receiving _____

- ◆ Learning Disability ___ no ___ yes: _____
- ◆ Any testing/ IEP _____
- ◆ Does your child's teacher describe any of the following as significant classroom problems?
 - Fidgeting in his/her seat _____
 - Frequently getting up and walking around the classroom _____
 - Shouting out/Not waiting to be called upon _____
 - Having difficulty waiting for his/her turn _____
 - Not cooperating well in group activities _____
 - Typically doing better in one-to-one relationships _____
 - Having difficulty respecting the rights of others _____
- ◆ Describe briefly any other classroom behavioral problems: _____

- ◆ All adolescents exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other adolescents their age.
 - Hyperactivity (high activity level) _____
 - Short attention span _____
 - Impulsivity (poor self-control) _____
 - Low frustration threshold _____
 - Temper outbursts _____
 - Interrupting frequently _____
 - Ignoring requests when spoken to _____
 - Sudden outbursts of physical abuse directed at others _____
 - Act like you are driven by a motor _____
 - Headless to danger _____
 - Excessive number of accidents _____
 - Poor memory _____
 - More active than siblings _____

2. Medical History

Physical

Has your child ever been hospitalized for physical reasons? ___ no ___ yes, for: _____

Where? _____ When? _____

Current physical problems? _____

Current medications? (Please list)

Name of medications	Dosage	What for?	Prescribed by:

Past medications (only psychotropic) _____

Physician

Physician's Name: _____ Phone Number: (____) _____
 Clinic Name & Address _____
 Date of last physical: _____

History of physical problems

Does your child have a thyroid condition? ___ no ___ yes: _____
 Any allergies? ___ no ___ yes: _____
 Has your child ever lost consciousness? ___ no ___ yes: _____
 Has your child ever had head injuries? ___ no ___ yes: _____
 Has your child ever had seizures? ___ no ___ yes: _____

5. Mental Health History

Psychiatric

- ◆ Has your child ever been hospitalized for *psychiatric* reasons? ___ no ___ yes, for _____
- ◆ Where? _____
- ◆ When? _____ How long? _____
 (Use back of page if necessary)

Counseling -- Please list counselors or psychiatrists your child has seen before or are seeing now:

- ◆ Name _____ Phone Number (____) _____
 Clinic & Address: _____
 When? _____ Purpose: _____
- ◆ Name _____ Phone Number (____) _____
 Clinic & Address: _____
 When? _____ Purpose: _____
 (Use back of page if necessary)

Testing

- ◆ Has your child ever taken any psychological testing? ___ no ___ yes
- ◆ Who administered the testing? _____
- ◆ What testing did you do? (Intellectual? MMPI? Ink blots? Other?) _____

SYMPTOM CHECKLIST – (To Be Filled Out By Parent)

Please mark all of the symptoms that currently apply to your child. If there are symptoms that they have also experienced in the past, please indicate these.

<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>	<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>
___	___	Parent/sibling problems	___	___	Racing thoughts
___	___	Relationship problems	___	___	Distractible
___	___	Difficulties with family	___	___	Excessive energy
___	___	Step-family problems	___	___	Overspending
___	___	Divorce issues	___	___	Anxiety
___	___	Difficulties with friends	___	___	Panic attacks
___	___	School problems	___	___	Fears of being outside the home alone
___	___	Work problems	___	___	Fears of being in a crowd or standing in line
___	___	Serious physical illness (in yourself)	___	___	Phobia
___	___	Serious physical illness (in someone else)	___	___	Fears of social situations
___	___	Death of family member	___	___	Obsessive thoughts
___	___	Death of friend	___	___	Compulsive behaviors
___	___	Depressed mood	___	___	Behavior to undo things
___	___	Loss of interest in activities	___	___	Physical abuse to others
___	___	Withdrawn/isolation	___	___	Physical abuse by others
___	___	Weight loss	___	___	Verbal abuse to others
___	___	Weight gain	___	___	Verbal abuse by others
___	___	Increase in appetite	___	___	Sexual abuse to others
___	___	Decrease in appetite	___	___	Sexual abuse by others
___	___	Sleep difficulties	___	___	Intrusive memories
___	___	Feeling restless or agitated	___	___	Recurrent distressing dreams
___	___	Fatigue or loss of energy	___	___	Recurrent flashbacks
___	___	Feeling worthless	___	___	Easily startled
___	___	Feeling guilty	___	___	Difficulties controlling worry
___	___	Feeling hopeless	___	___	Restlessness
___	___	Feeling ashamed	___	___	Feeling keyed up or on edge
___	___	Low self-esteem	___	___	Mind going blank
___	___	Trouble with concentration	___	___	Episodes of lost time
___	___	Trouble with memory	___	___	Episodes of unexplainable actions
___	___	Attention problems	___	___	Excessive fantasy or daydreaming
___	___	Confusion	___	___	Difficulty trusting others
___	___	Trouble making decisions	___	___	Avoidance of conflict
___	___	Suicidal thoughts	___	___	Shy/uneasy around others
___	___	Suicidal urges	___	___	Muscle tension
___	___	Suicidal plan	___	___	Headaches
___	___	Self-injury (e.g. burning, cutting)	___	___	Stomach aches
___	___	Crying spells	___	___	Motor or vocal tic
___	___	Anger	___	___	Overeating
___	___	Irritability	___	___	Not eating enough
___	___	Loss of temper/outbursts	___	___	Starving self to lose weight
___	___	Mood swings	___	___	Dissatisfaction with appearance
___	___	Inflated self-esteem or grandiosity	___	___	Gambling
___	___	Decreased need for sleep (e.g. feel rested after only 3 hours of sleep)	___	___	Overuse of Computer or Internet
___	___	More talkative than usual	___	___	Alcohol Abuse
___	___		___	___	Drug Abuse

<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>
_____	_____	Hold grudges, unforgiving
_____	_____	Sexual problems
_____	_____	Low sexual interest
_____	_____	Sexual orientation concerns
_____	_____	Lack close friends
_____	_____	Unusual thoughts or perceptions
_____	_____	Stealing
_____	_____	Breaking the law
_____	_____	Impulsive
_____	_____	Physical Fights
_____	_____	Aggressive/Violent behavior
_____	_____	Fears of abandonment
_____	_____	Difficulties with identity
_____	_____	Chronic feelings of emptiness
_____	_____	Need to be center of attention
_____	_____	Require excessive admiration
_____	_____	Believe others are envious of you
_____	_____	Arrogant
_____	_____	Avoid school/work due to fear of criticism
_____	_____	Fear of failure
_____	_____	Unwilling to get involved in things unless certain of being liked
_____	_____	Feel socially inferior
_____	_____	Reluctant to take risks due to embarrassment
_____	_____	Need to be liked by others
_____	_____	Need to please others
_____	_____	Difficulty saying "no"
_____	_____	Feel uncomfortable when alone
_____	_____	Difficulty making decisions
_____	_____	Fear of disapproval
_____	_____	Very occupied with details, lists, order
_____	_____	Perfectionism
_____	_____	Difficulties throwing things away
_____	_____	Hoard things
_____	_____	Rigid
_____	_____	Stubborn
_____	_____	Excessive devotion to work
_____	_____	Often fail to give close attention to details or make careless mistakes in schoolwork, work, or other activities
_____	_____	Often have difficulty sustaining attention in tasks or activities
_____	_____	Often do not seem to listen when spoken to directly
_____	_____	Often do not follow through on instructions & fail to finish schoolwork, chores, or duties in the workplace
_____	_____	Often have difficulty organizing tasks and activities

<u>Past</u>	<u>Current</u>	<u>SYMPTOM</u>
_____	_____	Often avoid, dislike, or are reluctant to engage in tasks that require sustained mental effort (such as homework)
_____	_____	Often lose things necessary for tasks or activities (e.g. assignments, pencils, books, or tools)
_____	_____	Often easily distracted by extraneous stimuli
_____	_____	Often forgetful in daily activities
_____	_____	Often fidget with hands or feet or squirm in seat
_____	_____	Often leave seat in classroom or in other situations in which remaining seated is expected
_____	_____	Often feel restless
_____	_____	Often have difficulty engaging in leisure activities quietly
_____	_____	Often "on the go" or act as if "driven by a motor"
_____	_____	Often talk excessively
_____	_____	Often blurt out answers before questions have been completed
_____	_____	Often have difficulty awaiting turn
_____	_____	Often interrupt or intrude on others (e.g. butt into conversations or games)
_____	_____	Other symptoms not listed:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any other concerns that you would like to alert me of or elaborate on at this time? (Please feel free to discuss concerns in person. This form is intended to help to obtain a great deal of information in a short period of time. It is not intended to replace important discussions with you.)